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

Log in

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

Accessibility

The BEACON Select

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

Home | You & Your Family ▾ | My Benefits ▾ | Sign & Submit | ‹ Back | Next ›

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:** 61FemaleWilliamPenn (First) | (MI) | ESPA-12MonthBi-weekly24 (Last) | (*Suffix*)

*** Date of Birth:** 02/05/1965

*** SSN:** ***-**-3231

*** Gender:** ○ Male ● Female ○ Other

Contact Info

*** Address:** USA

Country

100 Green Avenue

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.

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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	+
Spouse Test	***-**-8663	6/15/1965	M	Spouse	0	
Child Test		10/21/2010	F	Child	0	

Add a Dependent

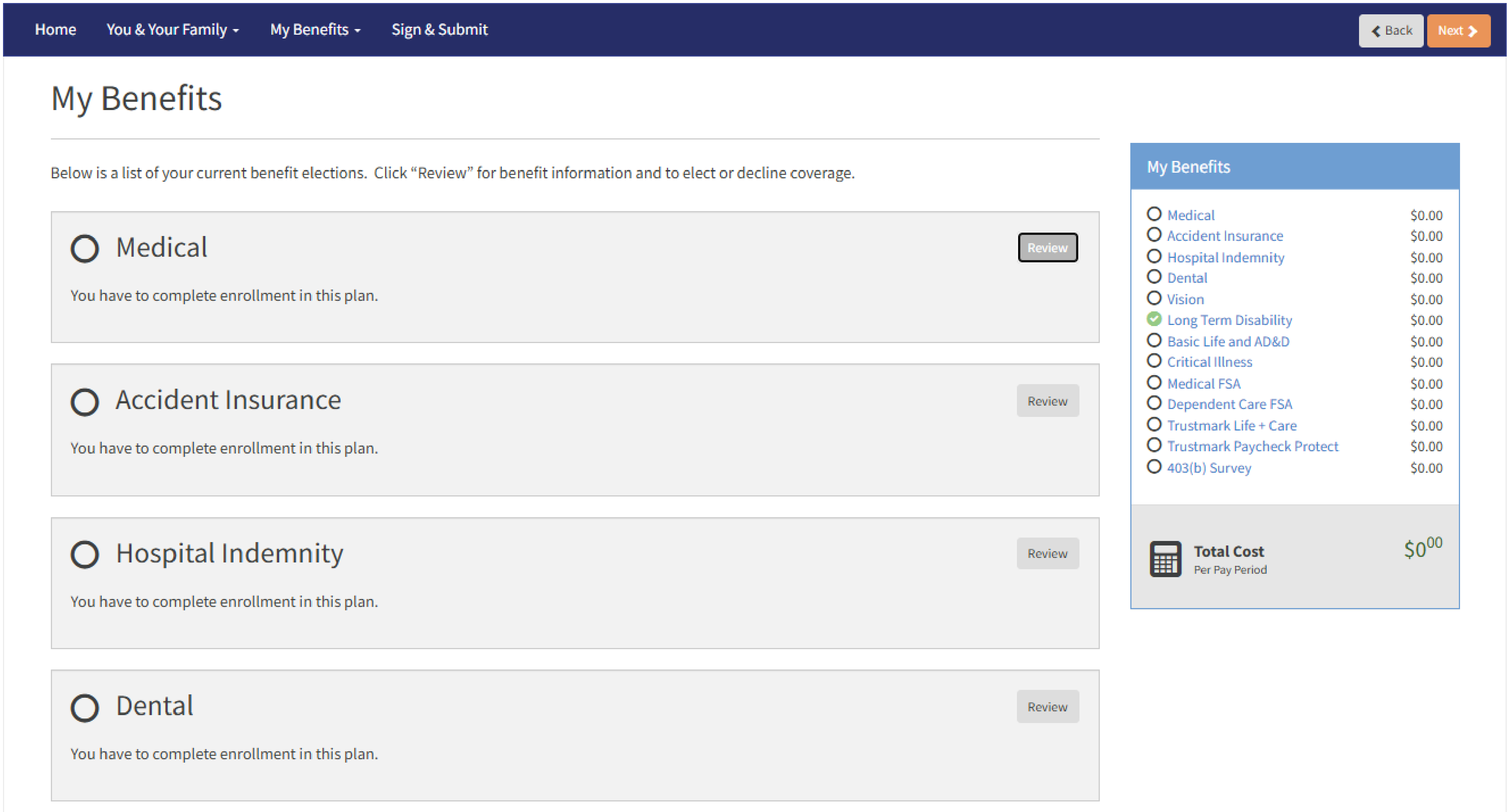
If your dependent is not listed above or you would like to add an additional dependent, simply click the *Add Dependent* button below.

+ Add Dependent

Back

Next

The ***My Benefits*** page shows your available benefit options. To begin your enrollment, click ***Next*** in the upper right corner of the screen.



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

- Enroll in the benefit: Select your desired plan and tier. Then click ***NEXT*** to choose covered dependents.
- Decline the plan: Select the ***Waive*** button and click ***NEXT*** to go to the next benefit.
- **NOTE**: **ALL** benefits must be either elected or waived.

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Medical

	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family
Keystone POS-HMO	$46.83	$106.77	$65.58	$103.10	$138.65
Personal Choice-PPO	$54.03	$131.49	$95.46	$115.93	$150.35
Waive Medical	$0.00				

Back | Next

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 Per Pay Period $0.00

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.

Click ***NEXT*** to go to the next benefit.

IMPORTANT NOTE: Coverage tiers for Medical, Dental and Vision must all be the same. (Employee Only, Employee + Spouse, Employee + Child, Employee + Children or Employee + Family)

Home You & Your Family My Benefits Sign & Submit Back 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
☑	61FemaleWilliamPenn ESPA-12MonthBi-weekly24	61
☑	Spouse Test	61
☑	Child Test	15

Back Next

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***

Home | You & Your Family | My Benefits | Sign & Submit | Back | 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: $0.00

Number of periods: 24

Total Amount: $0.00

Calculate

- I wish to apply for this coverage
- I wish to DECLINE this coverage

Back | Next

My Benefits

Benefit	Cost
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 Per Pay Period $0.00

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.

Home | You & Your Family | My Benefits | Sign & Submit | Back | Next

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: $0.00

Number of periods: 24

Total Amount: $0.00

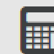
Calculate

- I wish to apply for this coverage
- I wish to DECLINE this coverage

Back | Next

My Benefits

Benefit	Cost
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 Per Pay Period $0.00

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.

Home | You & Your Family ▾ | My Benefits ▾ | Sign & Submit | 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	Employee Pretax Cost	Employee Posttax Cost
Medical	Personal Choice-PPO; FA	$150.35	$0.00
Accident Insurance	Low; FA	$0.00	$13.36
Hospital Indemnity	Wellfleet Group Hospital Indemnity - Enhanced; FA	$0.00	$33.21
Dental	UCCI Dental; FA	$0.00	$0.00
Vision	Vision; FA	$16.89	$0.00
Long Term Disability	Long Term Disability; $2,000	$0.00	$0.00
Basic Life and AD&D	Basic Life and AD&D; $50,000	$0.00	$0.00
Critical Illness	$20,000; EO	$0.00	$39.74
Medical FSA	Waived		
Dependent Care FSA	Waived		
Trustmark Life + Care	Waived		
Trustmark Paycheck Protect	Waived		
403(b) Survey	403(b) Survey	$0.00	$0.00
	Total	**$167.24**	**$86.31**

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	

Next ›

Review and Sign the **Benefit Confirmation/Deduction Authorization** form for the 2026-2027 plan year. To view the second page of the form, scroll down.

Home | You & Your Family | My Benefits | Sign & Submit | Next

Review / Sign Forms

ConfirmationStatement_SIGNFORMPAGE_PLANINSTRUCTIONS

1 of 2

William Penn School District

William Penn

Benefit Confirmation / Deduction Authorization

Name	Date of Birth	Home Phone	Work Phone
61FemaleWilliamPenn ESPA-12MonthB	02/05/1965		

Employee ID	Hire/Elig Date	Gender	E-mail Address
TEST15487	02/01/2025	F	

Address
100 Green Avenue
Lansdowne, PA 19050

Location	Department
William Penn	ADM
Job Class	**Title**
ESPA-12 Month	

Reason for Completing Form
Open Enrollment

Benefit Plan	Option	Cvg	Ded Cycle	Effective Date	Benefit Amount	Requested Benefit	Requested Cost	Employee Cost Pre-tax	Employee Cost After-tax	Employer Cost
Medical	Personal Choice-PPO	FA	24	07/01/2026				150.35	0.00	1,157.03
Accident Insurance	Low	FA	24	07/01/2026				0.00	13.36	0.00
Hospital Indemnity	Wellfleet Group Hospital Inder	FA	24	07/01/2026				0.00	33.21	0.00
Dental	UCCI Dental	FA	24	07/01/2026				0.00	0.00	46.35
Vision	Vision	FA	24	07/01/2026				16.89	0.00	0.00
Long Term Disability	Long Term Disability	EO	24	07/01/2026	2,000			0.00	0.00	4.12
Basic Life and AD&D	Basic Life and AD&D	EO	24	07/01/2026	50,000			0.00	0.00	2.03
Critical Illness	Wellfleet Group Critical Illness	EO	24	07/01/2026	20,000			0.00	39.74	0.00
Medical FSA	Waived									
Dependent Care FSA	Waived									
Trustmark Life + Care	Waived									
Trustmark Paycheck Protec	Waived									
							Total:	167.24	86.31	1,209.53

rev. 04-11-2007

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

Download Form

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.

Home | You & Your Family | My Benefits | Sign & Submit | Logout

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
Confirmation Statement	05/15/2026