

**State of Illinois
New Member Guide to MyBenefits
for the State Employees Group Insurance Program (SEGIP)**

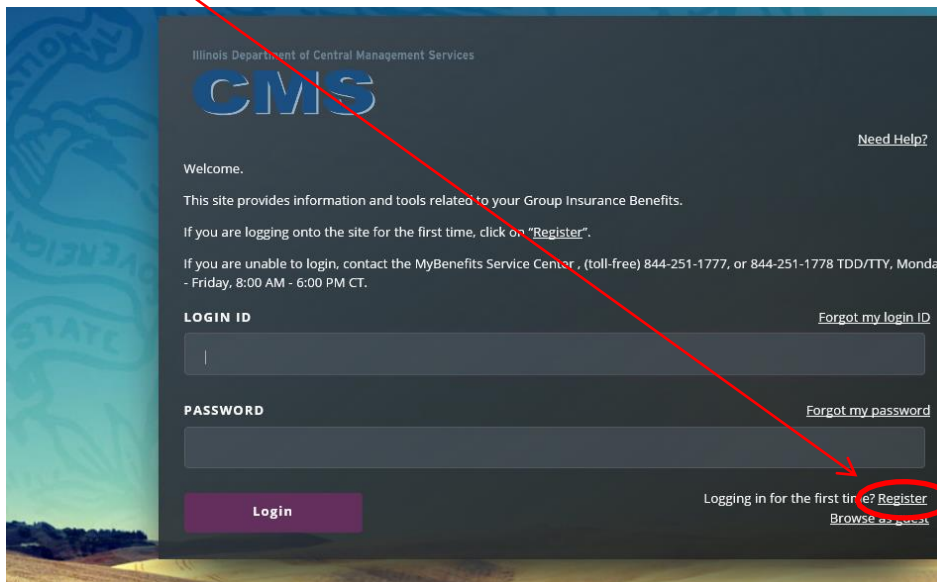
March 2018

Self-Registration

Click **Login** to begin.



On the Login page, click **Register** to begin.



Enter the requested information.

Illinois Department of Central Management Services
CMS
Please answer the following questions to register the user.

Please answer the following questions to register the user.

1 LAST 4 DIGITS OF SSN (9999)

2 DATE OF BIRTH (MM/DD/YYYY)

3 LAST NAME (AS PRINTED ON POSTCARD)

4 FIRST TWO LETTERS OF FIRST NAME (AS PRINTED ON POSTCARD)

5 MAILING ZIP CODE (99999)

I'm not a robot

Cancel Continue

- 1
 - 2
 - 3
 - 4
 - 5
- Enter the requested information

Note: Your name must be entered exactly as CMS has it documented, including any hyphens.

Check I'm not a robot

Click **Continue**.

You will be prompted to complete a security challenge selecting pictures to secure your access.

Illinois Department of Central Management Services
CMS
Please enter password and confirm password to finish the registration flow.

Please enter password and confirm password to finish the registration flow.

PASSWORD REQUIREMENTS

- Password must be between 8 and 12 characters.
- Should have at least one lower character.
- Should have at least one upper character.
- Should have at least one number.
- Should have at least one special character.
- Must not contain your login ID.
- Must not contain your first name or last name.
- Must not re-use your previous 10 passwords.
- Must not be repeated within the past 365 days.

PASSWORD

1

CONFIRM PASSWORD

2

Cancel Continue 3

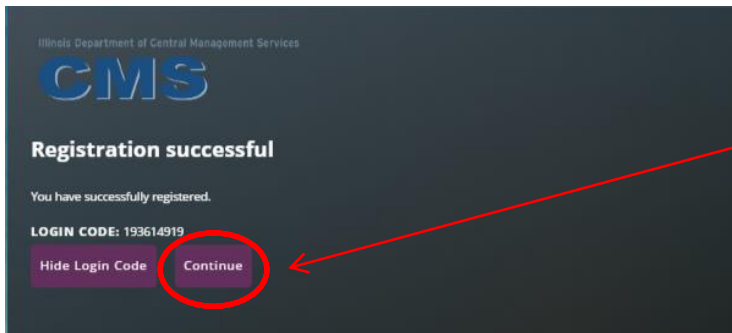
1. Enter a new password that meets the requirements shown on the screen.

2. Confirm the password.

3. Click **Continue**.

IMPORTANT

1. Click **Show Login Code**. Your Login Code will appear above the button. Make note of the displayed code for validation purposes, should you forget your login ID at a later date. To hide your Login Code Click **Hide Login Code**.
2. Click **Continue**.



1. Select a Challenge Question from the list.

2. Enter your answer to the question. The answers are case sensitive.

Repeat Steps 1 and 2 for Questions 2 and 3

3. Click **Continue**.

On the Confirmation page, review your questions and answers, and then click **Continue** again.

The portal displays a success page, telling you your challenge questions and answers have been saved. Click **Continue**.

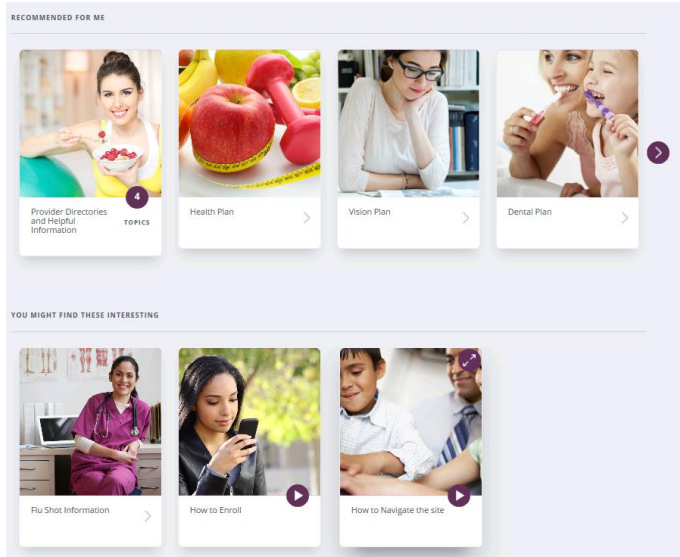
1. Review the disclaimer and click **I ACCEPT**.

2. Click **Continue**.

The portal displays a success page, telling you have successfully accepted the disclaimer. Click **Continue**. The home page of the portal is displayed.

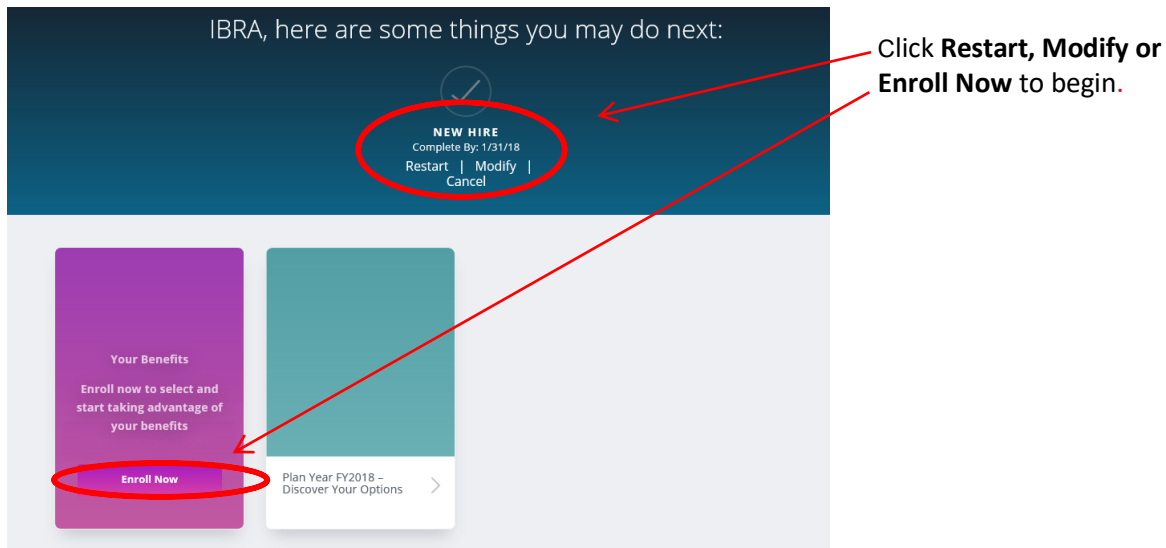
Benefits Enrollment

Once you have completed the registration process, you'll see the Home page. The home page will display cards, as shown below, that will allow users to review specific benefit date and plan details as it relates to each employee.



Enroll

Once you know which plans work best for you and your family, you're ready to enroll.



myElections

Below is a timeline of your elections. You can also [start a new event](#).

View Elections History Transactions: View All Options: Legend

New Hire
January 1, 2018

Today's Coverage

Personal Information **Your Coverage** Dependents

You have no coverage on file.

You'll see the New Hire event as well as an option to view Today's Coverage.

Click the **New Hire** box to continue.

New Hire
This transaction is: In progress

Transaction Details
The last date to complete this event is January 31, 2018
Event that has not been completed.

Restart
Modify
Cancel Event

Options: Legend

New Hire
January 1, 2018

Today's Coverage


Click **Restart** on the secondary menu to begin enrollment.

Review Profile and Add Dependents

Personalize your benefits plan

New Hire - January 1, 2018

1 Family 2 Benefits 3 Finalize



You currently have no dependents on file. You may add a dependent or navigate to a different page.

IBRA FANCHER
You
Age: 31

[View Profile](#)

[+ Add a Dependent](#)

1. Click **View Profile** under your name tile to review your information and make necessary changes.
2. Click **Add Dependent** if necessary, and enter the required information. See [Add a Dependent below](#) for details.
3. Click **Next** to continue. Skip to [Choose Your Benefits](#).

[Next >](#)

Add a Dependent

Add a Dependent

Personal Information

***Required Fields**

SSN:

First Name: *

Initials:

Last Name: *

Relationship: * ?

Gender: * Male Female

Date of Birth * ?

(MM/DD/YYYY):

Additional Coverage Information ?

Is this person currently covered under any other health and/or dental plan(s) (such as your spouse's employee benefit plan)?:

Dental Medical

Save and Add Another **Save and Close** **Cancel**

1. Add the dependent information. Required fields are marked with an asterisk (*). If the dependent does not yet have a SSN, members should use 111-11-1111. Employees should ensure the Additional Coverage question is answered correctly for the dependent. This only applies if the dependent you are enrolling in health/dental coverage has other health/dental coverage.
2. To add another dependent, click **Save and Add Another**. To return to the Family page, click **Save and Close**.

Note: You may be required to submit supporting documentation for covered dependents. See [Upload Required Documents](#) for more details.

Personalize your benefits plan

On this page, you can enroll in benefits, compare plans, and review provider information.

Compare Plans

Before you enroll in benefits, a decision support tool is available to help you investigate your options and choose the best one for you.

Click **Help me decide** to begin.

Personalize your benefits plan

New Hire - January 1, 2018

1 Family 2 Benefits 3 Finalize

Health & Group Benefits

Benefit	Coverage Options	Coverage Level	Your Monthly Cost
Medical	Quality Care Hea	Who is covered?	\$127.00
Help me decide			
Dental	Quality Care Den	Who is covered?	\$11.00

Next

Life Insurance

Flexible Spending Accounts (MCAP/DCAP)

Your Pre-Tax Costs

Your Costs \$138.00 / per month

Your Post-Tax Costs

Your Costs \$0.00 / per month

Medical

Select some plans to compare...

[Back to Enrollment Tool](#)

This is an overview of plan design for comparison only. Refer to the "Benefit Choice Book" for detailed information, or contact the plan directly.

Dependents

Compare Plans

Here are some other great plans that may interest you.

HMO OAP PPO

BlueAdvantage HMO	HMO Illinois
\$103 ⁰⁰ /mo	\$103 ⁰⁰ /mo
INCLUDES	INCLUDES

The user will then be able to compare plans and review their options.

Choose Your Benefits

Medical and Dental

Health & Group Benefits

Benefit	Your Monthly Cost
Medical	\$127.00
Dental	\$11.00

Your Pre-Tax Costs
Your Costs \$138.00 / per month

Your Post-Tax Costs
Your Costs \$0.00 / per month

Next

Life Insurance

Flexible Spending Accounts (MCAP/DCAP)

Previous Next

1. Click the Medical Selection list and choose your medical plan. Some medical plans require you to select a Primary Care Provider. See [Select a Primary Care Provider](#) for details.
2. If necessary, click **Change who is covered** to add or remove dependents from the benefit. See [Change Who Is Covered](#) for details.
3. Click the Dental Selection list and choose your dental plan.
4. If necessary, click **Change who is covered** to add or remove dependents from the benefit. See [Change Who Is Covered](#) for details.
5. If you chose to opt out or waive coverage, you must waive both medical and dental coverage. Full-time employees will also be required to show proof of existing coverage. See [Opting Out of Medical and Dental Benefits](#) for more details.
6. Click **Next** to move to [Life Insurance](#). If there is any missing information, a message will be displayed to alert you.

Change Who Is Covered

My Plan Covers:

JOHN ABBOTT
You

Family: [Select All](#) - [Select None](#)

1 JEANINE PEDERSEN
Spouse

CECILY ABBOTT
Child

GWENDOLYN ABBOTT
Child

Save and Close Cancel

1. Click the checkbox next to each participant's name to change whether or not they are covered by the selected benefit.
2. Click **Save and Close** to return to the Benefit page.

Opting Out of Medical and Dental Benefits

Personalize your benefits plan

New Hire - January 1, 2018

1 Family 2 **Benefits** 3 Finalize

Health & Group Benefits

Non-critical warnings If you are electing to Opt Out of the State group insurance health and dental coverage you are required to submit proof of other coverage. You will be prompted to do so at the end of the enrollment process.

Benefit	Coverage Options	Coverage Level	Your Monthly Cost
Medical	Opt Out	Who is covered? No one Opt-in with Default Option and Edit coverage details	-
Dental	Waive	Who is covered? No one Opt-in with Default Option and Edit coverage details	-

Next

Your Pre-Tax Costs
Your Costs \$0.00 / per month

Your Post-Tax Costs
Your Costs \$0.00 / per month

Life Insurance

Flexible Spending Accounts (MCAP/DCAP)

Opt Out

1. If you chose to opt out of or waive medical coverage, you will be required to upload proof of other coverage.
2. On the Medical and Dental Benefit selection page, click **Next** to move to [Life Insurance](#). If there is any missing information, a message will be displayed to alert you.

Select a Primary Care Provider

There are errors present.

Health & Group Benefits

Medical

Please click the "Select Your Primary Care Provider" button and enter PCP ID information for yourself and any dependents you have elected to cover.

Select your Primary Care Provider

Benefit	Coverage Options	Coverage Level	Your Monthly Cost
Medical	HMO Illinois	Who is covered?	\$103.00
		You Change who is covered	
Dental	Quality Care Deri	Who is covered?	\$11.00
		You Change who is covered	

Next

Life Insurance

Flexible Spending Accounts (MCAP/DCAP)


Your Pre-Tax Costs
Your Costs \$114.00 / per month

Your Post-Tax Costs
Your Costs \$0.00 / per month

If you have chosen an HMO:

1. Click **Select your Primary Care Provider**.
2. Enter the missing information. Required fields are marked with an asterisk (*).
3. If you don't know the 10-digit PCP number or Medical Group Number for HMO Illinois only, click the search button to open the Provider Directory in a separate tab or window and look it up. Make note of the PCP number or Medical Group Number, and then enter the information in the appropriate field.
4. Click **Save and Close** to return to the Benefit page.

Primary Care Provider

Please enter PCP information for yourself and any dependents you have elected to cover. Click the search icon  to access a link to the provider directory.

Required fields

Name	Relationship	PCP ID	PCP Name	Medical Group Number (BCBS Only)
IBRA FANCHER	You	<input type="text"/>	<input type="text"/>	<input type="text"/>

Next

Life Insurance

Flexible Spending Accounts (MCAP/DCAP)

Your Pre-Tax Costs
Your Costs \$114.00 / per month

Your Post-Tax Costs
Your Costs \$0.00 / per month

Save and Close Cancel

Select Life Insurance Coverage

Personalize your benefits plan
New Hire - January 1, 2018

1 Family 2 **Benefits** 3 Finalize

Health & Group Benefits

Life Insurance

Information In order to qualify for the benefit level you have chosen, you and/or your spouse are required to provide evidence of insurability. Complete and submit the Evidence of Insurability form, which will be available at the end of the enrollment process.

Benefit	Coverage Options	Coverage Level	Your Monthly Cost
Basic Life	1 x Annual Base	\$46,000.00	-
Optional Member Life	5 x Annual Base	\$230,000.00	\$18.40
Voluntary AD&D	Waive	-	-

Your Pre-Tax Costs
Your Costs \$138.00 / per month

Your Post-Tax Costs
Your Costs \$18.40 / per month

Previous Next

Flexible Spending Accounts (MCAP/DCAP)

Previous **Next >**

Life Insurance

1. Click each insurance selection list and choose your coverage amount. If you do not want to elect optional coverage, select Waive. **Note:** If you choose to add coverage over 4x your annual salary, you will need to submit a Statement of Health to Minnesota life. For more details, please review the form or contact Minnesota life directly. You will be enrolled in 4x coverage until approval for additional coverage is received.
2. Click **Next** to move to Flexible Spending Accounts.

Enrolling in Flexible Spending Accounts

Personalize your benefits plan

New Hire - January 1, 2018

1 Family 2 **Benefits** 3 Finalize

Health & Group Benefits

Life Insurance

Flexible Spending Accounts (MCAP/DCAP)

Benefit	Coverage Options	Coverage Level	Your Monthly Cost
Medical Care Assistance Plan (MCAP)	\$ 0	-	-
Dependent Care Assistance Plan (DCAP)	\$ 0	-	-

Your Pre-Tax Costs
Your Costs \$138.00 / per month

Your Post-Tax Costs
Your Costs \$18.40 / per month

Previous

Previous **Next >**

Flexible Spending Accounts

1. Click in the Medical Care Assistance Plan and enter the total annual amount you want to contribute.
2. Click in the Dependent Care Assistance Plan and enter the total annual amount you want to contribute.
3. Click **Next** to finish. If you want to review Medical/Dental or Life Insurance selections, click **Previous**.

Finalize Your Benefits

Personalize your benefits plan

New Hire - January 1, 2018

1 Family
 2 Benefits
 3 Finalize

This screen lists your personal information and your entries during this session. Review this information carefully. If you are not satisfied with your entries, go to the appropriate step. If you are satisfied with your entries, click NEXT to proceed.

Please note: Your monthly contribution amount reflected within this site is based on the most recent salary information received. FY2018 monthly contributions are based on your April 1, 2017 salary or initial salary for new hires. The contribution amounts will be adjusted as necessary, if updated salary information is provided.

Event Details
Type: New Hire effective January 1, 2018

Personal Information

Full Name:

Employee / Member Identification:

Type Enrollee Code:

Date of Employment:

April Salary:

Earnings:

Date of Birth:

Sex:

Full Address:

Preferred Email Address:

Group Insurance Rep / Health Plan Rep:

Cost Summary Items that have been changed

Your Pre-Tax Costs	
Your Costs	\$138.00 / per month
Your Post-Tax Costs	
Your Costs	\$18.40 / per month

Benefits

Benefit name	Coverage options	Coverage details	Employer Cost	Your Costs
Health & Group Benefits				
Medical	Quality Care Health Plan	Employee Only	\$1,001.46	\$127.00
Dental	Quality Care Dental Plan	Employee Only	\$25.26	\$11.00
Life Insurance				
Basic Life	1 x Annual Base Salary	\$46,000.00	\$15.18	-
Optional Member Life	5 x Annual Base Salary	\$230,000.00	-	\$18.40
Voluntary AD&D	Waive		-	-
Flexible Spending Accounts (MCAP/DCAP)				
Medical Care Assistance Plan (MCAP)	0		-	-
Dependent Care Assistance Plan (DCAP)	0		-	-
Totals:			\$1,041.90	\$166.40

Do you agree to the following terms and conditions?

I hereby declare that I have completed my enrollment or modified my coverage, my contribution rate, or other information because of New Hire. I understand that the modifications made during this session are effective 1/1/2018, subject to the approval of any required evidence of insurability. I declare that the information contained on this form, if any, is complete and true (any false or incomplete declaration may nullify coverage).

I certify that the information and documentation I have provided is true and complete. I understand that falsifying or misrepresenting any information or documentation, or failing to provide requested information or documentation, in order to obtain or continue coverage under the Program will be considered a fraudulent act which may result in the forfeiture of insurance coverage and that I may also be subject to a financial penalty, including but not limited to repayment of all premiums and claims paid by the State on behalf of myself or any of my dependents and all expenses incurred by the Program arising out of the coverage provided to me.

I consent to the collection, use, and exchange of my personal information by and between:

- My Employer,
- The administrators of my Employee benefits program,
- The agents retained by my Employer or the Benefits Administrator,
- A company who requires information for the purpose of retirement, savings, or other Employee benefits plan administration.

I authorize these parties to obtain, and exchange between them, any information about me, my spouse, or my dependent children that they require for the purpose of determining my benefit entitlements, and for record-keeping, file identification, reporting, procurement of health information, claims resolution, and other services provided to me and my Employer from time to time.

I understand and certify that, if I am enrolling in a Flexible Spending Account (DCAP and/or MCAP):

- I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.
- I intend to participate in MCAP and/or DCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.
- I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.
- If my payroll deductions cease, I understand my participation in the program will terminate on my last day of employment, or the end of the pay period in which a deduction was taken if on a leave of absence, unless I elect to continue my participation in MCAP through direct payments to the FSA Unit for the remainder of the plan year.
- I am responsible for any discrepancies that may affect my status with the IRS and I will comply with the IRS requirement to file an IRS Form 2441, as applicable for DCAP.

Specific to DCAP:

- I cannot submit claims for expenses incurred after June 30th.
- I will forfeit any unclaimed amount remaining in my account at the end of the run-out period, which is September 30th.
- I cannot submit claims for expenses incurred during periods when my spouse or I are not actively working or actively looking for employment.
- If either my spouse or I earn less than \$5,000, my DCAP contribution cannot exceed the lower income.
- If my spouse is a full-time student or incapable of self-care, my DCAP contribution cannot exceed \$250/month for one dependent of \$416.66/month for two or more dependents.
- If my spouse and I file separate federal income tax returns, my DCAP contribution cannot exceed \$2,500.

Specific to MCAP:

- I must submit reimbursement claims for medical expenses that were incurred on or prior to June 30th by the last day of the run-out period which is 90 days after the last day of the plan year (i.e., September 30th).
- I must re-enroll in MCAP for the new plan year in order to qualify for the rollover benefit of up to \$500. If I do not re-enroll, I will forfeit any unclaimed amount remaining in my account at the end of the run-out period which is September 30th.
- Deductions must continue during any paid leave of absence.

I authorize the company to deduct from my salary amounts required to pay the cost of coverage and/or contributions plus applicable taxes, if any.

Previous
Next

1. Review your Benefits Plan. Any changes you have made from your previous choices are highlighted in blue.
2. If you need to make changes, click **Previous**.
3. Review the Terms and Conditions. Click the checkbox to agree.



By completing this electronic enrollment, I agree to the following:

- The Medicare Advantage plans with prescription drugs (MAPD plans) have contracts with the federal government. I understand I must continue to be enrolled in Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health and prescription drug plan. Once I enroll, I may leave this plan or make changes only at certain times of the year or under certain special circumstances. I understand that disenrollment from this plan will terminate my coverage through the Insurance Program.
- The MAPD HMO networks serve specific areas. If I move out of that service area, I need to notify my retirement system so I can disenroll and find a new plan in my new area.
- Once I am a member of an MAPD plan, I have the right to appeal plan decisions about payment or service if I disagree. I will read the Evidence of Coverage document from the plan I have chosen when I get it to know which rules I must follow to get coverage with this MAPD plan. I understand that people with Original Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements.
- I understand that, if electing an MAPD HMO plan, beginning on the date the MAPD HMO plan coverage begins, I can only use network providers, except for emergency or urgently needed services or out-of-area dialysis services. I also understand that I will have to pay more for services that I receive from non-network providers. Services authorized by the plan and other services contained in my Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE MAPD PLAN WILL PAY FOR THE SERVICES.**
- I understand that the providers in the networks are independent contractors in private practice and are neither employees nor agents of MAPD plans or their affiliates.

Release of Information: By joining an MAPD health plan, I acknowledge that they will release my information to Medicare and other plans as is necessary for treatment, payment of claims and healthcare operations. Medicare may also use this information for research and other reasons which they can do under federal law.

Previous

Next

4. Click **Next** to finish.

Finalize Your Benefits cont.

Personalize your benefits plan

New Hire - January 1, 2018

Print your confirmation statement

The selections you made have been submitted successfully.

Event name: New Hire

Effective date: January 1, 2018

Date completed: January 12, 2018

[If you wish, you can print a summary of your new selections.](#)

[Administrative Event Details](#)

You will also need to provide the following forms in order to finalize the enrollment.

Forms

Forms

[STATE Enrollment Notice Initial](#)

(Provide by: n/a)

[Reminder Notice EOI](#)

(Provide by: January 31, 2018)

[STATE Benefits Confirmation Statement](#)

(Provide by: n/a)

[State Enrollment Follow-Up Notice](#)

(Provide by: n/a)

[COBRA Rights Notice](#)

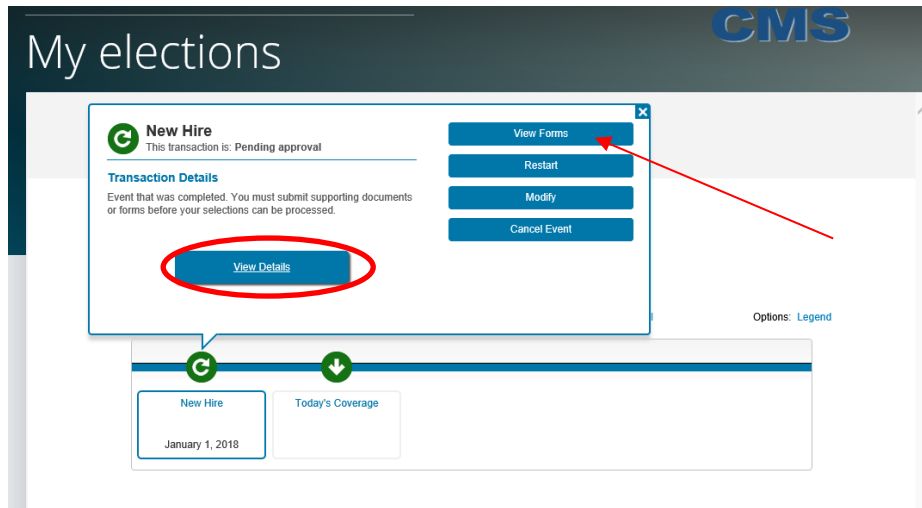
(Provide by: n/a)

Done

5. You'll see the confirmation page and the option to print your confirmation statement.
6. Click **Done** to leave enrollment and complete this step. You'll be notified if there are any required documents you'll need to upload. See [Upload Required Documents](#) for more details.

Upload Required Documents

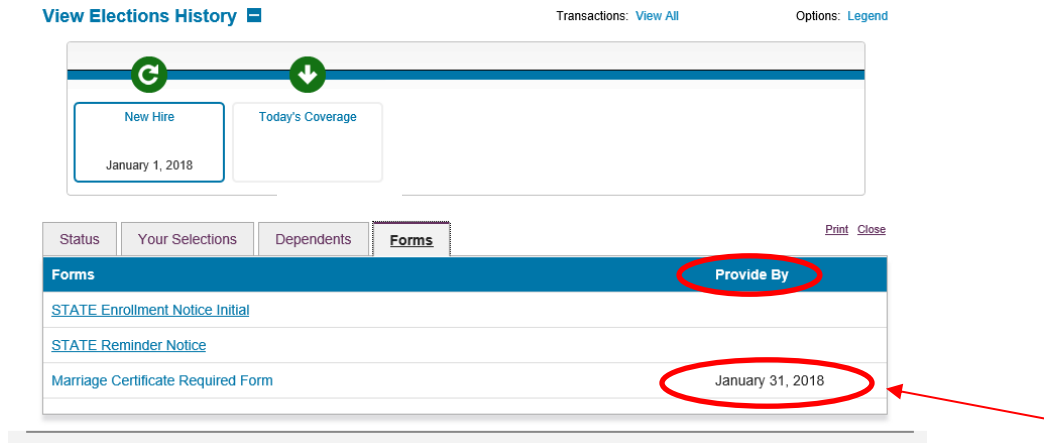
Some benefit choices will require you to provide supporting documentation before they can be applied. The user will be able to see the pending document approval within the event as well as view the details of the required docs.



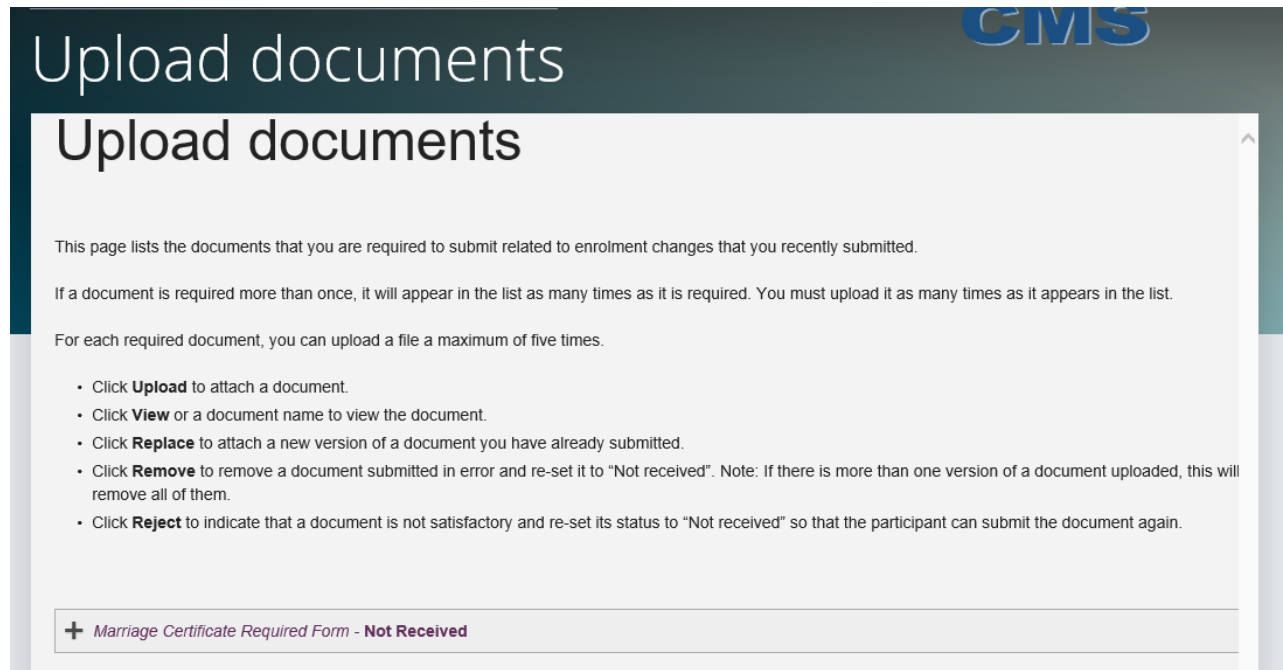
By clicking the View Details button the user will be able to see the Status, Selections, Dependent, and Forms associated with the event.

myElections

Below is a timeline of your elections. You can also [start a new event](#).



By accessing the Upload Documents page, the member or user will be able to upload the current pending documentation,



The screenshot shows the top portion of a web page. At the top right, there is a blue 'CMS' logo. Below it, the page title 'Upload documents' is displayed in a large, white font on a dark teal background. Underneath, the same title 'Upload documents' is repeated in a smaller black font on a white background. The main content area contains several paragraphs of text and a bulleted list of instructions. At the bottom of this section, there is a purple plus sign followed by the text 'Marriage Certificate Required Form - Not Received'.

Upload documents

Upload documents

This page lists the documents that you are required to submit related to enrolment changes that you recently submitted.

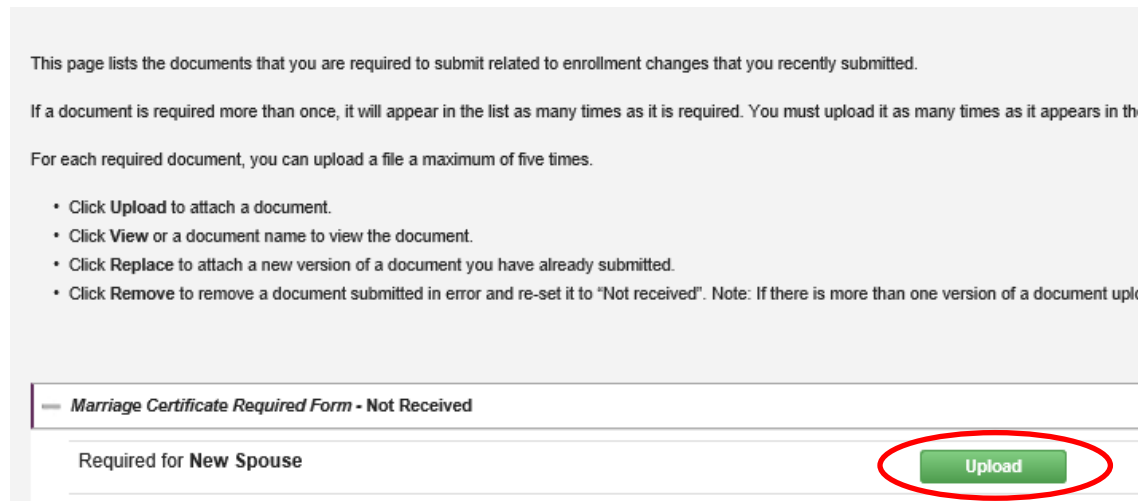
If a document is required more than once, it will appear in the list as many times as it is required. You must upload it as many times as it appears in the list.

For each required document, you can upload a file a maximum of five times.

- Click **Upload** to attach a document.
- Click **View** or a document name to view the document.
- Click **Replace** to attach a new version of a document you have already submitted.
- Click **Remove** to remove a document submitted in error and re-set it to "Not received". Note: If there is more than one version of a document uploaded, this will remove all of them.
- Click **Reject** to indicate that a document is not satisfactory and re-set its status to "Not received" so that the participant can submit the document again.

+ Marriage Certificate Required Form - Not Received

By clicking on + *Marriage Certificate Required Form – Not Received* the user will be directed to the upload page.



This screenshot shows the same text and instructions as the previous image, but with a more detailed view of the document entry. The document title 'Marriage Certificate Required Form - Not Received' is shown with a minus sign on the left. Below the title, the text 'Required for New Spouse' is visible. A green 'Upload' button is located to the right of the document title, and it is circled in red. A red arrow points from the bottom of the page towards the 'Upload' button.

This page lists the documents that you are required to submit related to enrollment changes that you recently submitted.

If a document is required more than once, it will appear in the list as many times as it is required. You must upload it as many times as it appears in the list.

For each required document, you can upload a file a maximum of five times.

- Click **Upload** to attach a document.
- Click **View** or a document name to view the document.
- Click **Replace** to attach a new version of a document you have already submitted.
- Click **Remove** to remove a document submitted in error and re-set it to "Not received". Note: If there is more than one version of a document uploaded, this will remove all of them.

— Marriage Certificate Required Form - Not Received

Required for New Spouse

Upload

Click Upload button then click Browse to upload your document.

Search here?

Illinois Department of Central Management Services
CMS

Upload documents

Upload a document

Marriage Certificate Required Form for New Spouse

- Click **Browse** and select the file to upload.
- Confirm that the file is a true copy of the original document by checking the box below.
- Click **Upload** to submit your file.
- A confirmation screen will appear when your file has been uploaded successfully.

About your file:

- It must be less than 10 MB in size.
- It must be one of the following types: JPEG, GIF, PNG, BMP, TIFF or PDF.

I attest that the file I am submitting, which contains an image of an original document, has not been falsified in any way and is a true representation of that original document.

Browse Cancel

You must check mark the attest box before the system will allow you to upload a document.

Search here?

Illinois Department of Central Management Services
CMS

Upload documents

Upload a document

Marriage Certificate Required Form for New Spouse

- Click **Browse** and select the file to upload.
- Confirm that the file is a true copy of the original document by checking the box below.
- Click **Upload** to submit your file.
- A confirmation screen will appear when your file has been uploaded successfully.

About your file:

- It must be less than 10 MB in size.
- It must be one of the following types: JPEG, GIF, PNG, BMP, TIFF or PDF.

I attest that the file I am submitting, which contains an image of an original document, has not been falsified in any way and is a true representation of that original document.

C:\Users\mcohe\Certificate.docx Cancel

Once the document has been selected and the attest box is check marked the member will see the upload button and must click **Upload** before proceeding.

Search here?

Illinois Department of Central Management Services
CMS

Upload documents

Upload a document

Marriage Certificate Required Form for New Spouse

- Click **Browse** and select the file to upload.
- Confirm that the file is a true copy of the original document by checking the box below.
- Click **Upload** to submit your file.
- A confirmation screen will appear when your file has been uploaded successfully.

About your file:

- It must be less than 10 MB in size.
- It must be one of the following types: JPEG, GIF, PNG, BMP, TIFF or PDF.

I attest that the file I am submitting, which contains an image of an original document, has not been falsified in any way and is a true representation of that original document.

C:\Users\mcoher\Certificate.docx **Upload** Cancel

Once the document selected is uploaded the user will see the green screen on the left to confirm that the document was successfully uploaded into the system.

Search here?

Upload documents

Upload

You have successfully upload the following document: Marriage Certificate.pdf.

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If you uploaded the wrong file, you can remove it or replace it with another file while it has the status "New". You can upload a file for each document you are required to submit a maximum of five times.

If we are not able to approve your document, the Benefits Administrator may notify you and ask you to submit it again. The status of your document will change back to "Not received".

If you have questions regarding the document approval process, contact MyBenefits Service Center toll free at-1-844-251-1777.

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