



BENEFIT MANAGEMENT
WEALTH STRATEGIES AND EMPLOYEE BENEFITS

iEnroll Employee Instructions

Go to: <https://ienroll.ociservices.com>

Enter username & password

Welcome Sample Group

Welcome to your Online Health Insurance Enrollment. By using an online enrollment process we will be able to quickly submit your applications to multiple insurance companies to receive quotes without you needing to fill out multiple applications.

Required Information Checklist

Please have the following information on hand to help the application process go smoothly

- Social Security Numbers, height, weight, and birthdates for yourself and any dependents applying for coverage
- Health History and medications for yourself and any dependents applying for coverage
- Information regarding previous Health Coverage or any coverage remaining in force in addition to coverage you are applying for

System Requirements

Please have the following information on hand to help the application process go smoothly

- Javascript and cookies must be enabled
- Adobe Reader must be installed ([Get Adobe Reader](#))

Begin Enrollment

Your Agent's Information:



Name: Cindy Morand
Email: admin@benefit-management.com
Phone: 402-420-7776
Fax: 402-420-7792
Address: 7130 S. 29th St STE G
Lincoln, NE 68516

Click **Begin Enrollment**

Basic Information

First Name Last Name

Birth Date (mm/dd/yyyy) / /

You can Choose to decline all coverage offered to you by your employer now by selecting "Yes" below. If you choose to decline all coverage, you will not be able to participate in your employer's health plan except in one of the following situations:

- You experience a life change event
- The next open enrollment period
- As a late enrollee (if applicable)

Do you want to DECLINE ALL COVERAGE offered to you at this time?

Next

Enter First Name,
Last Name, Date of
Birth

Do you want to
DECLINE all
coverage? Y/N

Click **Next**

Employee Data

Employee Name*	<input type="text" value="Betty Smith"/>	Gender*	<input type="text" value="Female"/>
Home Address*	<input type="text" value="123 ABC Lane"/>	Height* (ex. 5'8")	<input type="text" value="5"/> ft <input type="text" value="5"/> in
City*	<input type="text" value="Lincoln"/>	Weight* (in lbs.)	<input type="text" value="120"/>
State*	<input type="text" value="NE"/>	Marital Status*	<input type="text" value="Married"/>
Zip*	<input type="text" value="68505"/>	Number of Children*	<input type="text" value="2"/>
Work Phone*	<input type="text" value="402"/> - <input type="text" value="422"/> - <input type="text" value="2222"/>	Primary Care Physician	<input type="text"/>
Home Phone*	<input type="text" value="402"/> - <input type="text" value="323"/> - <input type="text" value="2222"/>	Job Title	<input type="text"/>
Email	<input type="text"/>	Date of Hire*	<input type="text" value="06/15/2012"/>
Social Security*	<input type="text"/> - <input type="text"/> - <input type="text"/>	Employment Status*	<input type="text" value="Full-Time"/>
Date of Birth*	<input type="text" value="05/04/1985"/>	Hours Per Week*	<input type="text" value="40"/>
Medicare Enrolled	<input type="text" value="no"/>	Salary / Wage	<input type="text" value="United States"/>
		Social Security Disabled	<input type="text" value="no"/>

Next

Enter all personal information. Click **Next**

Coverage Selection

Indicate Coverage Choice:

Medical	<input type="text" value="(Select)"/>	Please Select a Coverage Type
Dental	<input type="text" value="(Select)"/>	Please Select a Coverage Type
Disability	<input type="text" value="(Select)"/>	Please Select a Coverage Type
Life	<input type="text" value="(Select)"/>	Please Select a Coverage Type

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Select the coverage you would like to enroll in from the drop down. Click **Next**

Reasons for Declining Dental Coverage

You have chosen to DECLINE coverage for the following:

Dental: Spouse

Declining Coverage for the following Reason(s):

- Spouse's Employer Plan
- Covered by Medicare
- COBRA from prior employer
- I (we) have no other coverage at this time
- Disability
- Individual Plan
- VA Eligibility
- Tri-Care
- Medicaid
- Other, explain:

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply.

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If decline coverage, you must indicate why you are declining, then click **Next**

Dependent Data

Name (First, MI, Last)	Gender	Height	Weight	DOB	SS#	Primary Physician	Full-Time Student	Medicare Enrolled	SS Enrolled
Spouse									
<input type="text"/>	(Select) ▼	<input type="text"/> ft <input type="text"/> in	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	▼	▼	▼
Children									
<input type="text"/>	(Select) ▼	<input type="text"/> ft <input type="text"/> in	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	▼	▼	▼
<input type="text"/>	(Select) ▼	<input type="text"/> ft <input type="text"/> in	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	▼	▼	▼

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Enter Dependent Information, then click **Next**

Other Coverage

Do you or any of your dependents have Medicare Coverage?

Will you, your spouse or your dependents keep other coverage in addition to this coverage?

Within the last 18 months, did you have health insurance coverage?

Designated Beneficiaries - Group Term Life and/or Voluntary Life

Primary Beneficiaries

Name	Address	Percentage	Relationship	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Contingent Beneficiaries

Name	Address	Percentage	Relationship	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Answer questions regarding any other coverage, then click **Next**

Health Information

Section 1

Please provide the health history of you and any person named in this application who has been diagnosed or treated in the last 10 years by placing an "X" in the following boxes. Please further explain your selections in Section 3 - Health Statement Table.

- | | |
|--|--|
| <input type="checkbox"/> 1. AIDS/HIV | <input type="checkbox"/> 17. Heart/Circulatory Disorder |
| <input type="checkbox"/> 2. Allergy/Asthma | <input type="checkbox"/> 18. High Blood Pressure |
| <input type="checkbox"/> 3. Arthritis | <input type="checkbox"/> 19. High Cholesterol |
| <input type="checkbox"/> 4. Bladder/Urinary Disorder | <input type="checkbox"/> 20. Infertility |
| <input type="checkbox"/> 5. Blood, Bleeding or Clotting Disorder | <input type="checkbox"/> 21. Kidney Disorder (dialysis or failure) |
| <input type="checkbox"/> 6. Bone/Joint/Muscular Disorder | <input type="checkbox"/> 22. Liver (cirrhosis, hepatitis B, C, D or E) |
| <input type="checkbox"/> 7. Cancer | <input type="checkbox"/> 23. Mental or Nervous Disorder |
| <input type="checkbox"/> 8. Cyst | <input type="checkbox"/> 24. Migraine Headaches |
| <input type="checkbox"/> 9. Current Pregnancy | <input type="checkbox"/> 25. Neck, Back or Spine Disorder |
| <input type="checkbox"/> 10. Diabetes | <input type="checkbox"/> 26. Organ Transplant |
| <input type="checkbox"/> 11. Physical Deformity or Defect | <input type="checkbox"/> 27. Respiratory/Lung Disorder |
| <input type="checkbox"/> 12. Digestive/Intestinal Disorder | <input type="checkbox"/> 28. Skin Disorder |
| <input type="checkbox"/> 13. Drug or Alcohol Abuse | <input type="checkbox"/> 29. Stroke/Nervous System/Brain Disorder |
| <input type="checkbox"/> 14. Eating Disorder | <input type="checkbox"/> 30. Tumor |
| <input type="checkbox"/> 15. Endocrine/Pancreatic Disorder | <input type="checkbox"/> 31. Tobacco Product Use |
| <input type="checkbox"/> 16. Eye, Ear, Nose, Throat Disorder (Excluding glasses) | <input type="checkbox"/> 32. Vascular (blood vessel) Disorder |

Section 2

Please answer yes or no to the following Questions. Please further explain your "yes" selections in Section 3 - Health Statement Table.

33. Have you or any person named in this application received inpatient or outpatient services in the last three (3) years (excluding routine tests, physicals or inoculations)?
34. Do you or any person named in this application have tests, treatments, hospitalization or surgery planned or recommended in the future?
35. Do you or any person named in this application take any medicine, prescription drugs or require shots/injections?
36. Do you or any person named in this application have any other medical conditions which have not yet been previously mentioned?

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Answer questions in Section 1 & Section 2.

If you mark X or enter yes to any of the following you will have to answer health questions on next screen.

Click **Next**

Health Explanations

Section 3 - Health Statements

For any of the "X" or "Yes" responses provided in SECTION 1 and 2, please provide full details in the following table per Question Number. You can enter explanations by pressing the 'add' button below.

[Add](#)

No conditions listed. Please click Add to add explanations for each condition.

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Click "Add"

Section 3 - Health Statements

For any of the "X" or "Yes" responses provided in SECTION 1 and 2, please provide full details in the following table per Question Number. You can enter explanations by pressing the 'add' button below.

[Add](#)

No cond

Question	<input type="text"/>
Person	Sarah
Name of Condition	<input type="text"/>
Date Diagnosed	<input type="text"/>
Date Last Treated	<input type="text"/>
Treatment Type / Medications	<input type="text"/>
Medication ongoing?	<input type="checkbox"/> Yes
Degree of Recovery	<input type="text"/>

[Cancel](#) [Save](#)

Fill out for each "Yes" answer

Click **Save**

Processing Application

You Are Almost Done

Please Press next to review and sign your application. After the page loads please review the application for accuracy.

After you have reviewed your application you will be asked to sign the application using your mouse.

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Click **Next**

Review Application

Please review your application for accuracy

Press next to proceed with signing your application.

[Click Here](#) To download application for your records.

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Employer Name: **Sample Group**

Waiver - Detail
OCI Insurance and Financial Services

I decline Medical coverage for the following: _____
Declining coverage due to:
 Spouse's Employer's Plan
 Covered by Medicare
 COBRA from prior employer
 I (we) have no other coverage at this time
 Individual Plan
 VA Eligibility Tri-Care
 Medicaid
 Other, explain: _____

I decline Dental coverage for the following: Spouse
Declining coverage due to:
 Spouse's Employer's Plan
 Covered by Medicare
 COBRA from prior employer
 I (we) have no other coverage at this time
 Individual Plan
 VA Eligibility Tri-Care
 Medicaid
 Other, explain: _____

I decline Life coverage for the following: Child(ren)
Declining coverage due to:
 Spouse's Employer's Plan
 Covered by Medicare
 COBRA from prior employer
 I (we) have no other coverage at this time
 Individual Plan
 VA Eligibility Tri-Care
 Medicaid
 Other, explain: _____

I decline Vision coverage for the following: _____
Declining coverage due to: _____

Review your application and verify everything is accurate, then click **Next**

Note: These statements are provided as samples and are only to be used as guidelines. Please be aware the system could change at any time.

Sign Application

By Signing Below you Agree to the following Authorization Terms: [Read Authorization Agreement](#)

Terms and Conditions

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld.

I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability.

If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from the Carrier.

Electronic Signature

By electronically signing this application I agree that my electronic signature is the legal equivalent of my handwritten signature on this application and that I also consent to be legally bound by the terms and conditions above.

I agree that typing my name will be a representation of my signature

Please type your name in the spaces below to electronically sign the application.

Type Name:

Confirm signature:

✓ I agree that typing my name will be a representation of my signature

Type Name:

Confirm signature: Retype name

Click **Sign Application and Submit**

Done

Thank You

We have received your application and have logged you out

Please close all browser windows to help protect your privacy.

If you have further questions please contact your agent



Name: Cindy Morand

Email: admin@benefit-management.com

Phone: 402-420-7776

Fax: 402-420-7792

Address: 7130 S. 29th St STE G
Lincoln, NE 68516

If you have any questions regarding this application please contact Benefit Management at 402.420.7776 or admin@benefit-management.com