

# WILLIAM PENN SCHOOL DISTRICT

## Self Enroll Guidelines

Login Here: <https://app.thebeaconselect.com/enroll/Login.aspx?Path=WilliamPennSD>

Username: Social Security Number (no dashes or spaces)

Password: Last 4 digits of SSN and last two of Birth Year (ex: If last 4 SSN is 1234 and YOB 1994, PIN is 123494)

**WILLIAM PENN  
SCHOOL DISTRICT**

**THE BEACON**  
Benefits Education Administration & Communication Online  
*Select*

**ENROLLMENT SITE**

**Your Benefits Enrollment**

To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN). If you have questions or need help, please contact your Human Resources Department.

**Employee ID or SSN:**

**PIN:**

By entering your Employee ID or Username and Personal Identification Number, you are agreeing to the [Terms of Use](#).

[FORGOT PASSWORD](#)

Once logged in, the welcome screen will display your available benefits. Click **NEXT** to review and update your personal information.

07/01/2026 - 06/30/2027

## WILLIAM PENN SCHOOL DISTRICT



Home You & Your Family - My Benefits - Sign & Submit

Next >

### Welcome to Your Benefit Enrollment for Plan Year 2026-2027

At William Penn 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.

#### ✓ Your Available Benefits

- [Medical](#)
- [Accident Insurance](#)
- [Hospital Indemnity](#)
- [Dental](#)
- [Vision](#)
- [Long Term Disability](#)
- [Basic Life and AD&D](#)
- [Critical Illness](#)
- [Medical FSA](#)
- [Dependent Care FSA](#)
- [Trustmark Life + Care](#)
- [Trustmark Paycheck Protect](#)
- [403\(b\) Survey](#)

Press *Next* to review personal information and begin enrollment.

Next >

Review your personal information and make any necessary updates. Click **NEXT** to review and update your dependents.

## Personal Information

🚩 If any personal information needs to be updated, please contact the HR Department. Click the *Next* button to continue.

\* marked fields are required.

### Personal Info

\* **Name:**      
First *MI* Last *Suffix*

\* **Date of Birth:**

\* **SSN:**

\* **Gender:**  Male  Female  Other

### Contact Info

\* **Address:**    
Country

Review your current Dependents. To add a Dependent, click on the **Add Dependent** button. **Note:** SSN is required for dependents who will be covered on your benefits. After all Dependents are added, click **NEXT** to begin your enrollment.

## Spouse & 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

Name	SSN	DOB	Sex	Relation	Uploads	+
<a href="#">Spouse Test</a>	***-**-8663	6/15/1965	M	Spouse	0	<a href="#">✎</a> <a href="#">✕</a>
<a href="#">Child Test</a>		10/21/2010	F	Child	0	<a href="#">✎</a> <a href="#">✕</a>

### 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

< Back

Next >

The **My Benefits** page shows your current elections. To make updates or changes, Click the **Review** button in the upper right corner of each benefit.

Home   You & Your Family ▾   My Benefits ▾   Sign & Submit   [← Back](#)   [Next →](#)

## My Benefits

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

**Medical** Review

You have to complete enrollment in this plan.

**Accident Insurance** Review

You have to complete enrollment in this plan.

**Hospital Indemnity** Review


You have to complete enrollment in this plan.

**Dental** Review

You have to complete enrollment in this plan.

### My Benefits

<input type="radio"/> Medical	\$0.00
<input type="radio"/> Accident Insurance	\$0.00
<input type="radio"/> Hospital Indemnity	\$0.00
<input type="radio"/> Dental	\$0.00
<input type="radio"/> Vision	\$0.00
<input checked="" type="radio"/> Long Term Disability	\$0.00
<input type="radio"/> Basic Life and AD&D	\$0.00
<input type="radio"/> Critical Illness	\$0.00
<input type="radio"/> Medical FSA	\$0.00
<input type="radio"/> Dependent Care FSA	\$0.00
<input type="radio"/> Trustmark Life + Care	\$0.00
<input type="radio"/> Trustmark Paycheck Protect	\$0.00
<input type="radio"/> 403(b) Survey	\$0.00

 **Total Cost** \$0<sup>00</sup>  
Per Pay Period

Your current coverage will be displayed. If you wish to-

- Not make any changes: click **NEXT**
- Make changes: Select your desired coverage level and click **NEXT** to choose covered dependents.
- Decline the plan: Select the **Waive** button and click **NEXT**.

## Medical

	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family
Keystone POS-HMO	<input type="radio"/> \$46.83	<input type="radio"/> \$106.77	<input type="radio"/> \$65.58	<input type="radio"/> \$103.10	<input type="radio"/> \$138.65
Personal Choice-PPO	<input type="radio"/> \$54.03	<input type="radio"/> \$131.49	<input type="radio"/> \$95.46	<input type="radio"/> \$115.93	<input checked="" type="radio"/> \$150.35
Waive Medical	<input type="radio"/> \$0.00				

### My Benefits

- Medical \$0.00
- Accident Insurance \$0.00
- Hospital Indemnity \$0.00
- Dental \$0.00
- Vision \$0.00
- Long Term Disability \$0.00
- Basic Life and AD&D \$0.00
- Critical Illness \$0.00
- Medical FSA \$0.00
- Dependent Care FSA \$0.00
- Trustmark Life + Care \$0.00
- Trustmark Paycheck Protect \$0.00
- 403(b) Survey \$0.00

**Total Cost** \$0<sup>00</sup>  
Per Pay Period

Back

Next

When selecting coverage with multiple Dependents, verify which Dependents you want to be covered. To add or remove a dependent from the coverage, click the check box next to their name. After completed, click **NEXT**.

# Medical

## Application Details

### Individuals to Be Covered

Click on the checkbox next to each person's name to be included for coverage. When you are finished, click on the "NEXT" button to continue.

**Plan Name:** Medical

**Coverage Level:** Employee + Family

To Be Covered?	Name	Age
<input type="checkbox"/>	61FemaleWilliamPenn ESPA-12MonthBi-weekly24	61
<input checked="" type="checkbox"/>	Spouse Test	61
<input checked="" type="checkbox"/>	Child Test	15

If you choose to select a Medical FSA, enter the amount you wish to contribute per pay period **OR** the total annual amount. Then click **CALCULATE**. The system will calculate your contribution. Click **NEXT**

## Medical FSA

### Your FSA Election

A flexible spending account allows you to set aside pre-tax money to pay for expenses not covered by your insurance. The minimum and maximum contribution amounts for the next plan year are shown below. Please keep in mind that a Flexible Spending Account is "Use It or Lose It". If you do not use the funds by the end of the year, you will forfeit the remaining funds in your account.

- If you would like to enroll in the FSA plan, enter the amount you would like to contribute for plan year. Then click on the button next to the text which reads "I wish to apply for this coverage".
- If you do not want to enroll in the FSA, click on the button next to the text which reads "I wish to DECLINE this coverage".
- When you are finished, click on the **"NEXT"** button to continue.

Maximum Annual Contribution: \$3,400.00

Amount per pay period:

Number of periods: 24

Total Amount:

Calculate

I wish to apply for this coverage

I wish to DECLINE this coverage

### My Benefits

<input type="radio"/> Medical	\$0.00
<input type="radio"/> Accident Insurance	\$0.00
<input type="radio"/> Hospital Indemnity	\$0.00
<input type="radio"/> Dental	\$0.00
<input type="radio"/> Vision	\$0.00
<input checked="" type="radio"/> Long Term Disability	\$0.00
<input type="radio"/> Basic Life and AD&D	\$0.00
<input type="radio"/> Critical Illness	\$0.00
<input checked="" type="radio"/> Medical FSA	\$0.00
<input type="radio"/> Dependent Care FSA	\$0.00
<input type="radio"/> Trustmark Life + Care	\$0.00
<input type="radio"/> Trustmark Paycheck Protect	\$0.00
<input type="radio"/> 403(b) Survey	\$0.00



Total Cost  
Per Pay Period

\$0<sup>00</sup>

If you choose to select a Dependent Care FSA, enter the amount you wish to contribute per pay period **OR** the total annual amount. Then click **CALCULATE**. The system will calculate the contribution. Click **NEXT** to go to the next benefit.

## Dependent Care FSA

### Your FSA Election

A flexible spending account allows you to set aside pre-tax money to pay for expenses not covered by your insurance. The minimum and maximum contribution amounts for the next plan year are shown below. Please keep in mind that a Flexible Spending Account is "Use It or Lose It". If you do not use the funds by the end of the year, you will forfeit the remaining funds in your account.

- If you would like to enroll in the FSA plan, enter the amount you would like to contribute for plan year. Then click on the button next to the text which reads "I wish to apply for this coverage".
- If you do not want to enroll in the FSA, click on the button next to the text which reads "I wish to DECLINE this coverage".
- When you are finished, click on the **"NEXT"** button to continue.

Maximum Annual Contribution: \$7,500.00

Amount per pay period:

Number of periods: 24

Total Amount:

Calculate

I wish to apply for this coverage

I wish to DECLINE this coverage

### My Benefits

<input type="radio"/> Medical	\$0.00
<input type="radio"/> Accident Insurance	\$0.00
<input type="radio"/> Hospital Indemnity	\$0.00
<input type="radio"/> Dental	\$0.00
<input type="radio"/> Vision	\$0.00
<input checked="" type="radio"/> Long Term Disability	\$0.00
<input type="radio"/> Basic Life and AD&D	\$0.00
<input type="radio"/> Critical Illness	\$0.00
<input type="radio"/> Medical FSA	\$0.00
<input checked="" type="radio"/> Dependent Care FSA	\$0.00
<input type="radio"/> Trustmark Life + Care	\$0.00
<input type="radio"/> Trustmark Paycheck Protect	\$0.00
<input type="radio"/> 403(b) Survey	\$0.00



Total Cost  
Per Pay Period

\$0<sup>00</sup>

After completing your elections, the **Sign and Submit** screen will display your benefits for review. To make changes, click on the specific benefit. If you are satisfied with your elections, click **NEXT** at the bottom of the screen.

## 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	Employee Pretax Cost	Employee Posttax Cost
<a href="#">Medical</a>	Personal Choice-PPO; FA	\$150.35	\$0.00
<a href="#">Accident Insurance</a>	Low; FA	\$0.00	\$13.36
<a href="#">Hospital Indemnity</a>	Wellfleet Group Hospital Indemnity - Enhanced; FA	\$0.00	\$33.21
<a href="#">Dental</a>	UCCI Dental; FA	\$0.00	\$0.00
<a href="#">Vision</a>	Vision; FA	\$16.89	\$0.00
<a href="#">Long Term Disability</a>	Long Term Disability; \$2,000	\$0.00	\$0.00
<a href="#">Basic Life and AD&amp;D</a>	Basic Life and AD&D; \$50,000	\$0.00	\$0.00
<a href="#">Critical Illness</a>	\$20,000; EO	\$0.00	\$39.74
<a href="#">Medical FSA</a>	Waived		
<a href="#">Dependent Care FSA</a>	Waived		
<a href="#">Trustmark Life + Care</a>	Waived		
<a href="#">Trustmark Paycheck Protect</a>	Waived		
<a href="#">403(b) Survey</a>	403(b) Survey	\$0.00	\$0.00
<b>Total</b>		<b>\$167.24</b>	<b>\$86.31</b>

### Signatures Required

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

Form Name	Status	Date Signed/Reviewed
 Confirmation Statement	Unsigned	



Page 2 displays your dependents, their coverages and your beneficiaries. To sign the form and complete your enrollment, enter your PIN (last 4 of your SSN and last two of birth year) and select **Sign Form**.

**DEPENDENT INFORMATION**

Dependent Name	Relationship	SSN	Birth Date	Gender	Enrollment
Spouse Test	Spouse		06/15/1965	M	Medical, Accident Insurance, Hospital Indemnity, Dental
Child Test	Child		10/21/2010	F	Medical, Accident Insurance, Hospital Indemnity, Dental

**BENEFICIARY INFORMATION**

Beneficiary Name	Relationship	Benefit Plan	Beneficiary Type	Percentage
All Living Children		Accident Insurance	Primary	100.00
All Living Children		Basic Life and AD&D	Primary	100.00
All Living Children		Critical Illness	Primary	100.00

**PAYROLL DEDUCTION AUTHORIZATION/CANCELLATION**

By submitting my benefit choices, I acknowledge that I am authorizing my employer to take pre-tax and/or, to the extent relevant, after-tax deductions from my paychecks to pay for my benefit costs. I understand that pursuant to Internal Revenue Code section 125, this election can only be made during the annual open enrollment period before the beginning of each plan year (unless I am a new hire), and is irrevocable for the entire calendar year unless I incur a Qualifying Family Status Change or other permissible mid-year change event, as determined by the Pre-Tax Payment Plan and the underlying benefit plan(s) I have chosen to participate in (collectively, the "Plans").

I understand that the maximum salary reductions I can make are set forth in the Plans, and that the Plans govern all issues concerning my elections, payroll deductions, eligibility, and benefits. I acknowledge that my elections (with the exception of contributions to Reimbursement Accounts) will automatically rollover from year to year unless I submit a change during the annual open enrollment period.

I agree that in the event of any change in the required benefit plan contributions prior to the next enrollment period, my payroll deduction election will automatically be revised to take such change into account. I also understand that my contributions to Reimbursement Accounts, if any, can only be used to reimburse qualified health and/or dependent care expenses incurred in the same year as the contributions are deducted from my paychecks. Any funds remaining in my Reimbursement Account(s) not used for current year expenses will be forfeited after all current year reimbursements are processed. I understand that I may be required to provide Human Resources with proof of dependent eligibility in order to receive coverage for my dependent(s).

Finally, I am also authorizing my employer to use and send necessary personal information, including Protected Health Information under HIPAA, to my selected benefit vendors and providers in order to initiate and support my coverage elections.

Your total deduction per pay period

Total Deduction
\$ 253.55

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Please enter your PIN below and click on **"SIGN FORM"** to complete your enrollment and submit your elections. By entering your PIN, you are electronically signing the **Benefit Verification/Deduction Confirmation Form** above. Please review it carefully before entering your PIN.

PIN:

Sign Form

**CONGRATULATIONS** you have completed your Open Enrollment! To download a copy of your Confirmation Statement, click Confirmation Statement at the bottom of the screen.

## 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.**

#### ✓ Medical

##### Enrollment Details

**Product Name:** Personal Choice-PPO

**Coverage Level:** Employee + Family

First Name	MI	Last Name	DOB	Sex	Relationship
61FemaleWilliamPenn		ESPA-12MonthBi-weekly24	2/5/1965	F	Employee
Spouse		Test	6/15/1965	M	Spouse
Child		Test	10/21/2010	F	Child

#### ✓ 403(b) Survey

Enrolled

### 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
<a href="#">Confirmation Statement</a>	05/15/2026