

Online Processing: Life Change Event

Health Plans uses a secure online tool, WEBeci™, to enable our clients to process enrollment additions and changes for their employees. To process a Life Change Event for an employee or dependent, first log onto the Health Plans website at www.healthplansinc.com and select **Clients**. On the Client page, select **Enrollment/Eligibility (WEBeci)**, then **Log In** to access the WEBeci™ system.

1. LOG IN

On the WEBeci login page, enter your User ID and Password and click **Log In**.

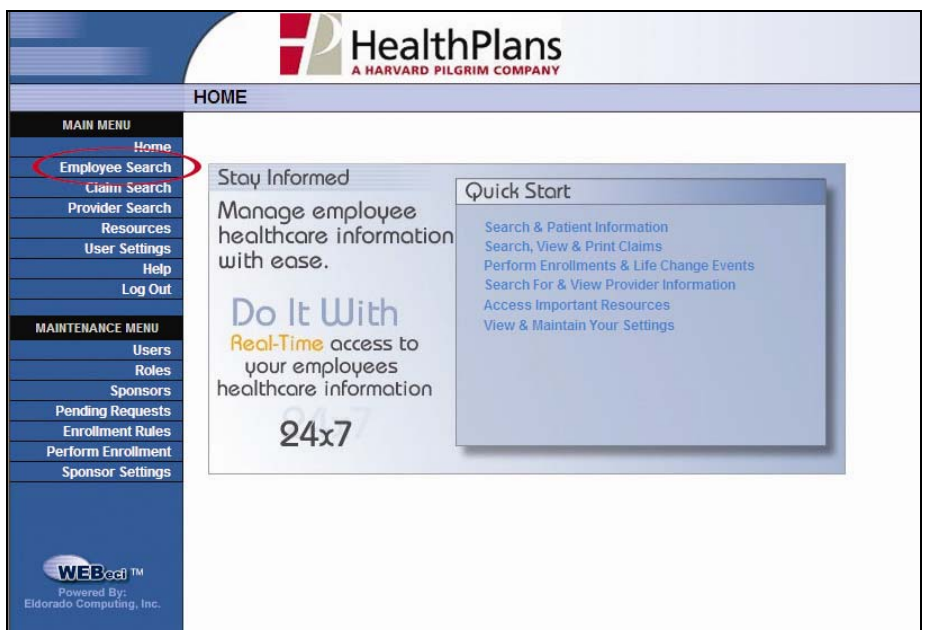
If you are newly-authorized to access the WEBeci™ system, you will receive a User ID and a password via secure email from Health Plans.

The first time you log in you will be able to change your temporary password to a personal, unique password.



2. LOCATE THE EMPLOYEE'S ELIGIBILITY FILE

On the WEBeci home page, click on **Employee Search**.



3. ENTER SEARCH PARAMETERS

Search by:

- Employee Name; **or**
- Employee ID (Health Plans member ID); **or**
- Alternate ID (employee Social Security Number)

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A HARVARD PILGRIM COMPANY

EMPLOYEE SEARCH

MAIN MENU

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MAINTENANCE MENU

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- Sponsor Settings

WEBcd™
Powered By:
Eldorado Computing, Inc.

Search Options

Last Name: NEWHIRE * First Name: SALLY

Employee ID: _____ (Employee SSN or Cert) *

Alternate ID: _____ *

Eligibility Date: _____

Search View All

4. SELECT THE COVERED PERSON AFFECTED BY THE LIFE CHANGE EVENT

Click on the name of the employee or dependent whose information requires updating.

For changes that affect the employee's entire policy (such as adding a dependent), click on the employee's name.

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MEMBER INFORMATION

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Search Results

Export All to Excel

Name	Employee ID	Status	Gender	Effective Date	Date of Birth	Hired Date
NEWHIRE, SALLY.	HHX000000	Active	Female	01/04/2010	01/01/1970	01/04/2010
NEWHIRE, JR., GEORGE.		School	Male	01/04/2010	01/31/1992	
NEWHIRE, SR., GEORGE.		Active	Male	01/04/2010	12/31/1970	

5. MEMBER INFORMATION

Confirm that the correct member has been selected, and click **Change Request**.

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MEMBER INFORMATION

[View Accumulations](#)

Demographics & Statistics

Name	Sally Newhire	Date of Birth	01/01/1970
Member ID	999SG1-HHX000000-00	Current Status	Active
SSN	HXX000000	Certificate Number	SSN-##-####
Alternate ID 1		Alternate ID 2	
Address	10 SAMPLE STREET	Effective Date	01/04/2010
City	ANYTOWN	Sp/Exp	/ N
State	MA	Hired Date	01/04/2010
Zip	01000	Marital Status	Married
County		Gender	Female
Home Phone	617 555-8876	Age	40
Work Phone	617 555-8789	Number of Dependents	
Email	SNEWHIRE@MYCOMPANY.COM		

Coverage Information As Of: 02/02/2010

Product	COV	Plan ID	DEP/Family COV	COB	Product	COV	Volume
MEDICAL PLAN	Y	MM-X00MED001	Family	N	FLEXIBLE SPENDING BENEFIT	Y	0.00
DENTAL PLAN	Y	DE-X00DEN001	Family	N			
RX PLAN	Y	RX-X00RX001	Family	N			
Vision	N						
Flex	N						

Short Term Disability: N

Change Request

6. LIFE CHANGE EVENT

Enter the effective date of the change, and click **Life Change Event**.

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ENROLLMENT

Enrollment and Change Options

Life Change Event

Date of Change: 02/01/2010 * mm/dd/yyyy

Use this option to request changes to your health coverage. Changes include things like: Newborn child, divorce, marriage, court mandates, termination of coverage, drop dependent coverage, change primary care physician etc. A date of change must be provided in order to begin the life event change process.

Existing Requests

Type of Request	Action	Status	Plan Year
New Hire	View	Approved	01/01/2010

7. MEMBER INFORMATION

Make any necessary changes to the member's information, then click **Save & Continue**.

PLEASE USE ALL CAPITAL LETTERS WHEN ENTERING INFORMATION.

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ENROLLMENT - LIFE EVENT

Progress: **Employee** | Dependent | Elections | Supplemental | Summary | Complete

* = Required

Plan Period: 01/01/2010

Employee Information

First Name: SALLY *
 Middle Initial:
 Last Name: NEWHIRE *
 Suffix:
 Employee ID: HHX000000 (9 characters, no spaces or dashes)
 Secondary ID: SSN-##-#### (up to 12 characters)
 Employee Status: Active *
 Gender: Female *
 Date of Birth: 01/01/1970 (mm/dd/yyyy) *
 Age: 40
 Address 1: 10 SAMPLE STREET *
 Address 2:
 City: ANYTOWN *
 State: MA *
 Zip: 01000 *
 County:
 Home Phone: 617 555-9876
 Work Phone: 617 555-6789
 E-Mail Address: SNEWHIRE@MYCOMPANY.COM (Recommended)
 Marital Status: Married
 Hired Date: 01/04/2010
 Beneficiary: GEORGE NEWHIRE, HUSBAND (Full name, relation)
 Employment: Full-Time
 Annual Earnings: 50000.00 (1,000.50)
 Department: NONUNION EMPLOYEES *
 Medicare Coverage Type: No Medicare *
 Do You Have Other Health Coverage: NO *
 If YES, please indicate which types of coverage you have and if they are primary.
 Major Medical Is Primary Coverage
 Dental Is Primary Coverage
 Vision Is Primary Coverage
 Prescription Drugs Is Primary Coverage

<< Back | Save & Continue >> | Cancel Enrollment

8. ADDING A DEPENDENT

To add a dependent, click **Add Dependent** after confirming the employee's information (Step 7 above).

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ENROLLMENT - LIFE EVENT

Progress: Employee | **Dependent** | Elections | Supplemental | Summary | Complete

Click on the dependent name to view or edit the dependent information.

Plan Period: 01/01/2010

Dependent Information

Dependent Name	Relationship	Date of Birth
GEORGE NEWHIRE SR.	Spouse	12/31/1970
GEORGE NEWHIRE JR.	Son	01/31/1992

Use employee address information when adding a dependent.

Add Dependent

<< Back | Save & Continue >> | Cancel Enrollment

9. ADDING A DEPENDENT – DATA ENTRY

Enter the new dependent’s personal and demographic information where indicated, then click **Save & Continue**. Fields marked with a * are required.

- Please enter the new dependent’s Social Security Number under “Secondary ID” (if known).
- Name suffixes such as Sr., Jr., etc. must be entered in the “Last Name” field, separated from the last name by a comma with no spaces (e.g., **NEWHIRE,JR.**).
- Please select Relationship Code “Other” for Domestic Partners.
- If the new dependent is a full-time student, please provide the name of the school and semester hours (if known).
- If the new dependent carries other insurance, please check the appropriate box(es) before continuing.
- **PLEASE USE ALL CAPITAL LETTERS WHEN ENTERING INFORMATION.**

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ENROLLMENT - LIFE EVENT

Progress: **Employee** **Dependent** Elections Supplemental Summary Complete

* = Required

Plan Period: 01/01/2010

Dependent Information

First Name: MARY *

Middle Initial:

Last Name: NEWHIRE *

Suffix:

Dependent ID: 9 characters, no spaces or dashes

Secondary ID: SSN-#-#### up to 12 characters

Status: Active

Date of Birth: 02/01/2010 * mm/dd/yyyy

Gender: Female *

Relationship Code: Daughter *

Address 1: 10 SAMPLE STREET

Address 2:

City: ANYTOWN

State: MA

Zip: 01000

County:

Home Phone: 617 555-9876

Work Phone: 617 555-6789

E-Mail Address:

Full Time Student: NO *

School Name:

Semester Hours:

Has Other Health Coverage: NO *

If YES, please indicate which types of coverage.

Major Medical

Dental

Vision

Prescription Drugs

<< Back Save & Continue >> Delete Cancel Enrollment

10. PLAN ELECTION – MEMBER/DEPENDENT COVERAGE CHANGE

If the Life Change Event which occurred warrants a change in coverage elections, make the appropriate changes and click **Save & Continue**.

Do not de-select coverages to process an eligibility termination. Health Plans must confirm COBRA eligibility before processing coverage terminations. Please use the Comments field on the Enrollment Summary page to indicate a coverage termination (see Step 12 below).

11. PLAN ELECTION – SUPPLEMENTAL PRODUCTS

A Life Change Event may also affect eligibility for Supplemental Products. Click on any available supplemental products listed, confirm or change as necessary, and click **Save & Continue**.

11. PLAN ELECTION – SUPPLEMENTAL PRODUCTS (CONTINUED)

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ENROLLMENT - LIFE EVENT

Progress: **Employee** | **Dependent** | **Elections** | **Supplemental** | Summary | Complete

FLEXIBLE SPENDING BENEFIT

When performing a life event/change request, benefit plan selections, covered dependents and supplemental products must be re-defined.

* = Required

Plan Period: 01/01/2010

Select This Product (Check to select)

Annual Earnings 50000.00

<< Back | Save & Continue >> | Cancel Enrollment

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ENROLLMENT - LIFE EVENT

Progress: **Employee** | **Dependent** | **Elections** | **Supplemental** | Summary | Complete

To elect or participate in any of the below supplemental products, click the Product Name link for the product you are interested in to view a description or be taken directly to the website where the product can be reviewed, elected and purchased. Note: some of the products listed below may not be administered by your health plan administrator. These products are offered to you by your employer and or health plan administrator and you are not obligated or required to select these products.

When performing a life event/change request, benefit plan selections, covered dependents and supplemental products must be re-defined.

✓ = Product Selected

Plan Period: 01/01/2010

Supplemental Products

Click on a product to view more information

ADD
EE LIFE
FLEX BEN ✓

<< Back | Save & Continue >> | Cancel Enrollment

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Once all Supplemental Products have been selected, click **Save & Continue**.


12. ENROLLMENT SUMMARY – LIFE CHANGE EVENT

Review the demographic information and coverage selections as entered for accuracy. If all of the information is correct, an authorized Human Resources representative should enter her or his name under “Electronic Signature”, followed by the current date. Please use the “Comments” field to summarize the information being submitted, then click **Submit Request**.

To indicate a termination or cancellation of coverage, please provide the information in the Comments box below the Electronic Signature. Please include the appropriate Termination Code.

TERMINATION CODES

- QE1** Involuntary Termination of Employment (other than by reason of gross misconduct)
- QE2** Voluntary Termination of Employment (employee resignation)
- QE3** Reduction in Hours
- QE4** Divorce or Legal Separation of Covered Employee
- QE5** Dependent Child ceasing to be a Dependent under Plan’s terms (e.g., over maximum age)
- QE6** Death of Covered Employee
- QE7** Covered Employee’s Entitlement to Medicare Benefits
- QE8** Disabled Individual who has sent notice of his/her Social Security Disability Determination



ENROLLMENT - LIFE EVENT

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Progress: [Employee](#) | [Dependent](#) | [Elections](#) | [Supplemental](#) | [Summary](#) | [Complete](#)

This is your benefit elections or changes summary statement, please review this information carefully and make sure all information is correct. Click the Submit Request button at the bottom of this page to submit this enrollment request to your employer for approval and review, once your review is complete and all remaining required fields are filled in. You will be provided with a printable version of your enrollment elections after you have submitted this form.

Plan Period: 01/01/2010

Insured Employee Information

Name	SALLY NEWHIRE	Employee ID	HHX-00-0000
Address 1	10 SAMPLE STREET	Secondary ID	SSN-##-####
Address 2		Date of Birth	01/01/1970
City	ANYTOWN	Age	40
State	MA	Marital Status	Married
Zip Code	01000	Gender	Female
County		Hired Date	01/04/2010
Home Phone	617 555-9876	Employment	Full-Time
Work Phone	617 555-6789	Annual Earnings	\$ 50,000.00
E-mail Address	SNEWHIRE@MYCOMPANY.COM	Department	NONUNION EMPLOYEES
Beneficiary	GEORGE NEWHIRE, HUSBAND	Medicare Coverage	No Medicare
		Status	Active

Dependent Information

Name	Relationship	Status	Address Information
George Newhire Jr.	Son	School	10 SAMPLE STREET, ANYTOWN, MA 01000
George Newhire Sr.	Spouse	Active	10 SAMPLE STREET, ANYTOWN, MA 01000
Mary Newhire	Daughter	Active	10 SAMPLE STREET, ANYTOWN, MA 01000

Plan Elections

Select	Plan Name	Coverage Options	Individuals To Be Covered	Employee Cost
✓	RX PLAN View Details	Family	<input checked="" type="checkbox"/> SALLY NEWHIRE <input checked="" type="checkbox"/> MARY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, JR. <input checked="" type="checkbox"/> GEORGE NEWHIRE, SR.	\$ 0.00 Per Pay Period
✓	DENTAL PLAN View Details	Family	<input checked="" type="checkbox"/> SALLY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, JR. <input checked="" type="checkbox"/> MARY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, SR.	\$ 0.00 Per Pay Period
✓	MEDICAL PLAN View Details	Family	<input checked="" type="checkbox"/> SALLY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, JR. <input checked="" type="checkbox"/> MARY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, SR.	\$ 0.00 Per Pay Period

Supplemental Product Options

Select	Product Name
✓	FLEX BEN

* = Required

Electronic Authorization Signature

First and Last Name * Date * mm/dd/yyyy

Change Request Effective Date * mm/dd/yyyy

Comments For Health Plan Administrator

ADDING NEW BABY MARY NEW HIRE EFF 2/1/2010.

<< Back
Submit Request
Cancel Enrollment

Also use the Comment box to indicate a coverage termination.

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13. ENROLLMENT CONFIRMATION

When you click **Submit Request**, the information is transmitted to Health Plans. You will receive a Confirmation Page. We encourage you to print the Confirmation Page in case you need to contact us at a later date.

Enrollment/Change Request Form

Insured Employee Information

Name SALLY NEWHIRE	Employee ID HHX-00-0000
Address 1 10 SAMPLE STREET	Secondary ID SSN-##-####
Address 2	Date of Birth 01/01/1970
City ANYTOWN	Age 40
State MA	Marital Status Married
Zip Code 01000	Gender Female
County	Hired Date 01/04/2010
Home Phone 617 555-9876	Employment Full-Time
Work Phone 617 555-6789	Annual Earnings \$ 50,000.00
E-mail Address SNEWHIRE@MYCOMPANY.COM	Department NONUNION
Beneficiary GEORGE NEWHIRE, HUSBAND	Medicare Coverage No Medicare
	Network Choice
	Status A

Dependent Information

Name	Relationship	Status	Address Information
George Newhire, Jr.	Son	S	10 SAMPLE STREET, ANYTOWN, MA 01000
George Newhire, Sr.	Spouse	A	10 SAMPLE STREET, ANYTOWN, MA 01000
Mary Newhire	Daughter	A	10 SAMPLE STREET, ANYTOWN, MA 01000

Plan Elections

Select	Plan Name	Coverage Options	Individuals To Be Covered	Employee Cost
<input checked="" type="checkbox"/>	DENTAL PLAN View Details	Family	<input checked="" type="checkbox"/> SALLY NEWHIRE <input checked="" type="checkbox"/> MARY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, JR. <input checked="" type="checkbox"/> GEORGE NEWHIRE, SR.	\$ 0.00 Per Pay Period
<input checked="" type="checkbox"/>	MEDICAL PLAN View Details	Family	<input checked="" type="checkbox"/> SALLY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, JR. <input checked="" type="checkbox"/> MARY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, SR.	\$ 0.00 Per Pay Period
<input checked="" type="checkbox"/>	RX PLAN View Details	Family	<input checked="" type="checkbox"/> SALLY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, JR. <input checked="" type="checkbox"/> MARY NEWHIRE <input checked="" type="checkbox"/> GEORGE NEWHIRE, SR.	\$ 0.00 Per Pay Period

Supplemental Product Options

Select	Product Name
<input checked="" type="checkbox"/>	FLEX BEN

Electronic Authorization Signature

First and Last Name SALLY NEWHIRE **Date** 02/02/2010

Change Request Effective Date 02/01/2010

Comments For Health Plan Administrator