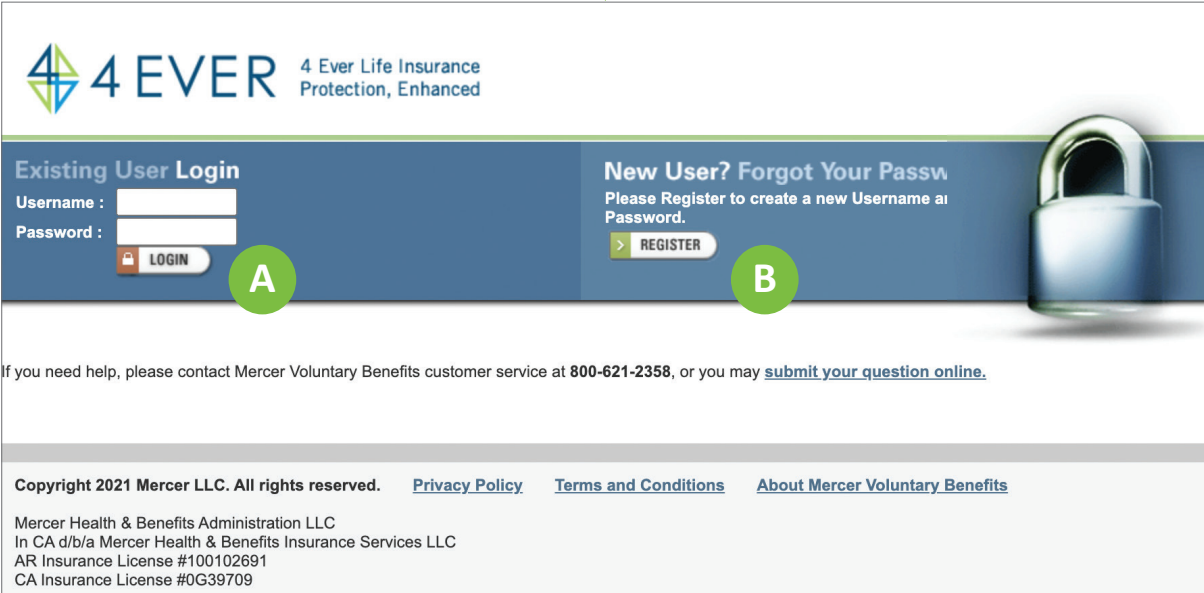



# 4Ever Universal Life Insurance

## Job Aid for signing into existing users account

Start the 4Ever Universal Life enrollment process by visiting

**4everlifebenefits.com**




The screenshot shows the 4Ever Universal Life Insurance website. At the top is the logo and tagline "4 EVER 4 Ever Life Insurance Protection, Enhanced". Below this is a dark blue banner with two main sections. The left section, labeled "Existing User Login" with a green circle "A", contains fields for "Username :" and "Password :", a "LOGIN" button, and a small lock icon. The right section, labeled "New User? Forgot Your Passw" with a green circle "B", contains the text "Please Register to create a new Username and Password." and a "> REGISTER" button. To the right of the banner is a large, detailed image of a silver padlock. Below the banner, there is a line of text: "If you need help, please contact Mercer Voluntary Benefits customer service at 800-621-2358, or you may [submit your question online.](#)". At the bottom of the page, there is a footer with copyright information and links for "Privacy Policy", "Terms and Conditions", and "About Mercer Voluntary Benefits".

Existing User Login

Username :


Password :

 LOGIN

**A**

New User? Forgot Your Passw

Please Register to create a new Username and Password.

 > REGISTER

**B**

If you need help, please contact Mercer Voluntary Benefits customer service at 800-621-2358, or you may [submit your question online.](#)

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Mercer Health & Benefits Administration LLC  
In CA d/b/a Mercer Health & Benefits Insurance Services LLC  
AR Insurance License #100102691  
CA Insurance License #0G39709

Sign in as an existing user or register for the first time. If you forgot your password, select the option to reset it

- A** Existing insureds sign into account
- B** New users and potential applicants need to register
- C. If you experience a problem, please contact Mercer Customer Service at 1.800.621.2358
  - Let the CSR know you are part of the Blue Cross Blue Shield 4Ever Universal Life
  - Write down the name of the representative and time of call

- D** Under **Select a Product** drop down menu select **4Ever Universal life**

**4EVER** 4 Ever Life Insurance Protection, Enhanced

Home My Account My Profile Self Service Contact Us Log Out

PersonalPlans For the employees of Blue Cross and/or Blue Shield and its subsidiaries TESTBCS02 SMITH

**Select a Product...** **D**

**Get a Quote & Enroll** **D**

**Your Voluntary Benefits**

[Group Universal Life](#)

User TESTBCS02 SMITH last logged in at 10:33 AM 07/21/2021

**PersonalPlans** is your connection to voluntary group insurance programs underwritten by 4 Ever Life Insurance Company and administered by Mercer Voluntary Benefits for employees of Blue Cross and/or Blue Shield and its subsidiaries.

**Learning Center**

General educational information about some of the products offered to you.

Don't know enough about insurance? Want to know why a program through PersonalPlans might be a benefit for you? Start by learning the basics about many of the products offered through this website. The Learning Center does not give you specific details about the programs available to you, but, instead, provides general educational information to help you make more informed decisions about your financial future.

[Go to the Learning Center](#)

**Message Center**

Important messages about enrollment, products, and updates to your voluntary benefits.

02/15/2018 [2018 Cash Accumulation Interest Rates](#)

02/01/2018 [GUL Employee Self-Service Documents](#)

01/21/2017 [NEW HIRE SPECIAL - The Clock is Ticking!](#)

01/21/2017 [Group Universal Life Videos](#)

01/21/2017 [GUL Application/Statement of Health Form Effective 1/1/2016](#)

## GUL Employee Self-Service Documents

- [Group Universal Life Insurance Child Conversion Form](#)
- [Mercer Customer Service Request Form\(Name/Address/Smoker Status Changes and Coverage Reductions\)](#)
- [Mercer Printable Beneficiary Designation Form](#)
- [Group Universal Life Insurance Cash Accumulation Deposit Form](#)

- E** Select your state of residence from the dropdown menu
- F** Select everyone to be covered. Employee must be covered in order to include spouse & children

**Start Your Quote**

**1.** Answer a few questions and select your coverage options.  
**2.** Review your no-obligation quote.  
**3.** Submit your online enrollment form.  
**4.** Once your enrollment information has been reviewed, you will be notified by mail if your coverage is approved and when it will begin.

**To start the quoting process, please tell us who you would like to insure.**

What is your state of residence? **Illinois** **E**

Check all persons you would like to quote on this policy:

☐ Self **F**

☐ Spouse

☐ Child(ren)

**Quick Tips**

[How does this process work?](#)

[When should I review my life insurance needs?](#)

[Why did the "Back" button take me back to this screen instead of my previous screen?](#)

**Continue**

**Spouse\*\*:** Means your spouse in a legally recognized union of two people. Spouse includes your civil union and domestic partner.

\*\* All information is saved as you continue through the process.

**G** Answer question about tobacco use by selecting Yes or No

**H** Enter your date of birth

**I** Your base salary will be auto populated

**J** Select the **total** coverage you want based on a multiple of your salary

**K** Select Yes or No to add Accidental Death coverage *(it doubles the coverage amount if insured dies in an accident)*

**L** If you choose to participate in the Cash Account, you can enter a set dollar amount or leave it blank and make a yearly contribution

**M** Select **Continue** to save your information and move forward to the next step

**N** Based on the coverage amount & additional options selected a quote is issued

**O** Review options selected

**P** Click on **Enroll** to start the process

### Background Information

Please provide the following information to determine coverage options.

Employee	
Have you smoked or used any form of tobacco in the last 12 months?	<input type="radio"/> Yes <input type="radio"/> No <b>G</b>
Date of Birth (mm/dd/yyyy):	<input type="text" value="03/25/1966"/> <b>H</b>

**i** Spouse\*\*: Means your spouse in a legally recognized union of two people. Spouse includes your civil union and domestic partner.

**Continue**

\*\* All information is saved as you continue through the process.

#### Quick Tips

[What if my birthdate is incorrect?](#)

### Select Your Coverages

Please enter all benefits you would like on your policy.

Employee	
Total Base Pay:	\$39,500.00 <b>I</b>
New coverage amount, including any current coverage:	<input type="text" value="\$79,000.00 (2.0X)"/> <b>J</b>
Accidental Death:	<input type="text" value="Yes"/> <b>K</b>
Monthly Cash Accumulation Fund Contribution (optional):	<input type="text" value="\$ 25.00"/> <b>L</b>

**i** Spouse\*\*: Means your spouse in a legally recognized union of two people. Spouse includes your civil union and domestic partner.

**M** **Continue**

\*\* All information is saved as you continue through the process.

### Your Quote

View your quote based on the coverages you selected.

Total	
Total Monthly Premium:	\$59.68 <b>N</b>

Employee	
Employee Total Monthly Premium:	\$59.68
Total Base Pay:	\$39,500.00
Date of Birth:	03/25/1966
Tobacco Use:	No
Base Coverage Multiple:	2.0X
New Coverage Amount:	\$79,000.00 <b>O</b>
Base Coverage Premium:	\$31.52
Accidental Death :	Yes
Accidental Death Premium:	\$3.16
Cash Accumulation Fund Contribution:	\$25.00

**i** In addition to the premium expense there is also a \$1.50 monthly administrative expense for each employee and/or spouse enrolled in the program.

[Change coverages and re-quote](#) **P** **Enroll**

[Change enrollees](#)

#### Quick Tips

[When does my coverage start?](#)

[Can I request more coverage later?](#)

[Will my rate ever go up or down?](#)

[Do current tax regulations affect my benefits?](#)

**Q** Your name will auto populate

**R** Enter email, phone number, & address

**S** All three questions must be answered correctly to receive the conditional guaranteed amount (must be actively at work, no hospitalization in past 90 days, and must be able to perform normal activities)

**T** Fill out questions about Medical Information

## Profile Information

Employee			
First Name:	TESTBCS02 <b>Q</b>		
Middle Name:	C		
Last Name:	SMITH		
Email (optional):	<input type="text"/> <b>R</b>		
Daytime Phone (optional):	<input type="text"/>		
Residence Address <b>R</b>			
Street #:	<input type="text"/>	Street Name:	<input type="text"/> Apt/Suite# (optional) <input type="text"/>
City:	<input type="text"/>	State:	Illinois Zip Code: <input type="text"/>
How did you hear about this enrollment opportunity? <input type="text"/>			
<b>Continue</b>			

\*\* All information is saved as you continue through the process.

## S Eligibility Information

Please answer the following health questions.	
Are you (employee) actively at work on the date of this enrollment form?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
Has anyone to be insured been hospitalized during the past 90 days?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
Is anyone to be insured unable to perform normal activities?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
<b>Continue</b>	

\*\* All information is saved as you continue through the process.

## T Medical Information

Have you been absent from work or unable to perform normal activities due to illness or injury more than 15 days during either of the past two years?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
Have you received consultation or treatment during the past 5 years for malignant tumor, including cancer, leukemia, or Hodgkins Disease?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
Have you received consultation or treatment during the past 5 years for circulatory impairment including heart disease, angina, coronary artery disease or stroke?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
Have you received consultation or treatment during the past 5 years for drug or alcohol abuse?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
Have you received consultation or treatment during the past 5 years for Acquired Immune Deficiency Syndrome, A.I.D.S. related complex, or A.I.D.S. related condition?	TESTBCS02 (Employee): <input type="radio"/> Yes <input type="radio"/> No
<b>Continue</b>	

\*\* All information is saved as you continue through the process.

- U Be sure to include all your beneficiary information
- V Select **Continue** to save and move forward

## Designate Beneficiaries

### Beneficiaries for TESTBCS02 SMITH

How many primary beneficiaries would you like to name?

In case your primary beneficiaries die before you, how many contingent beneficiaries would you like to name?



Note: If you change the number of beneficiaries after entering beneficiary information, you will be required to re-enter beneficiary information again.

V

Continue

\*\* All information is saved as you continue through the process.

- W Read the **Term & Conditions** and acknowledge your approval

## E-Signature Confirmation

### Terms and Conditions

**Note:** Please read the Certification Guidelines. You must agree to these terms and conditions to submit your enrollment form.

I understand and agree that the insurance herein applied for shall not become effective unless and until such insurance shall have been approved for issuance by BCS Life Insurance Company at its Home Office during the lifetime of the person proposed for coverage and while the health and physical condition of such person remains as represented herein. By this form (or photographic copy of it), I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility that has any records or knowledge of me or my spouse or children for whom

W

### E-Signature Confirmation

I have read and agree to the Authorization. ☐ Yes ☐ No

W

I understand that if I am an employee applying for 3.5 to 6 times my annual base pay or more than \$500,000, and/or applying for a spouse/domestic partner age 65 or older, or any late entrant I will be subject to more comprehensive evidence of insurability including a paramedical examination, inspection report, and blood testing. If any of the above applies to any applicant, please complete the Application/Statement of Health Form after. (See Quick Tips in right column)

☐ Yes ☐ No

Please enter your email address here to receive an email confirming that your enrollment data was submitted successfully. (Optional)

Enter password to confirm enrollment:

X

- X Enter your email address and password
- Y Select **Continue** to proceed



By submitting my enrollment online, I am stating that I have read the above information and agree to be bound by it as if I had provided these statements in writing with my handwritten signature. I understand these statements will be relied upon by third parties, including the Plan Administrator and 4 Ever Life Insurance Company.

Y

Continue

 Print the forms for your record

## Thank You for Your Enrollment

### Congratulations!

Your enrollment form has been automatically submitted. Your request for coverage will be reviewed. You will be notified by U.S. mail if we need additional information and when your coverage begins. Once the coverage becomes effective, you may view your coverage information by clicking the My Account button anytime. If you would like a copy of your completed enrollment form for your records immediately, click on the Print Completed Form button below.

### Where to go now!

You've taken an important step in your financial security by recognizing the need for protection. Now you may:

- 1) Click a product in the navigation bar above if you are considering other types of coverage that may be offered through PersonalPlans; or
- 2) Click the Home button above to return to your PersonalPlans home page; or
- 3) Exit the site by clicking the Log Out button above.

Thank you and best regards.

[Print Completed Form](#)



If you have additional questions about 4Ever Universal Life enrollment,  
please call 1.800.621.2358.