

BUTLER HEALTH PLAN RE-ENROLLMENT

October 22, 2010 - November 22, 2010

What you need to know...

- ✓ If you currently have medical and/or dental coverage through Butler Health Plan, you have to complete the online re-enrollment.
- ✓ You will need to have an Account Number and Password from Allied Benefit Systems. If you do not have this, please follow the instructions on the next page.
- ✓ All changes made online to your medical and/or dental plans will be effective January 1, 2011. ***Remember...Open Enrollment is the only time you can make changes without a qualifying event.***
- ✓ Any changes needed prior to January 1, 2011 must be completed on an Enrollment/Change form. You cannot make these changes online.
- ✓ Use the Medical and Dental summaries (enclosed) to review your benefit options.
- ✓ There are two (2) ways to re-enroll:
 - Online...through www.alliedbenefit.com. Submit your changes no later than midnight of November 22, 2010. Please review to ensure your information is submitted correctly.
 - Paper...by completing an ***Enrollment/Change Form*** and returning it to your benefit representative no later than midnight November 22, 2010. ***This option is only if you are adding a spouse and/or dependent.***

Changes will not be accepted after November 22, 2010

ACCESSING BUTLER HEALTH PLAN ONLINE RE-ENROLLMENT

I'VE NEVER LOGGED ON TO ALLIED...WHAT DO I DO?

Through your web browser type www.alliedbenefit.com in the address line and press enter. You will be at the home page of Allied Benefits.



Select "**Request New Account**"

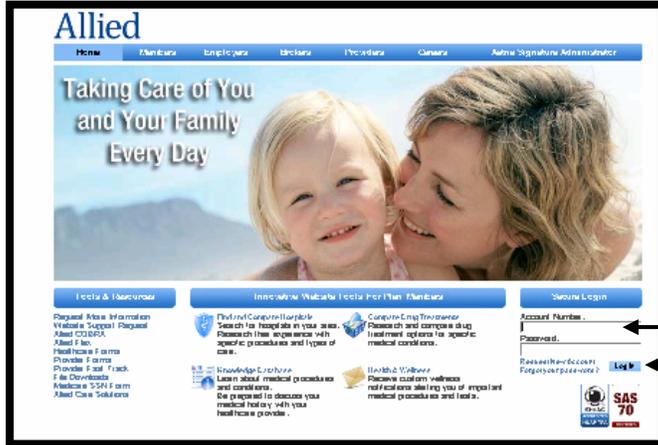
All fields must be completed. Note: The information you enter on this form must exactly match the account information in Allied's system. Your group number is located in the upper right corner of your ID card.

Press **SUBMIT**

After the form is submitted, you will receive a confirmation email to the email address that you provided. Keep this for your records. This information will be needed to access Allied Benefit System's website.

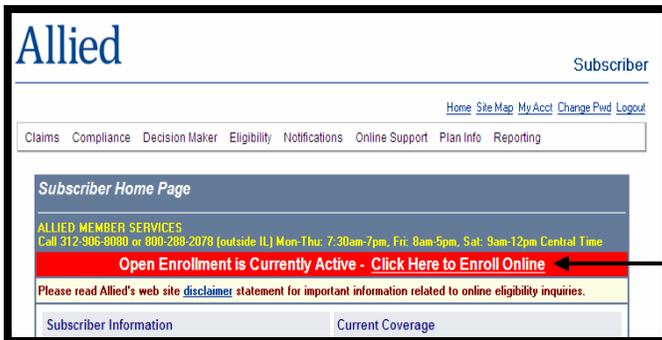
I HAVE MY ACCOUNT NUMBER AND PASSWORD...WHAT DO I DO NEXT?

Through your web browser type www.alliedbenefit.com in the address line and press enter. You will be at the home page of Allied Benefits.



Enter your *Account Number* and *Password*

Press **Log In**



Select "**Click Here to Enroll Online**"

Completing Re-Enrollment

Butler 2011 Open Enrollment

Open Enrollment Period 9/1/2010 to 10/30/2010 Enrollment Last Updated: 10/7/2010 9:21:40 AM

Data Formatting Rules
 Required fields denoted by * Provisionally required fields denoted by **
 Dates: MM/DD/YYYY Phone numbers: NNN-NNN-NNNN Zip codes: NNNNN or NNNNN-NNNN
 Money: NNNN.NN (no \$ symbol or other punctuation except decimal)

Subscriber Plan and Location Selection

Plan* CHOICE Location* GREAT OAKS INSTITUTE OF TECHNOLOGY
 Effective Date** 01/01/2011

IMPORTANT MESSAGE! - PLEASE READ - member benefits will be reset after a new plan is selected

Subscriber Information

First Name* CHARLES	Last Name* JONES	Middle Initial L	Gender* Male
Date of Birth* 04/23/1960	Soc Sec Num* 118811118	Medicare HIC Num** 155289695A	Unique ID** 118811118
Address Line 1* 210 N BROAD ST	Address Line 2	City* HARRIS	State* Ohio
Zip Code* 45030	Home Phone** 123-123-1234	Work Phone** 614-625-8574	Cell Phone** 614-623-3028
Address Effective Date** 01/01/2011	Marital Status* Married	Email Address** TEST@alliedbenefit.com Confirm** TEST@alliedbenefit.com	

Data Formatting Rules: Direction of how information is to be entered

Subscriber Plan and Location Selection:
 The online system will default to your current plan. Select the plan you elect as of January 1, 2011.

Subscriber Information:
 Update any blank field. Highlighted fields are mandatory. Verify the accuracy of your information.

Family Members

First Name* Social Sec Num*	Last Name* Medicare HIC Num**	Date of Birth* Relationship*	Gender*
MICHELE 123456789	JONES	12/02/1987 Spouse	Female
MICHAEL 321654987	JONES	04/21/1998 Dependent	Male
SARAH 789456123	CUNNINGHAM	11/09/1992 Dependent	Female
EVAN 123654789	JONES	06/24/1997 Dependent	Male

Member Benefits

Member Name	Relationship	Available Benefits
CHARLES	Subscriber	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHELE	Spouse	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHAEL	Dependent	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
SARAH	Dependent	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
EVAN	Dependent	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental

Family Members:

Update any blank field.
 Highlighted fields are mandatory.
 Verify the accuracy of your information

Member Benefits:

Selections for members will be effective January 1, 2011.
 Select Medical and/or Dental for each covered person

Member Benefits		
Member Name	Relationship	Available Benefits
CHARLES	Subscriber	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHELE	Spouse	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
MICHAEL	Dependent	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
SARAH	Dependent	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
EVAN	Dependent	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental
I am waiving: <input type="checkbox"/> Medical Coverage <input type="checkbox"/> Dental Coverage		

Waiving Coverage:

If you are waiving either medical or dental coverage for you or any covered person under the plan please select "I am waiving medical and dental coverage"

EVAN Dependent Medical Dental

I am waiving medical and dental coverage

Other Medical Insurance

Member	Other Ins?*	Relationship	Carrier Name**	Carrier Location (city, state, zip)**
CHARLES	<input type="radio"/> Yes <input checked="" type="radio"/> No	Subscriber		
MICHELE	<input checked="" type="radio"/> Yes <input type="radio"/> No	Spouse	CIGNA	ANY CITY, OH 45245
MICHAEL	<input type="radio"/> Yes <input checked="" type="radio"/> No	Dependent		
SARAH	<input type="radio"/> Yes <input checked="" type="radio"/> No	Dependent		
EVAN	<input type="radio"/> Yes <input checked="" type="radio"/> No	Dependent		

Important Notice - Please Read and Check the Confirmation Box(es) Below

Open Enrollment Disclaimer

General disclaimer text

I have read the above and certify that the above information is true and accurate

Click here to submit your enrollment Cancel

Other Medical Insurance: If you or any covered dependent has access to other insurance please provide this information

Important Notices: Please read the open enrollment disclaimer, by checking the box you have agreed to the terms and conditions of this enrollment.

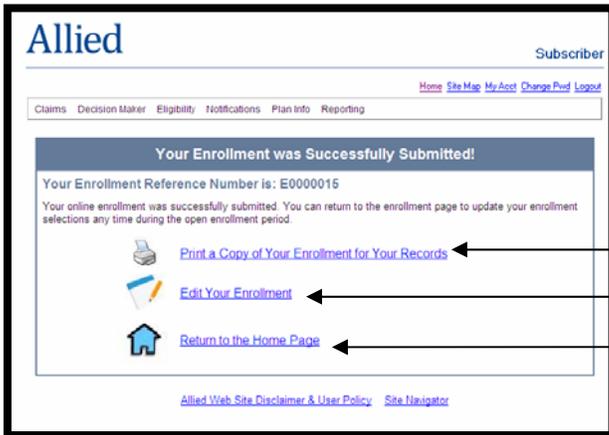
- a. Acknowledgment With Respect to Fraud. By checking the box, you are acknowledging you have read, understand and agree to the acknowledgement.
- b. Consent and Authorization. By checking the box, you are acknowledging you have read, understand and agree to the terms.

[Allied Web Site Disclaimer & User Policy](#) [Site Navigator](#)

Click here to submit your enrollment: Once you click this button your information will be submitted for re-enrollment to be effective January 1, 2011. You will see:

Your enrollment was successfully submitted!

Note: If you submit your enrollment and need to make additional changes, repeat the steps above and resubmit. This will override previous changes.



You can now:

- Print a copy of your enrollment for your records
- Edit your enrollment
- Return to the Home Page

Changes will not be accepted after November 22, 2010