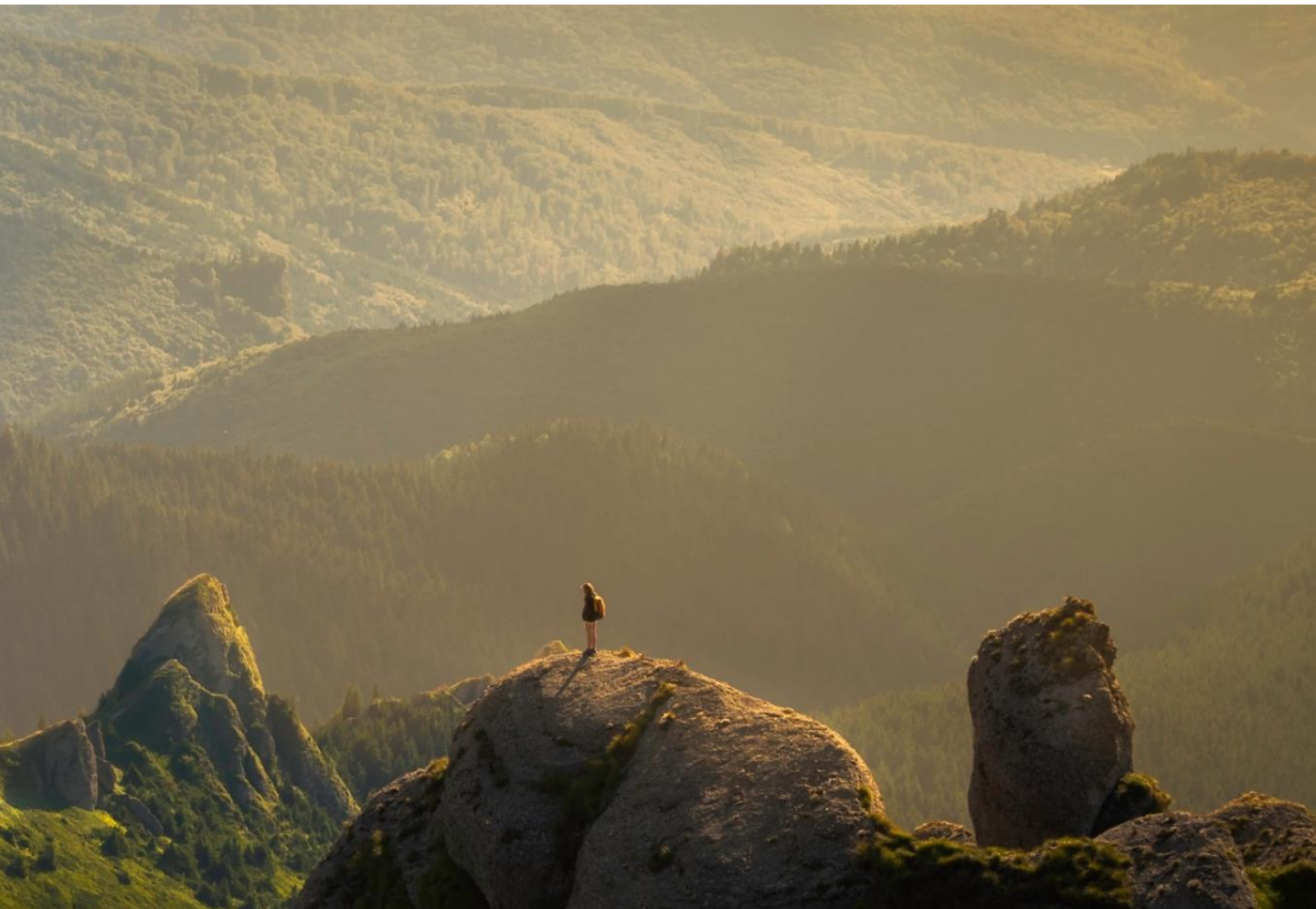
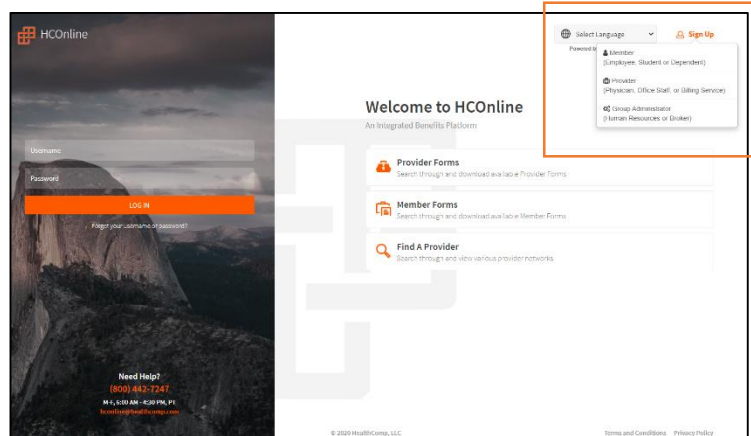


# HCOonline Open Enrollment Guide

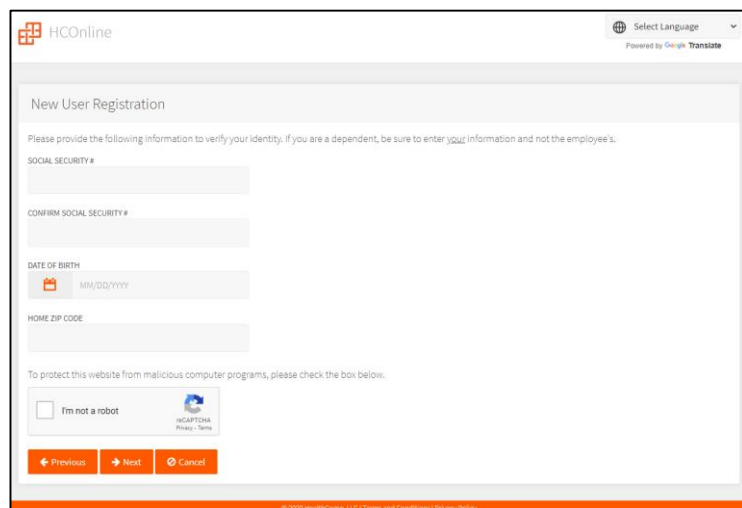


# Registering On HCOOnline

1. In a web browser, navigate to **HCOonline** ([hconline.healthcomp.com](http://hconline.healthcomp.com))  
If you already have an HCOonline account, use your existing credentials to log in.
1. In the upper-right corner, click **Sign Up**. From the dropdown menu, click **Member**. This will open the **New User Registration** wizard.
2. In the **Verification** step of the **New User Registration** wizard, enter your Social Security Number (omitting dashes), Date of Birth (MM/DD/YYYY), and Home Zip Code (#####). Click the **'I'm not a robot'** checkbox. Click **Next**.
3. In the **User Account** step of the **New User Registration** wizard, enter your email account, username, password, security questions, and security question answer. Click **Create New User**.
4. To complete registration, **HCOonline** will send a confirmation to your email address. Access your email and click the link within the email confirmation. This completes the registration process.



HCOonline Login Page

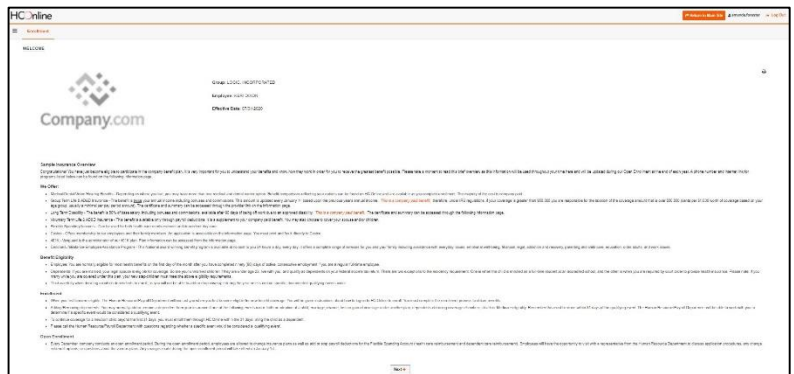
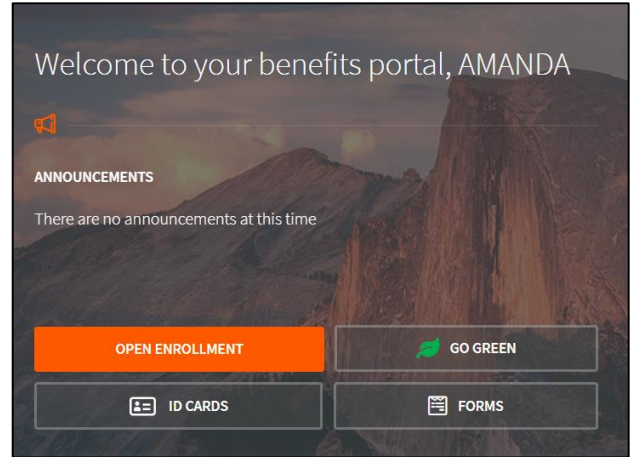


New User Registration Wizard

We recommend adding [hconline@healthcomp.com](mailto:hconline@healthcomp.com) to your address book to ensure you receive all HCOonline email notifications.

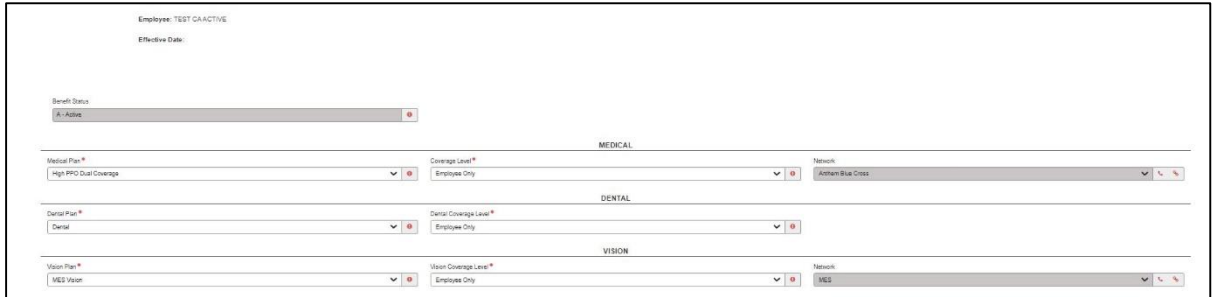
# Employee Demographics

1. Log into your **HOnline** account.
2. Select the **“Open Enrollment”** or **“New Hire Enrollment”** button to begin the enrollment Process.
3. A welcome letter may be displayed after clicking this button. Read the opening page then click **Next**.
4. Complete and/or verify all information on the **Employee Demographics** page.
5. When finished, click **Next**. The system will prompt you for any required fields that are not completed.



# Employee Benefits

The **Employee Benefits** page allows you to elect or waive coverage. You will also select the coverage level such as Employee only or Family.



Employee: TEST CA/ACTIVE  
Effective Date:

Benefit Status: [Active]

**MEDICAL**

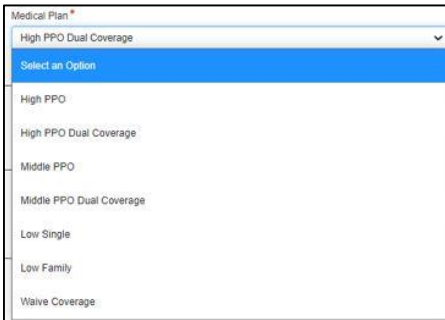
Medical Plan\*: [High PPO Dual Coverage] Coverage Level\*: [Employee Only] Network: [Athletis Blue Cross]

**DENTAL**

Dental Plan\*: [Dental] Dental Coverage Level\*: [Employee Only]

**VISION**

Vision Plan\*: [MEO Vision] Vision Coverage Level\*: [Employee Only] Network: [MEO]



Medical Plan\*

High PPO Dual Coverage

Select an Option

- High PPO
- High PPO Dual Coverage
- Middle PPO
- Middle PPO Dual Coverage
- Low Single
- Low Family
- Waive Coverage



Dental Plan\*

Dental

Select an Option

- Dental
- Waive Coverage



Vision Plan\*

MES Vision

Select an Option

- MES Vision
- Waive Coverage

Enter your beneficiaries for Basic Life/ AD&D. **Note:** If choosing multiple beneficiaries, the total must equal 100%. Once you are finished click **Next**.



ANCILLARY BENEFITS

EE LIFE/AD&D

Plan Options: [EE LIFE/AD&D] Coverage Amount: [10000.00]

Primary Beneficiary(ies) - Total must equal 100%. You are 100% of 100%.

Beneficiary	Name	%	Relationship
1st Beneficiary:	TEST	100	SPOUSE
2nd Beneficiary:	Name	%	Relationship
3rd Beneficiary:	Name	%	Relationship


[Previous] [Reset] [Next]

# Dependents


The **Dependents** page allows you to add dependents you want covered under your plan or update the coverage and demographics for current dependents.

Begin adding eligible dependents by clicking "Add". Then enter their information and select plan enrollment(s). After all dependents are entered, click "Next".


TEST SPOUSE <input checked="" type="checkbox"/>	Spouse	Coverage: No Coverage <input checked="" type="checkbox"/>
TEST SON <input checked="" type="checkbox"/>	Son	Coverage: No Coverage <input checked="" type="checkbox"/>



Update dependent information



Add a new dependent



Add or update coverage

## Dependent Coverage

Select the box next to the coverage you are electing for your dependent.

<input type="checkbox"/> Medical Coverage	<input checked="" type="checkbox"/>
<input type="checkbox"/> Dental Coverage	<input checked="" type="checkbox"/>
<input type="checkbox"/> Vision Coverage	<input checked="" type="checkbox"/>
Status	<input checked="" type="checkbox"/>

Check the Disabled box if this dependent is now incapable of self-support because of disability.

If the Disabled box is checked:


Please submit a copy of a physician's statement certifying disability to HealthComp PO BOX 45018 FRESNO, CA 93718-5018. When finished click **Next**.

<input checked="" type="checkbox"/> Medical Coverage	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> Dental Coverage	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> Vision Coverage	<input checked="" type="checkbox"/>
Status	<input checked="" type="checkbox"/>
<b>DEPENDENT DISABLED STATUS</b>	
<input checked="" type="checkbox"/> Disabled	<small># Disabled box is checked! Please submit a copy of physician's statement certifying TEST's disability to HealthComp PO BOX 45018 FRESNO, CA 93718-5018.</small>

# Other Insurance

If you or any of your dependents have other insurance coverage, click the **Add+** button and complete the other insurance form. If you do not have other insurance to report, click "**No Other Insurance**". Click **Next** to proceed.

**OTHER INSURANCES**



Group: LOGIC, INCORPORATED

Employee: KERI DIXON

Effective Date: 07/01/2020

← Previous
Add +
No Other Insurance
Unknown →

When adding other insurance, enter all required information then click **Next**. Click the **Add+** button again if you have multiple plans to report.

Employee: TEST CAACTIVE

Effective Date:

<p>Policy Holder's Name *</p> <input type="text"/>	<p>Policy Holder's Birth Date *</p> <input type="text" value="MMDDYYYY"/>
<p>Social Security # *</p> <input type="text"/>	<p>I am the Policy Holder's... *</p> <input type="text" value="Select an Option"/>
<p>Sponsoring Employer *</p> <input type="text"/>	<p>Insurance Carrier or Medicare *</p> <input type="text"/>
<p>Group # *</p> <input type="text"/>	<p>Benefit Types</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision</p>
<p>Policy Type *</p> <input type="text" value="Select an Option"/>	<p>Persons Covered Under This Policy *</p> <input type="text"/>
<p>Coverage Date Start *</p> <input type="text" value="MMDDYYYY"/>	<p>Coverage Date End</p> <input type="text"/>

← Previous
Reset
Next →

# Waive Coverage & Confirmation

If you are waiving coverage for yourself and/or any of your dependents. If you have not waived coverage click **next** to proceed to the final page.

This section only needs to be completed if you have elected to waive coverage for you and/or any of your dependents.

You still must select "Waive Coverage" on the Employee Eligibility screen if you are declining coverage for yourself. To decline coverage for a dependent, uncheck the Coverage checkbox(es) on the Dependent Enrollment screen.

Coverage Declaration: To be completed if any coverage is Declined/Waived by an eligible employee and/or eligible family members for medical and/or dental/vision coverages.

Myself ✓

Spouse/DP ✓

Children ✓

Spouse/DP and Children ✓

Reasons for declining coverage: (Check all that apply)

Covered by Spouse's/DP's/Ex-Spouse's group coverage ✓

Spouse/DP/Ex-Spouse covered by employer's group medical ✓

Medicare ✓

Other (explain) ✗

Other Explain:

I acknowledge that information about the available benefit coverages has been provided to me by my employer, and I have decided not to enroll myself and/or my dependent(s), if any. I understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has had to influence me to decline coverage.

## Submitting Your Enrollment

The final page gives you a view of all of the information you have entered. If you find that you need to edit any information, click the **edit** button on the top of the section you wish to edit. Be sure to **print** this page for your records by selecting the print icon in the upper right of the screen.

Once all information has been reviewed and you have read the disclaimer information, click **Submit** at the bottom of the page.

**CONFIRMATION**

Group: LOGIC, INCORPORATED

Employee: KERI DIXON

Effective Date: 07/01/2020

Event

Open Enrollment

Effective Date

07/01/2020

Print Date

8/26/2021 1:12:32 PM

**DEMOGRAPHICS**

[EDIT](#)

**DISCLAIMER INFORMATION**

1. I understand that I cannot change or modify my benefit election during the plan year unless there is a change in my family status such as:
  - Marriage
  - Birth of a child, adoption of a child or placement for adoption of a child
  - Divorce
  - Death of spouse or child
  - Termination of spouse's employment or commencement of spouse's employment that results in a change in coverage
  - An unexpected event of spouse leaves by you or your spouse that results in a loss of coverage
  - A significant change, as determined by the plan, in health coverage for you or your spouse due to your spouse's employment
  - An unmarried dependent child turns 19 years of age or turns 23 years of age. (See the section "Who is Eligible" in the Summary Plan Description Booklet)

See the section "Qualifying Change in Family Status" in the Summary Plan Description Booklet. If I qualify to make a change, I must do so within 30 days of the qualifying event. I understand that I may only add or delete dependents. I further understand that if I have a qualifying event change, I may not change the plan deductible or carrier that I have chosen at the time of enrollment.
2. Waiver Release - I acknowledge that the group benefits, both medical, dental and vision have been offered to me and/or my family members and that I am waiving my rights to enroll due to the fact that I have coverage elsewhere. I understand that by waiving enrollment in a medical or dental plan will not be available until the next open enrollment date as set forth by my employer. Furthermore, I release my company from any liability which may be incurred as a result of this decision.
3. The Plan Sponsor reserves the right to cancel or modify any of the plans.

**RETAIN THE INFORMATION**

Print this page for your own records.

**CONFIRMATION AND SUBMISSION OF ENROLLMENT**

- I have examined the rates on the benefits summary page, and I authorize my employer to place a portion of my salary, before taxes, in the spending accounts above based on my selections.
- I have read all of the material in the "Disclaimer info" section and understand the limitations and liability rates as they apply to me regarding the Flexible Spending Account.
- I have read the Group Term Life & AD&D "Schedule of Insurance".
- I have read the Long Term Disability "Schedule of Benefits".
- To the best of my knowledge, the information furnished on this form is accurate and complete.

[Submit](#)