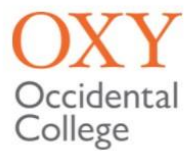




Welcome to Oxy's 2022 annual Open Enrollment! The Open Enrollment period is from 11/15/21 to 11/30/21. The Flexible Spending Account (FSA) plans require an active enrollment and you must enroll/re-enroll in order to participate in the FSA in 2022.

Employee Enrollment Experience

1. To enroll and/or make changes to your Oxy benefit plans logon to: <http://oxy.ease.com>. Select the SSO button and type in your email address and email password



Single Sign On (SSO)

[Log in with SSO](#)

[Log in with email or username](#)

[Español](#) · [简体中文](#) · [繁體中文](#)

example@email.com

[Forgot?](#)
.....

[Login](#)

[Log in with mobile phone](#)

2. Review your personal information and provide any missing information, if needed. All fields marked with an * are required.

The Sample Company > Benefits Enrollment 0% Complete [Exit](#)

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 Benefits
- 6 Coverage
- 7 Summary
- 8 Sign Forms
- 9 Finish

Personal Information

First Name *

Last Name *

Sex *

SSN *

Marital Status *

Tobacco User (Last 12 Months) *

Disabled? *

Middle Name

Birth Date (30y) *

[Need Help?](#) [Get support](#)

3. Click **Continue**

4. Add any eligible dependents that you will be enrolling in coverage by clicking "Add."

Dependents

If you have any dependents (e.g. spouse, domestic partner, children) please add them here. If you do not have any dependents please click 'Continue'.

Add a Dependent Add

Continue



5. Provide information for each eligible dependent as prompted. Click "**Add Dependent.**"

Add Dependent Close

First Name *

Last Name *

Middle Name

Sex

Birth Date

SSN

Relationship *

Employer

Different address than employee?

Add Dependent

6. Click **Continue.**

7. If you or any of your dependents applying for coverage have Medicare Coverage please add that information. Otherwise, click **Continue.**

- 1 Profile
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Medicare

If you or any of your dependents applying for coverage have Medicare Coverage please add that information here. Otherwise please click "Continue"

[Need Help?](#) [Get support](#)

Add Medicare Coverage

Add

Continue

8. You will be guided through your benefit options. To Enroll click the checkmark; to Waive click the "X." Choose the plan you would like by clicking "Select."

- 1 Profile
- 2 Dependents
- 3 Documents
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Medical Plan

Specify your coverage

Select Enrolled or Waived for each eligible member below

Alice Cornwell
Employee

Enrolled

Are you waiving dependents?

You have not entered any children. If you have dependent children and are waiving coverage for them, check the box below. Otherwise keep the box unchecked.

Children Waived

Benefits Summary

Employee Cost Per Pay Period
(Semi-Monthly)

Medical \$47.88

Total \$47.88
Per Pay Period (Semi-Monthly)

[Need Help?](#) [Get support](#)

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 **Benefits**
- 6 Medical
- 7 Coverage
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Select your plan

[See breakdown of plans and costs](#) [Compare Plans >](#)

The cost below is the employee cost deducted on a [Per Pay Period \(Semi-Monthly\)](#) basis.

Anthem BCBS

Blue Shield Silver 70 PPO 2000/45 + Child Dental

Documents

[SIC](#)

\$47.88

Per Pay Period

[Selected](#)

This election will be effective starting 2/1/2019.

[Continue](#)

Benefits Summary

Employee Cost Per Pay Period (Semi-Monthly)

Medical \$47.88

Total \$47.88
Per Pay Period (Semi-Monthly)

[Need Help?](#) [Get support](#)

9. If electing the Blue Shield of CA TRIO or Access+ plan, enter the Primary Care Physician Name (PCP) and PCP ID or select "Auto Assign."
10. Select **Continue**.
11. You can review your Benefit Summary under the **Summary** tab. If you need to edit your benefit elections prior to submission, select the corresponding benefit tab found on the left side of your screen and make the necessary changes.

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 Benefits
- 6 Coverage
- 7 **Summary**
- 8 Sign Forms
- 9 Finish

Benefit Summary

Review your benefit elections. If you need to make changes, click [Edit](#). Otherwise, click [Continue](#) and sign your forms.

Medical

Anthem BCBS

Blue Shield Silver 70 PPO 2000/45 + Child Dental
Employee

Effective 2/1/2019

\$47.88

Per Pay Period (Semi-Monthly)

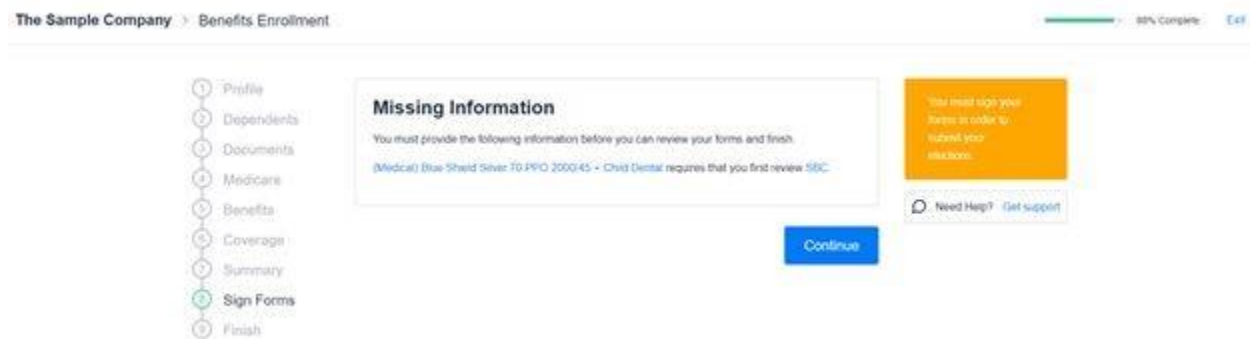
[Edit](#)

[Continue](#)

You must sign your forms in order to submit your elections.

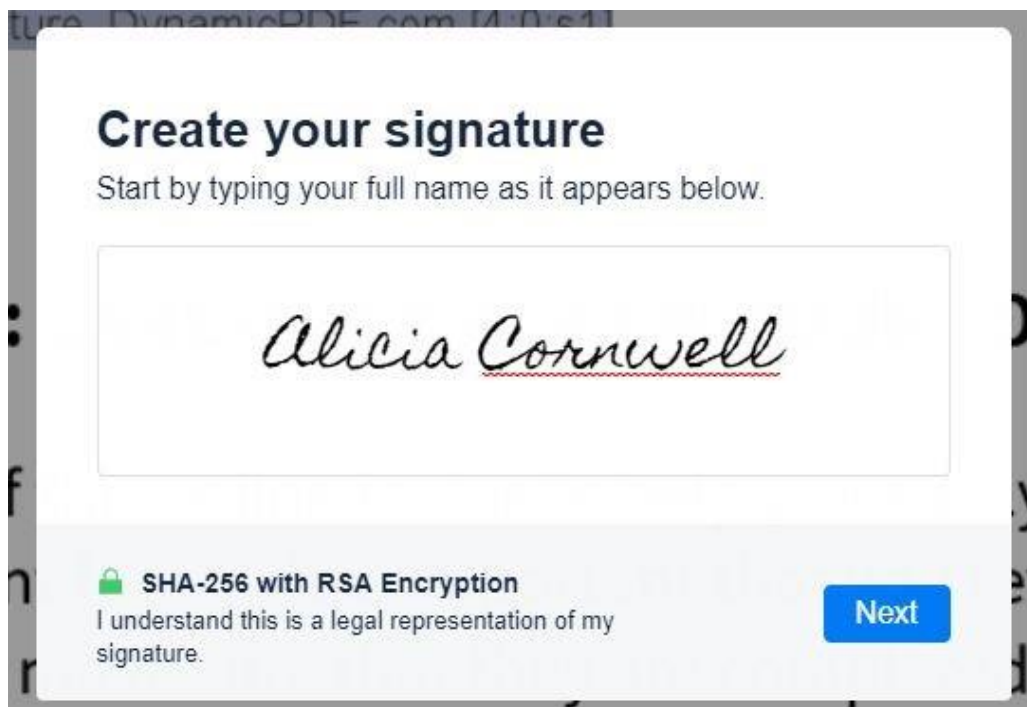
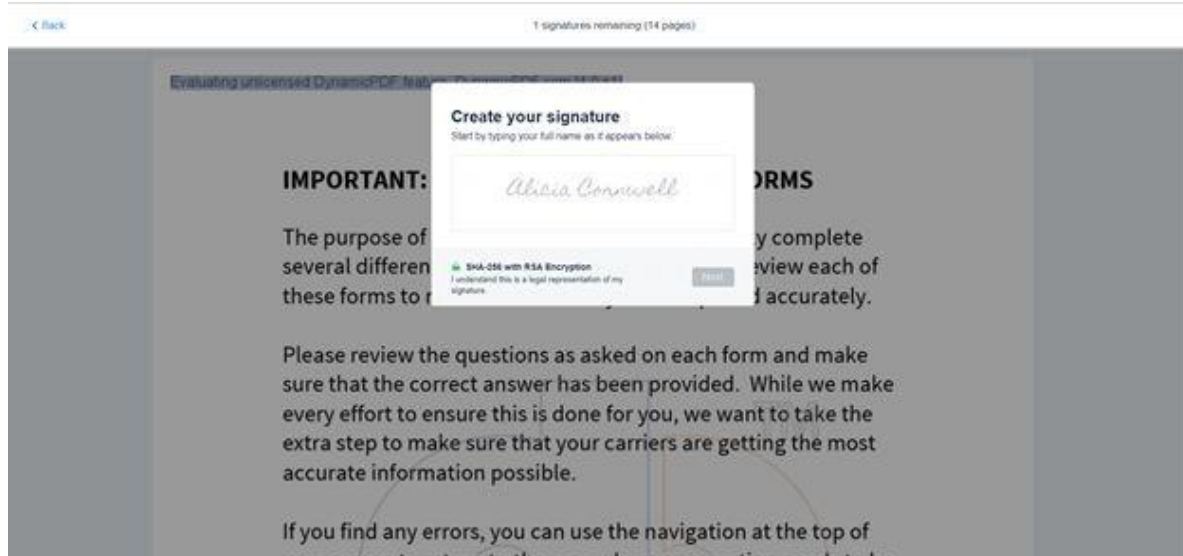
[Need Help?](#) [Get support](#)

12. If you are missing required information or need to review certain documents, you can select the blue highlighted text to be brought back to the page or document. After completing the required information, you can proceed to review and sign your forms.



13. After clicking “**Sign Forms**,” you will be prompted to type your signature as well as electronically sign with your mouse.






14. Once forms are generated, type your full name as it appears in "Create your signature."


Signature DynamicPDF.com [4.0.61]

Create your signature

Some carriers require a hand-drawn signature. Please draw your signature in the box below.



A blue hand-drawn signature is shown in a white signature box. The signature consists of two loops followed by a long horizontal stroke. A dashed line is at the bottom of the box, and a small 'x' is on the left. A 'clear' button is in the top right corner of the box.

 **SHA-256 with RSA Encryption**
I understand this is a legal representation of my signature.

[Next](#)

15. Using mouse or touch screen, add a hand-drawn signature.

16. Click **Next**.


17. Review forms for completeness and accuracy.
18. Click **Next**.

ture DynamicPDF.com [4.0.611

Review & Sign Forms

Please review all of the information presented for completeness and accuracy.

When you are ready, sign each section by tapping on the green signature prompts. If at any time you feel like you need to make changes, you can go back to enrollment by selecting 'Back' in the top navigation bar. For additional help, please reach out to your HR administrator.

 **SHA-256 with RSA Encryption**
I understand this is a legal representation of my signature.

[Next](#)

the questions as asked on each form

19. Tap each green signature prompt as they appear.

← Back 1 signature remaining (14 pages)

Section 8 - Disclosure of personal and health information

All Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others, including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at blueshieldca.com/bsca/documents/about-blue-shield/privacy.

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this enrollment form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which I am enrolled under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this enrollment, Blue Shield may remove me of the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or following automatic termination may be required. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California.

SIGN HERE

Signature of employee: Alicia Cornwell Date: _____
Print employee name

**All pages of this form are necessary to process your enrollment.
Missing Information may delay processing.**

100% Complete Finish

[Submit Feedback](#)

well as provide dashboard.

IMPORTANT: CAREFULLY REVIEW YOUR FORMS

The purpose of this online system is to help you easily complete several different forms. It is important that you review each form to make sure that they are completed

20. Once complete, click **Finish Signing**.

21. Optional add star rating and comments, then click **Submit Feedback**.