

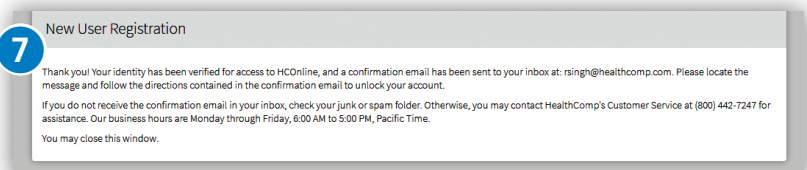
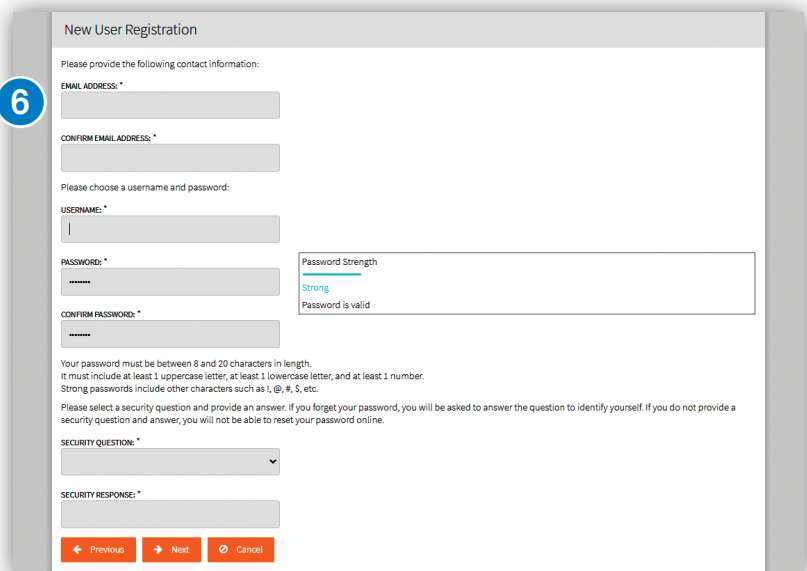
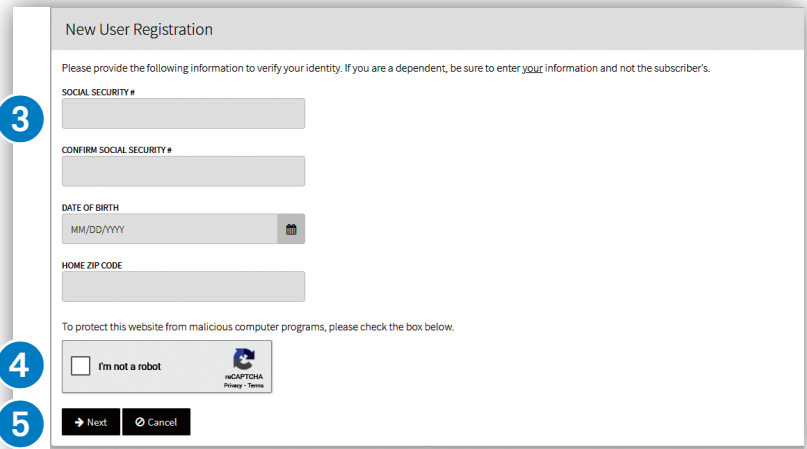
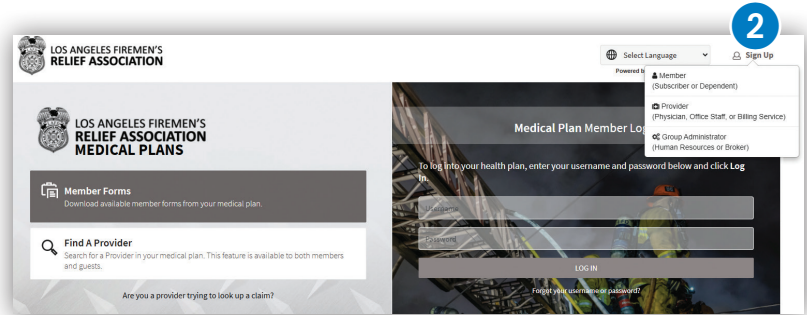


LAFRA Member

# HCOonline Enrollment Guide

# Registering On HCOOnline

- 1 In a web browser, navigate to **HCOOnline** [hconline.healthcomp.com/lafra](https://hconline.healthcomp.com/lafra). If you have already registered, use your existing credentials to log in.
- 2 If you have not yet registered, click **SignUp**. From the drop down menu, click **Member**. This will open the **New User Registration** screen. If you are unable to continue, contact LAFRA Member Services.
- 3 On the New User Registration screen, enter your **Social Security Number** (omitting dashes), **Date of Birth** (MM/DD/YYYY), and **Home Zip Code** (#####).
- 4 Click the **I'm not a robot** checkbox.
- 5 Click **Next**.
- 6 In the User Account step of the **New User Registration**, enter your **email address**, **username**, **password** and **security question** and **answer**. Click **Next**.
- 7 **To complete registration**, HCOOnline will send a confirmation to your email address. Access your email and click the link within the email confirmation. This completes the registration process.



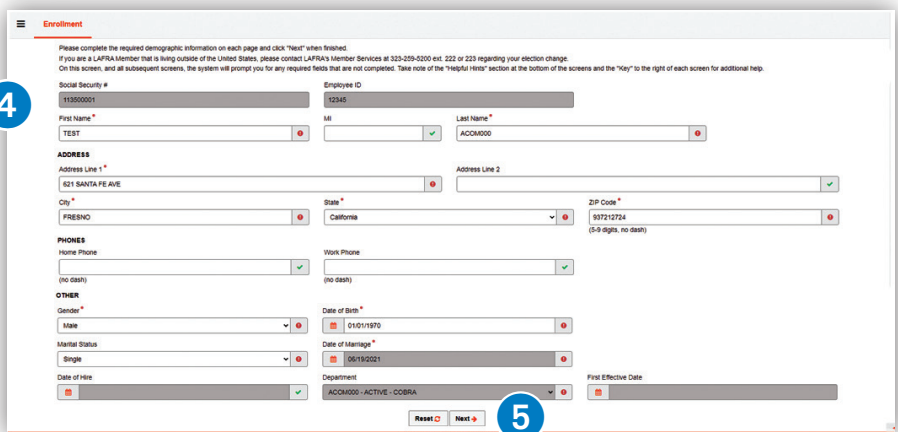
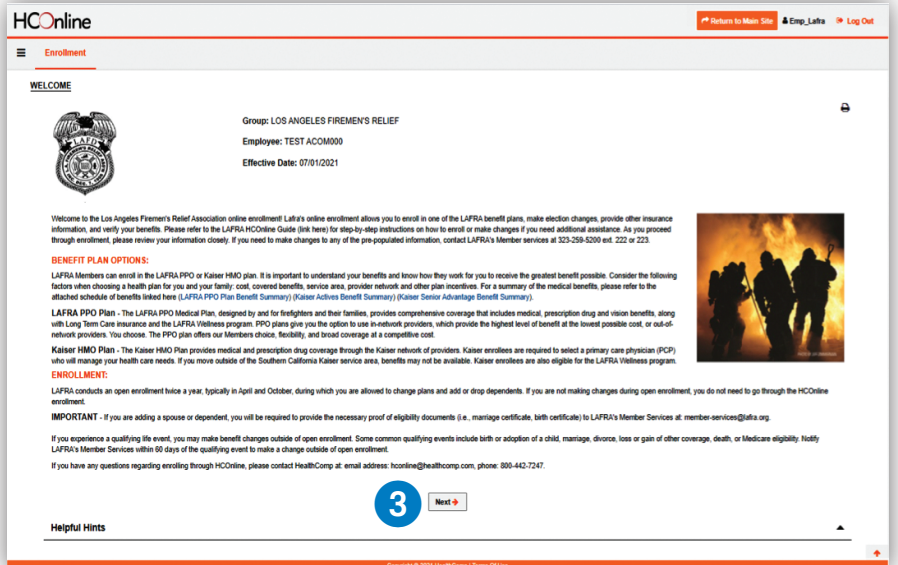
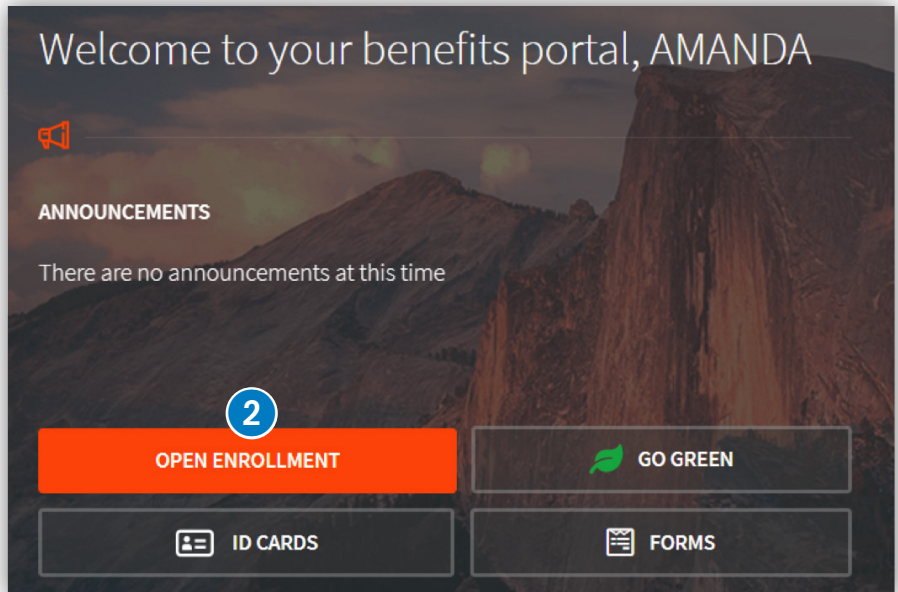
We recommend adding [hconline@healthcomp.com](mailto:hconline@healthcomp.com) to your address book to ensure you receive all HCOonline email notifications.

# Employee Demographics

- 1 Log into your **HCOOnline** account.
- 2 Select the **Open Enrollment** or **New Hire Enrollment** button to begin the enrollment process.
- 3 A welcome page will display after clicking this button. Read the opening page then click **Next**.
- 4 Complete and/or verify all information on the **Employee Demographics** page.

**Note:** If any of the pre-populated information is incorrect, please contact LAFRA's Member Services at (323) 259-5200 (ext 222 or 223).

- 5 When finished, click **Next**. The system will prompt you for any required fields that are not completed.



# Benefit Elections

The **Employee Benefits** page allows you to elect or waive coverage.

- 1 The Medical Plan menu lets you choose the plan of your choice or terminate coverage.

Medical Plan \*

PPO Plan

Select an Option

PPO Plan

Kaiser of CA

Terminate Coverage

- 2 Select the coverage level. **Note:** If adding more than one spouse/dependent, select Employee + 2 or more.

Medical Coverage Level \*

Employee + 2 or more

Select an Option

Employee Only

Employee + 1

Employee + 2 or more

**EMPLOYEE BENEFITS**

**Group:** LOS ANGELES FIREMEN'S RELIEF ASSOCIATION  
**Employee:** TEST ACOM000  
**Effective Date:** 07/01/2021

You have the option of enrolling in LAFRA's PPO or Kaiser HMO plan. Please select a Plan and the appropriate Medical Coverage Level based on your total number of covered enrollees. The Network field will populate based on your Medical Plan selection. Please note that if you are newly enrolling in a LAFRA Plan or are switching between the LAFRA PPO and Kaiser plans, you will be prompted to complete a Cancellation Card.

Benefit Status  
A - Active

**MEDICAL**

Medical Plan \* PPO Plan  
Medical Coverage Level \* Employee + 2 or more  
Network Anthem Blue Cross

**CANCELLATION OF PAYROLL DEDUCTION**

**FEDERAL LAW P.L. 93-579 SECTION 7 re:** Federal Privacy Act and Use of Social Security Numbers. This law requires you be informed when asked for your Social Security Number, that it must be provided for use in employment, personnel and payroll processes. Authority for requiring this information is based upon provisions of the City's payroll and personnel candidate processing system operational prior to January 1, 1975 and applicable Federal law.

Please discontinue deductions from salaries payable to me by the City of Los Angeles for:

Name of City Approved Plan: Kaiser  
Date: 09/09/2021  
Signature: TEST  
Social Security Number: XXX-XX-0001  
Department: LAFD  
Form Cont. 138 (11/00)  
Name: TEST ACOM000  
Home Address: 621 SANTA FE AVE, FRESNO, CA, 937212724

← Previous Reset Next →

Helpful Hints

- 3 If you are terminating coverage under another plan and enrolling in a LAFRA plan, you'll need to complete the cancellation of payroll deduction section to terminate the payroll deduction from your current plan and enroll in a LAFRA plan. **Select the plan you are currently enrolled in.**

Name of City Approved Plan:

Kaiser

Select an Option

PPO

Kaiser

UFLAC

No City Plan

- 4 Type your **first and last name** to sign.

- 5 Then click **Next**.

# Adding Spouse/Dependents to Coverage

The **Dependents** page allows you to add a spouse or dependent you want covered under your plan or update the coverage and demographics for current dependents.

- 1 Select **Add +** to add a spouse or dependent and click **Next**.
- 2 Complete all fields with an **\*** then click **Next**.

**Note:** If adding a spouse or dependent, email the applicable eligibility verification documents (i.e., birth certificate, marriage certificate) to [member-services@lafra.org](mailto:member-services@lafra.org). Make sure to include the Primary Member's name in your email. Your enrollment is not complete until all required documents are received.

- 3 Click on the box next to Medical Coverage for the dependent whose coverage you would like to add. Then click **Next**.

The screenshot shows the 'DEPENDENTS' page for the Los Angeles Firemen's Relief Association. It displays a table with three rows: 'TEST SPOUSE' (Spouse, MED), 'TEST SON' (Son, MED), and 'TEST DAUGHTER' (Daughter, No Coverage). A blue circle with the number '1' highlights the 'Add +' button in the navigation bar at the bottom.

The screenshot shows the 'DEPENDENT DEMOGRAPHICS' page. It contains various form fields for personal information, including First Name, Last Name, Gender, Date of Birth, Relation, Social Security #, Address, City, State, ZIP Code, Home Phone, and Work Phone. A blue circle with the number '2' highlights the 'First Name' field.


This screenshot shows the 'DEPENDENT DEMOGRAPHICS' page with the 'Medical Coverage' checkbox selected. A blue circle with the number '3' highlights the 'Next' button in the navigation bar at the bottom.

# Spouse/Dependent Coverage Termination

The **Dependents** page also allows you to terminate the coverage for covered spouses and dependents.

- 1 Go to the row showing the spouse or dependent's name that you want to remove from coverage and click on the **orange icon** next to **Coverage: Med** and click **Next**.
- 2 Un-click the **blue check box** to remove coverage.
- 3 Then click **Next**.

**DEPENDENTS**


 **Group:** LOS ANGELES FIREMEN'S RELIEF ASSOCIATION  
**Employee:** TEST ACOM000  
**Effective Date:** 07/01/2021

Click "add" to input your eligible dependents. After you enter a dependent's details, click "Next" to add the plans you wish to enroll them in. After all dependents are entered, click "Next".  
To terminate a spouse or dependent's coverage, please click on the Coverage: MED  for the spouse or dependent whose coverage you would like to terminate. This will take you to the next page where you will click on the check box next to "Medical Coverage" to remove the check mark. Once the check mark is removed, click the "Next" button at the bottom of the page to complete the termination.

TEST SPOUSE <input checked="" type="checkbox"/>	Spouse	Coverage: MED <input checked="" type="checkbox"/> <b>1</b>
TEST SON <input checked="" type="checkbox"/>	Son	Coverage: MED <input checked="" type="checkbox"/>
TEST DAUGHTER <input checked="" type="checkbox"/>	Daughter	Coverage: No Coverage <input checked="" type="checkbox"/>

Helpful Hints

**DEPENDENT DEMOGRAPHICS**

 **Group:** LOS ANGELES FIREMEN'S RELIEF ASSOCIATION  
**Employee:** TEST ACOM000  
**Effective Date:** 07/01/2021

**2**  Medical Coverage

Status  
Active

**3**


**Note:** If deleting spouse or dependent coverage, please send the required documentations (i.e., divorce decree) to [member-services@lafra.org](mailto:member-services@lafra.org).

Contact LAFRA's Member Services at (323) 259-5200 (ext 222 or 223) if you have questions about the required documents.

# Other Insurance

- 1 If you or your dependents do NOT have other insurance, please enter your name in the **Signed** box at the bottom of the page and click on **Submit for Review**.

**OTHER INSURANCES**



**Group:** LOS ANGELES FIREMEN'S RELIEF ASSOCIATION  
**Employee:** TEST ACOM000  
**Effective Date:** 07/01/2021

If you or your dependents have other insurance, please complete the information below and click on "Submit for Review". If you or your dependents do not have other insurance, please enter your name in the "Signed" box at the bottom of the page and click on "Submit for Review".

**THIS IS NOT FINAL PAGE FOR ENROLLMENT, PLEASE CONTINUE ENROLLMENT ON NEXT PAGE.**

**Other Insurance**

Employee Name TESTACOM000	Medical Id No. or SSN ****0001	Employer Name LAFRA
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Is this related to a specific claim?  Yes  No

Do you or any of your covered dependents have existing health coverage (this includes Medicare)?  Yes  No


**Covered Members Without Other Insurance**  
Please list the name and date of birth for all covered members who do NOT have other insurance coverage (including yourself).

Member Name	Date of Birth MM/DD/YYYY	<a href="#">+ Add Another Member</a>
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I declare under penalty of perjury that the above statements are true and complete to the best of my knowledge.

Signed	Date 9/9/2021
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**Attachments(e.g. proof of court-ordered coverage for a dependent)**


  
Drag & Drop Files Here!

**1** [Submit For Review](#)

[← Previous](#)

- 2** If you or your dependents **HAVE other insurance**, please complete the Carrier information and click **Submit for Review**. When adding other insurance, enter all required information. Click the **+Add Another Carrier** button if you have multiple plans to report.

**OTHER INSURANCES**



**Group:** LOS ANGELES FIREMEN'S RELIEF ASSOCIATION  
**Employee:** TEST ACOM000  
**Effective Date:** 07/01/2021

If you or your dependents have other insurance, please complete the information below and click on "Submit for Review". If you or your dependents do not have other insurance, please enter your name in the "Signed" box at the bottom of the page and click on "Submit for Review".

**THIS IS NOT FINAL PAGE FOR ENROLLMENT, PLEASE CONTINUE ENROLLMENT ON NEXT PAGE.**

**Other Insurance**

Employee Name: TESTACOM000      Medical Id No. or SSN: \*\*\*\*0001      Employer Name: LAFRA

Is this related to a specific claim?  Yes  No

Do you or any of your covered dependents have existing health coverage (this includes Medicare)?  Yes  No

**Carrier**

Carrier Name: \_\_\_\_\_      Policyholder Name: \_\_\_\_\_      Date of Birth: MM/DD/YYYY

Plan Type: Choose Plan \_\_\_\_\_      Coverage Type (Check all that apply):  
 Medical    Dental    Vision    Rx

Effective Date: MM/DD/YYYY      Termination Date (if applicable): MM/DD/YYYY

**Dependents covered under this carrier**

Dependent Name: \_\_\_\_\_      Relationship to policyholder: \_\_\_\_\_

Is coverage court-ordered? (If yes please attach relevant documents. If you previously submitted up-to-date documents to HealthComp, disregard this.)  Yes  No

Person with whom child primarily resides & relationship to child: \_\_\_\_\_

+ Add Dependent

+ Add Another Carrier

**Covered Members Without Other Insurance**


Please list the name and date of birth for all covered members who do NOT have other insurance coverage (including yourself).

Member Name: \_\_\_\_\_      Date of Birth: MM/DD/YYYY      + Add Another Member

I declare under penalty of perjury that the above statements are true and complete to the best of my knowledge.

Signed: \_\_\_\_\_      Date: 9/9/2021

Attachments(e.g. proof of court-ordered coverage for a dependent)

  
 Drag & Drop Files Here!

Submit For Review

← Previous



# Confirmation

## Submitting Your Enrollment

You must scroll to the bottom and click **Submit** to finalize your enrollment.

**IMPORTANT:** You cannot print your confirmation once you click submit.

The final page gives you a view of all of the information you have entered.

- 1 **Review the information on this page.** If no changes are needed, be sure to **print this page** for your records by selecting the print icon in the upper right of the screen. You can select print and then **SAVE AS PDF** if you do not have a printer.

The screenshot shows a confirmation page with the following details:

- CONFIRMATION** (Page Title)
- Group:** LOS ANGELES FIREMEN'S RELIEF ASSOCIATION
- Employee:** TEST ACOM000
- Effective Date:** 07/01/2021
- Event:** Open Enrollment
- Effective Date:** 07/01/2021
- Print Date:** 9/9/2021 12:40:07 PM

A red banner at the bottom of the page reads: **\*YOU MUST SCROLL TO THE BOTTOM AND CLICK "SUBMIT" TO FINALIZE YOUR ENROLLMENT\***

- 2 If you find that you need to edit any information, click the **Edit** button on the top of the section you wish to edit.

The screenshot shows the **MEDICAL** section with the following options:

- Medical Plan:** PPO Plan
- Medical Coverage Level:** Employee + 2 or more
- Network:** Anthem Blue Cross (800-888-8288)

An **EDIT** button with a pencil icon is visible in the top right corner of the section.

- 3 Once all information has been reviewed and you have read the disclaimer information, click **Submit** at the bottom of the page.

The screenshot shows the **CONFIRMATION AND SUBMISSION OF ENROLLMENT** page with the following disclaimer text:

- I have read all the material in the "Disclaimer Information" section and understand this information as it applies to me and any covered family members of mine.
- To the best of my knowledge, the information furnished herein is accurate and complete.
- I desire to participate in the coverage selected and hereby authorize the necessary deduction from my earnings (if any) required to cover my share of the premium.
- If at any time, the amount of said charges should be changed by the Board of Trustees of the Los Angeles Firemen's Relief Association, Inc., I hereby authorize the deduction from my salary or wages and the payment of the Los Angeles Firemen's Relief Association for this purpose, such sum as may be specified by the Board of Trustees of the Los Angeles Firemen's Relief Association. This authorization shall be effective as long I am covered under any LAFRA plan.
- Your enrollment will not be complete until you click on "Submit" but may be delayed if any necessary information is missing. If you have any questions, contact LAFRA's Member Services Department.
- By Pressing "Submit", I understand this is as legally binding as my signature.

A **Submit** button with a red arrow icon is located at the bottom center of the page.

**Congratulations on successfully submitting your Benefit Enrollment!**