



Welcome to Your Employee Benefits Supersite!
<https://mm.benselect.com/enroll/login.aspx>

NEW MEMBER LOGIN

Username: Full SSN, no dashes, no spaces

Password: 4-digit birth year

WHEN CAN I ENROLL?

Open Enrollment

You may enroll and make changes online during the annual open enrollment window **10/01/2020 through 10/31/2020**. Once open enrollment has closed, you may not make any changes to your benefit elections unless you experience a qualifying event. However, you can update your personal information and beneficiary selections at any time.

HOW DO I ENROLL?

Use the following pages to guide you in electing voluntary whole life insurance for you and your family.

Home You & Your Family My Benefits Sign & Submit

Welcome to Your Benefit Enrollment for Plan Year 2021

At St. Johns County School District, we know that benefit requirements change. That's why we have an open enrollment period each year.

For most benefits, Open Enrollment is the only time of year you are allowed to make changes in your benefits. Unless you experience some qualifying life event, you will only be able to make benefit changes during the Open Enrollment period. During open enrollment, you should consider the benefits you have today and ask yourself if they will serve you and your loved ones well in the coming plan year.

Benefit enrollment is easy! Just follow these steps.

- First, review and contact HR to update personal information about you or your covered dependents.
- Review each of your benefit elections and make your choices.
- Sign the Enrollment Confirmation form to complete your enrollment.

Click [Next](#) to begin.

Press [Next](#) to review personal information and begin enrollment.

[Next](#)

✓ Your Benefit Options
MassMutual@Work Whole Life

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Use SSN number (no dashes, no spaces) for username and 4 digit birth year for password. This is the Welcome page when you log in. ***Pro tip: Follow the orange Next button to proceed.**

Home You & Your Family My Benefits Sign & Submit

Personal Information

Please review your personal information to ensure it's correct and complete. Please correct any errors and click the Next button when you are finished.
Optional items are in *italics*.

Personal Info

Name:

First Last Suffix

Date of Birth:

SSN:

Gender: Male Female Other

Contact info

Address: Country

Street

Street (cont.)

City State Zip

Mailing Address: Same as home address

Country

Street

Street (cont.)

City State Zip

Home Phone:

Work Phone:

Mobile Phone:

Email:

Personal Email:

Personal Information. Some information will be pre-filled. If you hit the Next button and additional information is needed on this screen, it will indicate which required fields are missing. Verify all your information is correct.

Dependents

Click *Add* ("Plus" icon at top right of table) to add your spouse or dependent children. Dependent children may only be covered in a plan if they meet the necessary requirements defined by the plan. Click the *Next* button when you are finished.

Dependents

No Dependent Information Available

Name	SSN	DOB	Sex	Relation	Uploads	+
No items found.						

Add a Dependent

If your dependent is not listed above or you would like to add an additional dependent, simply click the *Add Dependent* button below.

+ Add Dependent

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You may add dependents here by either clicking the plus icon on the right-hand side or by clicking the "Add Dependent" button towards the bottom. ***Pro tip: Dependents added here will also appear in your beneficiaries. Dependents are eligible for \$25,000 in Whole Life coverage when an employee elects \$25,000 or more in coverage.**

Add Dependent

Add information on your dependents below. Optional fields are marked in *italics*.

Required information is missing or invalid.

- *First Important: Please complete this required field*
- *Last Important: Please complete this required field*
- *Date of Birth Important: Please complete this required field*

Dependent Info

Relationship:

Name:
First MI Last Suffix

Date of Birth:

SSN:

Gender: Male Female Other

Full-time Student: Yes No

Disabled: Yes No

Address: Same as employee

Country

Street

Street (cont.)

City State Zip

Email Address:

When adding a dependent, the only necessary information is their relationship to you, "Spouse" or "Child" (for grandchild, use "Child"), first and last names, date of birth, gender, and if they are a full time student, and/or disabled. Then click Save.

My Benefits

Below is a list of your current benefit elections. Click "Review" for benefit information and to elect or decline coverage.

MassMutual@Work Whole Life Review

You have to complete enrollment in this plan.

My Benefits	
<input type="radio"/> MassMutual@Work Whole Life	\$0.00
Post-tax cost	\$0.00
Total Cost Per Pay Period	\$0 ⁰⁰

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Here you begin your election for Whole Life coverage by clicking inside the circle "MassMutual@Work Whole Life." Please click the Next button.

MassMutual@WorkSM Whole Life Insurance

Select the desired benefit amount or cost from the list below. If you wish you may enter a specific coverage amount or benefit amount. You may select any optional coverages (if offered) from the list below.

To apply, select *I wish to apply for this coverage*. If you do not wish to purchase this coverage, choose *I wish to DECLINE this coverage*. Press Next when you are finished.

Additional Information

- Product Summary
- Whole Life Insurance coverage visual overview
- Important Consumer and Privacy Notice
- COVID19 Notice

My Benefits	
MassMutual@Work Whole Life	\$0.00
Periodic cost	\$0.00
Total Cost Per Pay Period	\$0⁰⁰

Insurance for **Aimee Test**

Within the last 12 months, have you used tobacco or other nicotine containing products (e.g. cigarettes, e-cigarettes/vape, pipes, snuff, chewing tobacco, or nicotine delivery device such as gum or the patch), or more than 24 cigars?

Is your Spouse currently applying for or collecting any disability benefits (including but not limited to Social Security Disability)?

During the last 2 years, has any Proposed Insured been treated for, received medical advice for, been hospitalized for, been prescribed medication for, or been diagnosed by a licensed member of the medical profession as having, any of the following:

- Cancer or malignancy of any kind including carcinomas in situ and melanoma (excluding non-melanoma skin cancer)
- Alcohol or drug abuse
- Diabetes for which the recommended treatment is insulin
- Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy
- Stroke or transient ischemic attack (TIA)
- Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)
- Cirrhosis of the liver or hepatitis (excluding Hepatitis A)
- Parkinson's disease or paralysis
- Chronic kidney disease or kidney failure (excluding kidney stones)
- AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immunodeficiency Virus) or its antibodies?

Have you ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

Benefit Amount: \$0.00

Cost per Pay Period: \$0.00

I wish to apply for this coverage
 I wish to CANCEL this coverage

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Answer the 4 questions on this page. Be sure you select “yes” for actively at work. A chart with amounts ranging from \$10,000 to \$250,000 will appear after you have answered the questions, if eligible. Despite your answer to the third question, you are fully eligible for up to \$100,000 in Guaranteed Issue coverage. ***Pro tip: If you have a cost per pay period or coverage amount desired that is not listed in the chart, you can customize the coverage in increments of \$5,000 by typing your selection into the calculator function and hit the calculator button.**

At this point, you can either apply for coverage or waive the coverage and click the orange Next button. ***Pro Tip: You can learn more about the product and coverage features by clicking on the links provided under additional information at the top of the page.**

MassMutual@WorkSM Whole Life Insurance

MassMutual@Work Whole Life

Each person currently covered is listed below. If you wish to make a change to the coverage, click the person's name.

Primary Insured	Relationship	DOB	Policy #	Benefit	Premium	Options
Tom Test	Employee	1/1/1976		100,000	\$80.50	Withdraw

You may apply for coverage for any of the individuals listed below, if eligible. To view prices or apply, click the name of the person in the list below.

Name	Relationship	Sex	DOB	Riders
Aimee Test	Spouse	F	9/14/1985	
Jack Test	Child	M	5/15/2015	

- I wish to CONFIRM the changes made in this enrollment session.
- I wish to CANCEL changes made in this enrollment session.

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If you added dependents and elected \$25,000 or more in coverage for yourself, you are able to enroll an eligible spouse, child, or grandchild here by clicking on their name.

MassMutual@WorkSM Whole Life Insurance

Select the desired benefit amount or cost from the list below. If you wish you may enter a specific coverage amount or benefit amount. You may select any optional coverages (if offered) from the list below.

To apply, select *I wish to apply for this coverage*. If you do not wish to purchase this coverage, choose *I wish to DECLINE this coverage*. Press Next when you are finished.

Additional Information

- Product Summary
- Whole Life Insurance coverage visual overview
- Important Consumer and Privacy Notice
- COVID19 Notice

My Benefits	
MassMutual@Work Whole Life	\$0.00
Periodic cost	\$0.00
Total Cost Per Pay Period	\$0⁰⁰

Insurance for *Aimee Test*

Within the last 12 months, have you used tobacco or other nicotine containing products (e.g. cigarettes, e-cigarettes/vape, pipes, snuff, chewing tobacco, or nicotine delivery device such as gum or the patch), or more than 24 cigars? Please Select

Is your Spouse currently applying for or collecting any disability benefits (including but not limited to Social Security Disability)? Please Select

During the last 2 years, has any Proposed Insured been treated for, received medical advice for, been hospitalized for, been prescribed medication for, or been diagnosed by a licensed member of the medical profession as having, any of the following: Please Select

- a. Cancer or malignancy of any kind including carcinomas in situ and melanoma (excluding non-melanoma skin cancer)
- b. Alcohol or drug abuse
- c. Diabetes for which the recommended treatment is insulin
- d. Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy
- e. Stroke or transient ischemic attack (TIA)
- f. Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)
- g. Cirrhosis of the liver or hepatitis (excluding Hepatitis A)
- h. Parkinson's disease or paralysis
- i. Chronic kidney disease or kidney failure (excluding kidney stones)
- j. AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV (Human Immunodeficiency Virus) or its antibodies?

Have you ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? Please Select

Benefit Amount: \$0.00

Cost per Pay Period: \$0.00

I wish to apply for this coverage

I wish to CANCEL this coverage

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Next

Spouses are on "Express Issue" and must answer the questions here accordingly.

MassMutual@WorkSM Whole Life Insurance

Select the desired benefit amount or cost from the list below. If you wish you may enter a specific coverage amount or benefit amount. You may select any optional coverages (if offered) from the list below.

To apply, select *I wish to apply for this coverage*. If you do not wish to purchase this coverage, choose *I wish to DECLINE this coverage*. Press Next when you are finished.

Additional Information

- Product Summary
- Whole Life Insurance coverage visual overview
- Important Consumer and Privacy Notice
- COVID19 Notice

Insurance for Jack Test

Indicate any dependent child who is currently applying for or collecting disability benefits (including but not limited to Social Security Disability).

Benefit Amount: \$0.00

Cost per Pay Period: \$0.00

I wish to apply for this coverage
 I wish to CANCEL this coverage

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My Benefits	
MassMutual@Work Whole Life	\$0.00
Post-tax cost	\$0.00
Total Cost Per Pay Period	\$0⁰⁰

Children and grandchildren are on Guaranteed Issue and must not be collecting nor applying for disability benefits.

MassMutual@WorkSM Whole Life Insurance

MassMutual@Work Whole Life

Each person currently covered is listed below. If you wish to make a change to the coverage, click the person's name.

Primary Insured	Relationship	DOB	Policy #	Benefit	Premium	Options
Tom Test	Employee	1/1/1976		100,000	\$80.50	Withdraw
Aimee Test	Spouse	9/14/1985		25,000	\$13.38	Withdraw
Jack Test	Child	5/15/2015		25,000	\$6.88	Withdraw

- I wish to CONFIRM the changes made in this enrollment session.
- I wish to CANCEL changes made in this enrollment session.

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[Next](#)

This screen shows all coverages elected and applied for. Please click Next to proceed.

MassMutual@WorkSM Whole Life Insurance

Choose Beneficiaries

A beneficiary is a person, organization, or trust who is designated by the certificate owner to receive benefits under the certificate. A certificate owner may designate multiple beneficiaries and indicate each beneficiary's share of the benefit amount as either primary or secondary beneficiaries. Secondary beneficiaries will receive a share only in the event that there are no surviving primary beneficiaries at the time a benefit is payable to a beneficiary. If a beneficiary does not survive to receive a share, the share is paid proportionately to the surviving beneficiaries of the same class.

- Place a checkmark next to each desired primary and contingent beneficiary. The percentage allocations will automatically calculate.
- Click Add (Plus sign) if you do not see the desired person or trust in the list.
- You may change the percentages, as long as they add up to 100%.
- Clicking *All living children* will clear any children already selected.
- Beneficiaries may not be both primary and contingent at the same time.

Note: Editing a beneficiary that is of a coverable type (such as spouse or child) will edit that dependent's information as well. For this reason, it is recommended to add a new beneficiary rather than edit one that is already in the list as a dependent.

Beneficiary	Relationship	Primary	Contingent	
Estate		<input type="checkbox"/> 0.00%	<input type="checkbox"/> 0.00%	+ ✕

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Next

This is where you will enter your beneficiaries. If dependents were entered, they will automatically appear here. You can add beneficiaries here by clicking on the "+" icon on the right side of the screen. Make sure to check the appropriate box under primary or contingent. ***Pro Tip: It is best practice to always list both a primary and contingent beneficiary.**

MassMutual@WorkSM Whole Life Insurance

Choose Beneficiaries

A beneficiary is a person, organization, or trust who is designated by the certificate owner to receive benefits under the certificate. A certificate owner may designate multiple beneficiaries and indicate each beneficiary's share of the benefit amount as either primary or secondary beneficiaries. Secondary beneficiaries will receive a share only in the event that there are no surviving primary beneficiaries at the time a benefit is payable to a beneficiary. If a beneficiary does not survive to receive a share, the share is paid proportionately to the surviving beneficiaries of the same class.

- Place a checkmark next to each desired primary and contingent beneficiary. The percentage allocations will automatically calculate.
- Click Add (Plus sign) if you do not see the desired person or trust in the list.
- You may change the percentages, as long as they add up to 100%.
- Clicking *All living children* will clear any children already selected.
- Beneficiaries may not be both primary and contingent at the same time.

Note: Editing a beneficiary that is of a coverable type (such as spouse or child) will edit that dependent's information as well. For this reason, it is recommended to add a new beneficiary rather than edit one that is already in the list as a dependent.

Relationship: <Choose Relationship>

Name:
First MI Last Suffix

Gender: Male Female Other

Type: Primary

Save Cancel

To enter beneficiary information, please follow the prompts when adding.

Home You & Your Family My Benefits Sign & Submit

MassMutual@WorkSM Whole Life Insurance

Secondary Addressee (Provide name and address of the person you wish to receive notice prior to termination of coverage for non-payment of premium.)

First Name	Last Name	Middle Initial	Suffix	Address Line 1	Address Line 2	City	State	Zip Code	+
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If you would like to enter a secondary addressee (somehow who would receive policy information if the policy was at risk of termination), you may do so here by clicking the “+” icon.

MassMutual

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MassMutual@W

Secondary Addressee (Pr
termination of coverage f

First Name	<input type="text"/>
Last Name	<input type="text"/>
Middle Initial	<input type="text"/>
Suffix	<input type="text"/>
Address Line 1	<input type="text"/>
Address Line 2	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>

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Save Cancel

Follow the prompts to enter secondary addressee information.

MassMutual@WorkSM Whole Life Insurance

Product Features

1. Automatic Premium Loan: [Click for more info](#)

Yes No

2. Dividend Option (Select one): [Click for more info](#)

Paid-Up Additions (default)
 Dividend Accumulations
 Cash

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Next

Product features. You can learn more about the product features by clicking on the links provided. Please make the desired choices and press the Next button.

MassMutual@WorkSM Whole Life Insurance

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

By my electronic signature, I, the Employee certify under penalties of perjury that (1) the number shown in the Employee section is my correct Taxpayer Identification Number; (2) I am a US person (including US resident alien); (3) the FATCA code entered on this form (if any) indicating that I am exempt from FATCA (Foreign Account Tax Compliance Act) reporting is correct; and (4) I certify that my response below is true:

- Yes, I am subject to back up tax withholding.
 No, I am not subject to back up tax withholding.

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Next

IRS question relating to tax backup withholding. This is most commonly answered "No" but if you are subject to backup withholding, select "Yes."

MassMutual@WorkSM Whole Life Insurance

I acknowledge receiving the disclosure statement regarding the Accelerated Death Benefit for Terminal Illness feature, if required by the state I reside in.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

I understand that I will be the owner of any Certificate issued as a result of this application. I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements I make which materially affect the acceptance of the risk assumed may result in loss of coverage under the Certificate to which the application is attached. I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

I hereby authorize payroll deduction of any premiums for insurance purchased from Massachusetts Mutual Life Insurance Company.

By clicking the submit/agree button you are agreeing to the terms of this Electronic Signature Agreement and authorize Massachusetts Mutual Life Insurance Company (MassMutual) to accept as valid and legally binding your electronic submission of this application and all other required documentation for MassMutual@Work insurance coverage. This electronic signature will have the same effect as a physical wet signature on a paper application.

In addition, you agree that MassMutual will deliver to you electronically all disclosure forms, notices and any other information required to be provided to you during the application process (all such documentation, including the application, is referred to as "electronic records"). You acknowledge that you have the necessary hardware and software requirements to access and retain the electronic records. You have the right to obtain a paper copy of the electronic records at no cost to you by contacting us at 844-975-7522.

Your consent to electronic signature and electronic delivery only applies to this transaction and does not apply to any future transactions with MassMutual.

If you decline the Electronic Signature Agreement, we will not be able to process your application, and no insurance coverage will be issued.

Agree
 Disagree

Acknowledge disclosures, select Agree, then Next.

Go Paperless! View your documents online and print only what you need!

Thank you for choosing Massachusetts Mutual Life Insurance Company (MassMutual) as your insurer.

How It Works! When your documents are available, we'll send you an email with a link and instructions to view them. Documents can also be downloaded for you to save or print.

Voluntary Consent to Use Electronic Signatures and Receive Documents Electronically ("Consent")

This Consent will apply to all MassMutual group certificates insuring you, your spouse, or your dependent children for which you are the group certificate owner. If you provide your email address and agree to electronically sign this Consent and to electronic delivery of documents related to your coverage then we will email you a link and instructions on registering for the secure portal where your documents are delivered. In the portal, you'll be able to confirm your e-delivery preferences and Go Paperless!

Hardware and Software Requirements: In order to consent to electronic delivery you must be able to receive email, access the portal, read, and download, and print or save the electronically delivered documents. You will need (1) a computer or mobile device with Internet access; (2) a current version of an Internet browser (e.g., Google Chrome[®], Safari[®], or similar); (3) the ability to download and/or print documents; (4) a current version of a Portable Document Format (PDF) reader (e.g., Adobe Acrobat Reader[®]); and (5) a valid email address. To keep electronic delivery, you will need to keep your email address on record with us for notification of new electronically delivered documents.

Terms: You are voluntarily consenting to electronically signing this Consent and are consenting to MassMutual electronically delivering your group insurance certificate, endorsements, statements, invoices, forms, correspondences, and notices, including late premium notices, grace period notices, and lapse notices (state law may require that one or more notices are delivered by US Mail but a copy will be available electronically for your convenience), in accordance with the preferences recorded on the portal at the time of delivery. You may not consent if you do not have the Hardware and Software Requirements and an active email address. If you do not consent to these Terms, your documents will be sent to you by US Mail. You can change your preferences on the portal at any time. You can, at no cost, cancel future electronic delivery service and request a paper copy of documents be sent by US Mail by calling (844) 975-7522 or by logging into <https://massmutual.ins-portal.com>

Acknowledgement: By signing this Consent you are representing that you (1) read, understand and agree to the Terms; (2) have provided your active email address; (3) have the Hardware and Software Requirements; (4) are authorizing electronic delivery of documents; and (5) are authorizing MassMutual to accept as your valid and legally binding signature for this Consent, your clicking the "I Agree" button.

- I agree
- Decline

Notify me at email address:

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Next

Acknowledge electronic signature disclosures and e-delivery by selecting Agree, enter email address, and click Next.

Sign and Submit

Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your pre-tax and post-tax contributions **per pay period** for each plan.

- **Are You Satisfied With Your Elections?** If you are satisfied with your choices, click on the "NEXT" button at the bottom of this screen to sign your Enrollment Verification Form electronically using your PIN.
- **Need to Make Some Changes?** If you wish to make any changes to your elections, click on the benefit plan name in the menu on the left.

Your Benefits

Plan	Description	Pretax Cost	Posttax Cost
MassMutual@Work Whole Life	Massmutual@work Group Whole Life Insurance; EO	\$0.00	\$41.25
Total		\$0.00	\$41.25

Signatures Required

To complete your enrollment, you must sign the following forms. Press Next to begin signing forms.

Form Name	Status	Date Signed/Reviewed
<input type="checkbox"/> Enrollment Confirmation	Unsigned	

Next

Almost done! Here you will see your total cost per pay period and the benefit elected. Click next to e-sign the application and get the coverage in force!

Sign/Submit Complete

Congratulations!

Your enrollment is now complete. You may log-in to the system at any time during the year to review your benefit elections.

Recap of Your Elections

Listed below is a recap of your elections including who is covered under each benefit plan and your named beneficiaries. **Scroll down to the bottom of this screen to view a list of your completed enrollment forms.**

 MassMutual@Work Whole Life

Enrollment Details

Person Name	Relationship	Description	Policy #	Cost
Tom Test	Employee	Massmutual@work Group Whole Life Insurance; EO		\$41.25

Beneficiary Information

Name	Relationship	Address	Phone	Percent	Type
Estate				100.00	Primary

Completed Forms

Following is a list of forms reviewed and/or signed during the enrollment. Click on the form name to view or print. Press Logout to exit the website.

Form Name	Date Signed/Reviewed
 Enrollment Confirmation	09/25/2020

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Congratulations! Your application is complete. You have Whole Life coverage in force right now!

Even prior to payroll deductions starting for this benefit, at the time of enrollment completion you are granted a “temporary insurance agreement”. This means that if any covered person dies between now and when premiums begin, the coverage amount will be paid out, tax free, to your beneficiaries.

***Pro Tip:** Click on [Enrollment Confirmation](#) to download your confirmation certificate. Save this with your important documents.