



## Self Service Instructions for NEW HIRES

1. Log into [Oracle Self Service](#)
2. Click **BENEFITS**



Click ACCEPT

Click NEXT

Legal Disclaimer

Cancel Printable Page Next

Welcome,

As an employee eligible for benefits:

- Current employees may,
  - Review current benefits
  - Update their beneficiary information
- Newly hired employees, within 30 days of their date of hire, may,
  - Elect to enroll in,
    - medical, prescription, dental, vision coverage,
    - flexible spending account (FSA) (health and/or child care),
    - supplemental life insurance (optional life, spouse life, child life and/or long term disability)
  - Designate beneficiary(ies) for their life insurance

When electing benefits:

- Benefits coverage is effective the first of the month following the date you elect to enroll (ie. If you are electing coverage in October, coverage would be effective November 1st)
  - If you choose not to participate in benefits, you MUST elect the "no coverage option".
- All benefit eligible employees are eligible for PGCPS sponsored life insurance coverage, and are encouraged to update their beneficiaries as they experience life changing events. Updating your beneficiaries for your life insurance can be done at any time.

Disclaimer:

The Oracle Employee Self Service website is the gateway to selecting your benefits. Selections made within the Employee Self Service System are binding for the benefit plan year (January - December); unless you experience an IRS (Section 125) "qualifying life event", also known as "qualifying event" or "family status change". Examples of qualifying life events include, marriage, divorce, birth, adoption, loss of coverage, or gain of coverage.

If you experience a "qualifying event" or "family status change" you have 30 days from the date of the event or status change to make changes to your benefit elections during the plan year.

By proceeding, you agree that:

- All the information provided is accurate.
- You will provide the designated third party administrator with any required supporting documentation (marriage certificate, birth certificate(s), and Social Security Number(s) etc..) to properly enroll your dependent(s) on the benefit plan(s) elected.
- The information submitted represents your enrollment choice(s) and that you are authorizing contributions to be withheld from your pay on a pre-tax basis for the healthcare coverage selected.
- You authorize participating vendors to forward general information concerning medical services or supplies provided to you or to any of your family member(s) listed on the coverage for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of coverage.
- You will contact the Benefits Services Office immediately if your coverage level is incorrect, as you may be subject to a catch up deduction.

Questions and/or concerns: email [pgcps.benefits@pgcps.org](mailto:pgcps.benefits@pgcps.org) or contact 301-952-6600 for assistance.

Benefits Services

- Accept  
 Decline

Cancel Printable Page Next

3. Please confirm each family member you are adding to your health/life insurance are listed in the box titled, "**CONTACTS and BENEFICIARIES**". If the name is not listed click **ADD ANOTHER PERSON** and enter dependent information. Click **NEXT**

**Contacts and Beneficiaries**

Name: Jane Doe

[Add Another Person](#)

Name	Relationship	Social Security Number	Birth Date	Update
Michael Doe	Spouse	████████3333	15-Jan-1956	
Katy Doe	Child	████████5666	01-Sep-2016	
Henry Doe Jr.	Brother	████████8888	15-Jan-1973	
Shenelle Doe	Sister		14-Apr-1985	

**TIP** Press update icon to validate address and other information.  
**TIP** Click on the button labeled: "Next" to update your benefit elections.

Cancel Next

#### 4. Click **UPDATE BENEFITS**

Benefits Enrollment | Current Benefits

Name: Jane L. Doe  
Event Name: Open  
Program: Active Benefits Program  
Enrollment Period: 04-OCT-2016 - 28-OCT-2016

[Update Benefits](#)

**Benefit Selections**

Plan	Option	Coverage	Start Date	Coverage	Cost 1	Cost 2	Cost 3	Cost 4
Life Insurance - Basic Life Insurance		01-Jul-2016	109000.00	0.00	0.00	0.00	0.00	8.10
<b>Total</b>				<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>8.10</b>

**Beneficiaries**

Plan	Option	Beneficiary	Relationship	Social Security Number	Primary %	Contingent %
Life Insurance - Basic Life Insurance		Jarell Rauch	Child	████████	90	0
		Janette Do	Contact	████████	10	0

[Update Benefits](#)

Benefits Enrollment | Current Benefits | Home | Logout | Preferences | Help

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5. Check the box for each level of coverage you wish to elect, for example:  
**Medical, Dental, Vision, Prescription, Dependent Child Life Insurance, Spouse Life Insurance, Long Term Disability, Optional Life Insurance, Flexible Spending Accounts.** Click Next

Benefits Enrollment | Current Benefits

Update Enrollments | Update Enrollments Additional Data | Cover Dependents | Update Beneficiaries | Update Primary Care Providers | Confirmation Statement

Update Benefits: Update Enrollments

Name: Jane L. Doe  
Event Name: Open  
Program: Active Benefits Program  
Enrollment Period: 04-OCT-2016 - 28-OCT-2016

Currency = US Dollar

[Recalculate](#) [Back](#) [Next](#)

**Medical Insurance**

Plan	Option	Select	Cost
Medical	Employee Only	<input type="checkbox"/>	41.66
	Employee + 1	<input type="checkbox"/>	101.17
	Family	<input checked="" type="checkbox"/>	106.50
Medical-No Coverage		<input type="checkbox"/>	

**Dental Insurance**

Plan	Option	Select	Cost
Dental	Employee Only	<input type="checkbox"/>	4.24
	Employee + 1	<input type="checkbox"/>	13.30
	Family	<input checked="" type="checkbox"/>	14.00
Dental-No Coverage		<input type="checkbox"/>	

Vision Insurance			
Plan	Option	Select	Cost
Vision	Employee Only	<input type="checkbox"/>	0.18
	Employee + 1	<input type="checkbox"/>	0.44
	Family	<input checked="" type="checkbox"/>	0.46
Vision-No Coverage		<input type="checkbox"/>	

  

Prescription Insurance			
Plan	Option	Select	Cost
Prescription	Employee Only	<input type="checkbox"/>	18.40
	Employee + 1	<input type="checkbox"/>	35.19
	Family	<input checked="" type="checkbox"/>	37.04
Prescription-No Coverage		<input type="checkbox"/>	

6. Click **NEXT** again

Benefits Enrollment | Current Benefits

Update Enrollments | Update Enrollments Additional Data | Cover Dependents | Update Beneficiaries | Update Primary Care Providers | Confirmation Statement

Update Benefits: Update Enrollments Additional Data

Name: Jane L. Doe      Program: Active Benefits Program  
 Event Name: Open      Enrollment Period: 04-OCT-2016 - 28-OCT-2016

\* Indicates required field  
 The benefit selections you have made do not require any Enrollments Additional Data. Please click Next to continue.

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7. Check the box next to the name of dependent(s) you are adding to your **HEALTH AND LIFE INS.** Click Next

Update Benefits: Cover Dependents

Name: Jane L. Doe      Program: Active Benefits Program  
 Event Name: Open      Enrollment Period: 04-OCT-2016 - 28-OCT-2016

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**Dependent Selection**

TIP Missing Persons may not be family members or are ineligible.

**Medical Insurance : Medical Family**

Dependent	Relationship	Social Security Number	Eligible	Ineligibility Reason	Cover
Michael Doe	Spouse	[REDACTED]	Yes		<input checked="" type="checkbox"/>
Katy Doe	Child	[REDACTED]	Yes		<input checked="" type="checkbox"/>

**Dental Insurance : Dental Family**

Dependent	Relationship	Social Security Number	Eligible	Ineligibility Reason	Cover
Michael Doe	Spouse	[REDACTED]	Yes		<input checked="" type="checkbox"/>
Katy Doe	Child	[REDACTED]	Yes		<input checked="" type="checkbox"/>

**Vision Insurance : Vision Family**

Dependent	Relationship	Social Security Number	Eligible	Ineligibility Reason	Cover
Michael Doe	Spouse	[REDACTED]	Yes		<input checked="" type="checkbox"/>
Katy Doe	Child	[REDACTED]	Yes		<input checked="" type="checkbox"/>

**Prescription Insurance : Prescription Family**

Dependent	Relationship	Social Security Number	Eligible	Ineligibility Reason	Cover
Michael Doe	Spouse	[REDACTED]	Yes		<input checked="" type="checkbox"/>
Katy Doe	Child	[REDACTED]	Yes		<input checked="" type="checkbox"/>

**Dependent Child Life : Dependent Child Life \$10,000**

Dependent	Relationship	Social Security Number	Eligible	Ineligibility Reason	Cover
Katy Doe	Child	[REDACTED]	Yes		<input checked="" type="checkbox"/>

**Dependent Spouse Life : Dependent Spouse Life \$20,000**

Dependent	Relationship	Social Security Number	Eligible	Ineligibility Reason	Cover
Michael Doe	Spouse	[REDACTED]	Yes		<input checked="" type="checkbox"/>

**Add Dependents**

The people listed above are eligible for dependent coverage. Please add any dependents you want to cover and restart the enrollment process.

[Add Dependents](#) [Back](#) [Next](#)

8. **(Note: Please insure to update your beneficiary information for Basic Life and Optional Life insurance (if elected). The election amounts should total 100%)**

**Life Insurance : Basic Life Insurance**

Family Members and Others

Beneficiary	Relationship	Social Security Number	Primary %	Contingent %	Clear
Henry Doe Jr.	Brother	[REDACTED]	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="checkbox"/>
Janette Do	Contact	[REDACTED]	<input type="text" value="10"/>	<input type="text" value="0"/>	<input checked="" type="checkbox"/>
Jarell Rauch	Child	[REDACTED]	<input type="text" value="90"/>	<input type="text" value="0"/>	<input checked="" type="checkbox"/>
Katy Doe	Child	[REDACTED]	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="checkbox"/>
Michael Doe	Spouse	[REDACTED]	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="checkbox"/>
Shenelle Doe	Sister	[REDACTED]	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="checkbox"/>

**Note** The following beneficiaries do not exist: Janette Do , Jarell Rauch . You should remove these beneficiary designations.

[Recalculate](#)

Primary %	Contingent %
100	0

**TIP** Total Percentages for the plan must equal 100

**Optional Life Insurance : Optional Life Insurance \$200,000**

Family Members and Others

Beneficiary	Relationship	Social Security Number	Primary %	Contingent %	Clear
Henry Doe Jr.	Brother	[REDACTED]	<input type="text" value="25"/>	<input type="text" value="0"/>	<input type="checkbox"/>
Katy Doe	Child	[REDACTED]	<input type="text" value="25"/>	<input type="text" value="0"/>	<input type="checkbox"/>
Michael Doe	Spouse	[REDACTED]	<input type="text" value="25"/>	<input type="text" value="0"/>	<input type="checkbox"/>
Shenelle Doe	Sister	[REDACTED]	<input type="text" value="25"/>	<input type="text" value="0"/>	<input type="checkbox"/>

9. Click NEXT

Please read **WARNING** section that requires possible further action that you may be required to take. Example: If you elected Employee + One or Family health insurance coverage you will be contacted by our third party administrator Bolton (see message below)

Previous Update Primary Care Providers Confirmation Statement

**Warning**

- Your changes have been saved. However, there are additional action items to complete for the enrollments you selected. Any required action item suspends the election. Optional action items are requests for additional information. These include:
- Dental - <Optional> - Michael Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent. <Optional> - Katy Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent.
- Dependent Child Life - <Required> - Enrollment in this benefit requires that you complete the Personal Health Application (Evidence of Insurability) form. This form can be found on the Benefits Services webpage (www1.pgcps.org/benefits/index.aspx?id=139370). Please complete the required form and email it to benefits.documents@pgcps.org
- Dependent Spouse Life - <Required> - Enrollment in this benefit requires that you complete the Personal Health Application (Evidence of Insurability) form. This form can be found on the Benefits Services webpage (www1.pgcps.org/benefits/index.aspx?id=139370). Please complete the required form and email it to benefits.documents@pgcps.org
- Long Term Disability - <Required> - Enrollment in this benefit requires that you complete the Personal Health Application (Evidence of Insurability) form. This form can be found on the Benefits Services webpage (www1.pgcps.org/benefits/index.aspx?id=139370). Please complete the required form and email it to benefits.documents@pgcps.org
- Medical - <Optional> - Katy Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent. <Optional> - Michael Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent.
- Optional Life Insurance - <Required> - Enrollment in this benefit requires that you complete the Personal Health Application (Evidence of Insurability) form. This form can be found on the Benefits Services webpage (www1.pgcps.org/benefits/index.aspx?id=139370). Please complete the required form and email it to benefits.documents@pgcps.org
- Prescription - <Optional> - Katy Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent. <Optional> - Michael Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent.
- Vision - <Optional> - Katy Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent. <Optional> - Michael Doe - Designation of dependent for this benefit requires that you provide proper certification. You will be contacted by AON Hewitt with instructions on how to submit supporting documentation for this dependent.

**Please review Confirmation page. Click Confirmation Statement (Print or save to your desktop) Click Finish**

Confirmation Statement

Name Jane L. Doe Program Active Benefits  
 Event Name Open Enrollment Period 04-OCT-2016 - 28-OCT-2016

Back Printable Page Confirmation Statement Finish

**TIP** Click Confirmation Statement to get a PDF document of your enrollments. Click Finish to complete the enrollment process, then click the Logout link when you are ready to leave the application.

**Benefit Selections**

Plan	Option	Coverage Start Date	Coverage	Cost 1	Cost 2	Cost 3
Medical Insurance - Medical	Family	01-Jan-2017		106.50	0.00	0.00
Dental Insurance - Dental	Family	01-Jan-2017		14.00	0.00	0.00
Vision Insurance - Vision	Family	01-Jan-2017		0.46	0.00	0.00
Prescription Insurance - Prescription	Family	01-Jan-2017		37.04	0.00	0.00
Life Insurance - Basic Life Insurance		01-Jul-2016	109000.00	0.00	0.00	0.00
Dependent Child Life - Dependent Child Life(Suspended)	\$10,000	01-Jan-2017	10000.00	0.00	0.23	0.00
Dependent Spouse Life - Dependent Spouse Life(Suspended)	\$20,000	01-Jan-2017	20000.00	0.00	7.89	0.00
Long Term Disability - Long Term Disability(Suspended)	LTD	01-Jan-2017	4539.66	0.00	29.90	0.00
Optional Life Insurance - Optional Life Insurance(Suspended)	\$200,000	01-Jan-2017	200000.00	0.00	52.62	0.00
Flexible Spending Accounts - FSA Dependent Care		01-Jan-2017	1000.00	38.46	0.00	0.00
Flexible Spending Accounts - FSA Health Care		01-Jan-2017	500.00	19.23	0.00	0.00
<b>Total</b>				<b>215.69</b>	<b>0.00</b>	<b>0.00</b>

**\*\*\* PGCPs has contracted Bolton to perform ongoing dependent eligibility verification services. All employees who added new dependents to PGCPs group health plans will be required to provide verification of eligibility of their newly enrolled dependent(s). Employees will receive correspondence directly from Bolton and are encouraged to respond to such correspondence as soon as possible. Dependents that are not verified in accordance with the terms included in the correspondence received from Bolton will not be eligible for coverage on PGCPs group health plans. \*\*\***