



Ease allows you to view your benefit options and make benefit elections for you and your family. You can view plan details, coverage amounts and costs. Your family's information only needs to be entered once, in one place and all carrier application forms will automatically be completed.

1. You will receive an email with a link that you will use to register and access Ease. Click the Sign Up button within the email message.

Welcome Alicia,

Your Manager just added you to Ease.

Ease helps you manage your benefits and other important HR activities.

Please log in now and complete your profile here:

Important: This email is intended only for Alicia Cornwell and should not be forwarded to anyone else.

[Sign Up](#)

2. Once you click the link, you will need to choose a password. Please be sure the password has at least one uppercase letter, one lowercase letter, one special character or number and is at least 8 characters long. Click the Sign Up button to continue.

You have been invited to Ease. Please choose a password and click 'Sign Up' to continue.

Password *
Password

Confirm *
Confirm

I agree to the [Terms of Service](#)

Your password must contain a minimum of 8 characters, with at least 1 lowercase, 1 uppercase, and 1 numeric or special character.

[Sign Up](#)

[Sign In](#)



3. If you have logged in before, you will need to enter your email address or username and your password. If you are logging in with your mobile phone, select Log in with mobile phone. If you are having trouble logging in, select Forgot? If you need further assistance, select I need additional help to log in.

The image displays two screenshots of the login interface. The left screenshot shows a standard login form with a text input for 'Email or Username' containing 'example@email.com', a password input field with a 'Forgot?' link, a blue 'Login' button, and a link for 'Log in with mobile phone'. The right screenshot shows a 'Forgot your Password?' form with the title 'Request login assistance', an 'Enter your email address' field containing 'example@email.com', a blue 'Submit' button, and a link for 'I need additional help to log in'.

4. After you have logged in, you will click on the green Get Started button. You will also see links to Profile, Benefits, and Documents.

The image shows a user dashboard for Alicia Cornwell. At the top, there is a green banner for 'New Hire Onboarding' with the text 'Welcome to the team! Let's begin the onboarding process.' and a 'Get Started' button. On the left side, there is a sidebar with navigation links: 'Dashboard', 'Profile', 'Benefits', and 'Documents'.

5. Ease will walk you through the process of onboarding and enrolling in your benefits. After completing the optional onboarding module, you will be taken to enroll in benefits.



Benefits Enrollment

You're about to begin enrollment. Please note the following:

 Takes 10-15 mins ... or a cup of coffee	 Good to have ready Information about your dependents, Medicare, and previous coverage (if applicable)	 Your progress will be saved Exit and finish later if you need to
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[Start](#)

6. Review your personal information and provide any missing information, if needed. All fields marked with an * are required.

The Sample Company > Benefits Enrollment 0% Complete [Exit](#)

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 Benefits
- 6 Coverage
- 7 Summary
- 8 Sign Forms
- 9 Finish

Personal Information

[Need Help?](#) [Get support](#)

First Name *	Middle Name
<input type="text" value="Alicia"/>	<input type="text" value="Middle Name"/>
Last Name *	
<input type="text" value="Cornwell"/>	
Sex *	Birth Date (30) *
<input type="text" value="Female"/>	<input type="text" value="1/1/1989"/>
SSN *	
<input type="text" value="Show"/>	
Marital Status *	
<input type="text" value="Select"/>	
Tobacco User (Last 12 Months) *	
<input type="text" value="Select"/>	
Disabled? *	
<input type="text" value="Select"/>	

7. Add any dependents that you will be enrolling in coverage by clicking Add.

Dependents

If you have any dependents (e.g. spouse, domestic partner, children) please add them here. If you do not have any dependents please click 'Continue'.

Add a Dependent

Add

Continue

8. Provide information for each dependent as prompted. Click Add Dependent.

Add Dependent

Close

First Name *

First Name

Last Name *

Last Name

Middle Name

Middle Name

Sex

Select

Birth Date

mm/dd/yyyy

SSN

XXX-XX-XXXX

Relationship *

Select

Employer

Different address than employee?

Add Dependent

9. If documents are required to review click **Review** and acknowledge receipt for each document.

The Sample Company > Benefits Enrollment 25% Complete [Exit](#)

- 1 Profile
- 2 Dependents
- 3 **Documents**
- 4 Medicare
- 5 Benefits
- 6 Coverage
- 7 Summary
- 8 Sign Forms
- 9 Finish

Documents

Please review and sign the following documents if applicable. Once you've reviewed each document please click 'Continue'.

Handbook Acceptance
170 B [Review](#)

SPD
29.6 KB [Review](#)

[Continue](#)

[Need Help?](#) [Get support](#)

10. If you or any of your dependents have Medicare Coverage, click Add and complete Medicare information.

The Sample Company > Benefits Enrollment 38% Complete [Exit](#)

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 **Medicare**
- 5 Benefits
- 6 Coverage
- 7 Summary
- 8 Sign Forms
- 9 Finish

Medicare

If you or any of your dependents applying for coverage have Medicare Coverage please add that information here. Otherwise please click 'Continue'.

Add Medicare Coverage [Add](#)

[Continue](#)

[Need Help?](#) [Get support](#)

11. You will be guided through your benefit options. To enroll, click the checkmark , to waive click the X. Choose the plan you would like by clicking Select.

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 **Benefits**
- 6 Medical
- 7 Coverage
- 8 Summary
- 9 Sign Forms
- 10 Finish

Medical Plan

Specify your coverage

Select Enrolled or Waived for each eligible member below.

Alicia Cornwell Enrolled ×
Employee

Are you waiving dependents?

You have not entered any children. If you have dependent children and are waiving coverage for them, check the box below. Otherwise keep the box unchecked.

Children Waived

Benefits Summary

Employee Cost Per Pay Period (Semi-Monthly)

Medical \$47.88

Total \$47.88
Per Pay Period (Semi-Monthly)

[Need Help?](#) [Get support](#)

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 **Benefits**
- 6 **Medical**
- 7 Coverage
- 8 Summary
- 9 Sign Forms
- 10 Finish

Select your plan

See breakdown of plans and costs. [Compare Plans >](#)

The cost below is the employee cost deducted on a [Per Pay Period \(Semi-Monthly\)](#) basis.

Anthem BCBS \$47.88
Per Pay Period Selected
Blue Shield Silver 70 PPO 2000/45 + Child Dental
Documents


This election will be effective starting 2/1/2019.

Benefits Summary

Employee Cost Per Pay Period (Semi-Monthly)

Medical \$47.88

Total \$47.88
Per Pay Period (Semi-Monthly)

[Need Help?](#) [Get support](#)

[Continue](#)

12. You may be prompted to provide your previous or current coverage, Click Add and enter all information as required.

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 Benefits
- 6 **Coverage**
- 7 Summary
- 8 Sign Forms
- 9 Finish

Previous & Current Coverage

If you have more than one insurance policy at the same time, your carrier will want to know about it. If you are going to maintain a second policy, please add the details here.

Also, The Affordable Care Act requires that we all maintain continuous coverage. Please provide details of the coverage you have had over the last 12 months here.

Add Coverage

Add

Continue

You must sign your forms in order to submit your elections.

[Need Help?](#) [Get support](#)

13. You may see a series of health questions based on the coverage you are applying for. Answer each question with a checkmark for yes or X for no. If prompted, please provide any additional details.

- 6 Benefits
- 7 Coverage
- 8 **Health**
- 9 **Conditions**
- 10 Questions
- 11 Height & Weight
- 12 Details
- 13 Summary
- 14 Sign Forms
- 15 Finish

Heart/Circulatory

Please Select

Such as: Abnormal heart catheterization, Aneurysm, Angina, Angioplasty, Angioplasty/Stent, Arrhythmia / Irregular heartbeat, Arteriosclerosis, Artery or blood vessel disease, Atherosclerosis, Atrial Fibrillation, Blood clots, Blood vessels, Bypass, Cardiomyopathy, Cardiovascular, Carotid Artery disease / Stenosis, Cerebrovascular, Chest pain, Circulatory disorder, Congestive heart failure, Coronary artery disease, Defibrillator use, Edema, Elevated cholesterol levels, Elevated triglycerides, Endocarditis, Heart attack, Heart disease or disorder, Heart Failure, Heart murmur, Heart regurgitation, Heart surgery, Hemorrhage, High blood pressure, Hyperlipemia, Hypertension, Irregular heartbeat, Low blood pressure, Mitral valve prolapse, Pacemaker, Peripheral artery disease, Phlebitis, Shortness of breath, Skin ulcerations, Stent, Stress test (electrodiagram or echocardiogram), Stroke, Tachycardia, Temporal arteritis, Thrombophlebitis, Transient ischemic attack, Valvular heart disease, Varicose veins, Vascular disorder, Other heart/circulatory disorder

Blood

Please Select

Such as: Albumin, Anemia, Bleeding disorder, Blood disorder, Bubonic plague, Hemophilia, Malaria, Polycythemia, Sickle Cell, Thalassemia, Thrombocytopenia, Other blood disorder

14. You can review your Benefit Summary under the Summary tab. Make any updates by selecting the Edit button.

Benefit Summary
Review your benefit elections. If you need to make changes, click [Edit](#). Otherwise, click [Continue](#) and sign your forms.

Medical
Anthem BCBS
Blue Shield Silver 70 PPO 2000/45 + Child Dental
Employee
Effective 2/1/2019

\$47.88
Per Pay Period (Gross Monthly)
[Edit](#)

[Continue](#)

You must sign your forms in order to submit your elections.
[Need Help?](#) [Get support](#)

15. If you are missing required information or need to review certain documents you can select the blue highlighted text to be brought back to the page or document. After completing the required information, you can proceed to review and sign your forms.

Missing Information
You must provide the following information before you can review your forms and finish.
(Medical) Blue Shield Silver 70 PPO 2000/45 + Child Dental requires that you first review SEC.

[Continue](#)

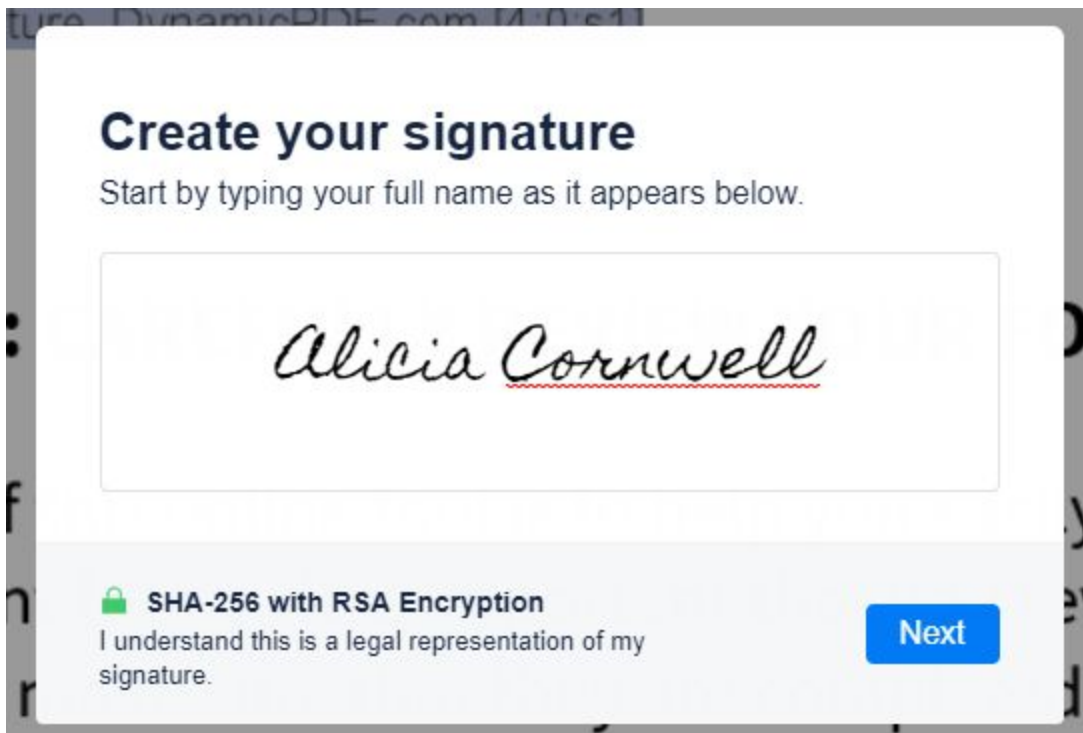
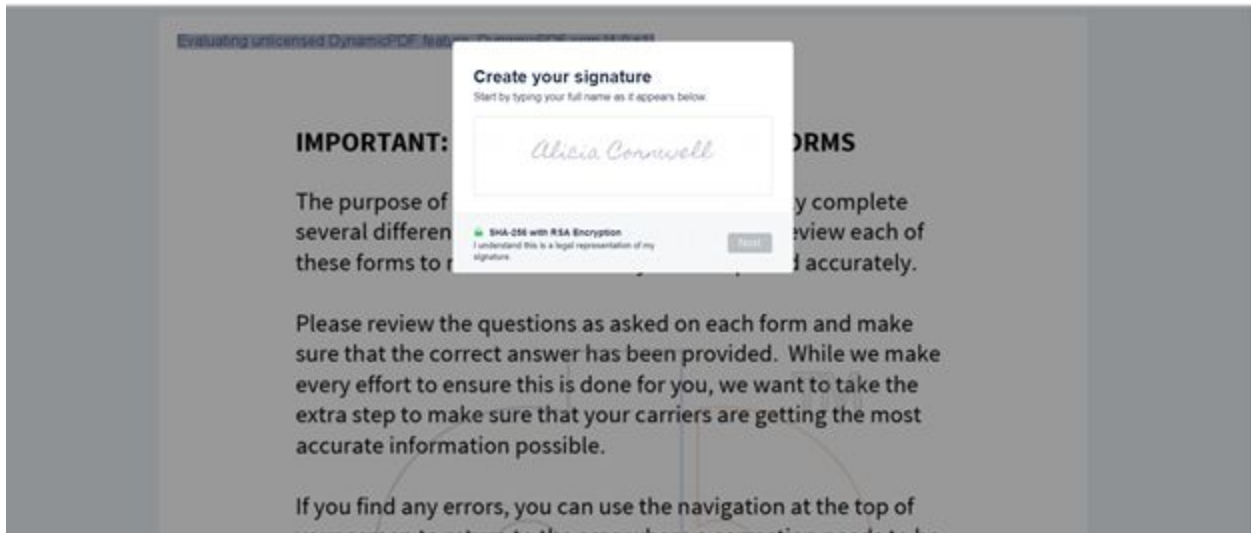
You must sign your forms in order to submit your elections.
[Need Help?](#) [Get support](#)

16. After clicking Sign Forms, you will be prompted to type your signature as well as electronically sign with your mouse.

Sign Forms
You are required to review and sign your forms before your information can be submitted. Click [Sign Forms](#) below.

[Sign Forms](#)


You must sign your forms in order to submit your elections.
[Need Help?](#) [Get support](#)




Signature DynamicPDF.com [4:0:51]

Create your signature

Some carriers require a hand-drawn signature. Please draw your signature in the box below.



A blue hand-drawn signature is shown within a white rectangular box. To the right of the signature is a blue 'clear' button. Below the signature is a dashed horizontal line. A small 'x' icon is located at the bottom left corner of the box.

 **SHA-256 with RSA Encryption**
I understand this is a legal representation of my signature.

[Next](#)

Review and sign your forms by tapping each green signature prompt as they appear.

Review & Sign Forms

Please review all of the information presented for completeness and accuracy.

When you are ready, sign each section by tapping on the green signature prompts. If at any time you feel like you need to make changes, you can go back to enrollment by selecting 'Back' in the top navigation bar. For additional help, please reach out to your HR administrator.

 **SHA-256 with RSA Encryption**

I understand this is a legal representation of my signature.

Next

[Back](#)

1 signatures remaining (14 pages)

Section 8 - Disclosure of personal and health information

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card, or by visiting our website at blueshieldca.com/bzca/documents/about-blue-shield/privacy.

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this enrollment form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which I am enrolled under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this enrollment, Blue Shield may remove me of the following remedial coverage may be cancelled, or the applicable premium may be adjusted, or following notice. Coverage may be reinstated. I hereby authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that this coverage does not become effective until the end of my employer's application have been approved by Blue Shield of California.

Signature of employee

Date

Alicia Cornwell

Print employee name

DynamicPDF

All pages of this form are necessary to process your enrollment.
Missing information may delay processing.

17. Once you have finished signing, you will be able to rate your enrollment experience as well as provide any additional comments. This is optional and you may click on Finish to return to your dashboard.

 100% Complete [Finish](#)

Congratulations! Your enrollment elections have been submitted for review.

How was your enrollment experience?



Tell us about your experience

 [Need Help? Get Support](#)

[Submit Feedback](#)