



Birdville ISD Employee Benefits Portal



Login



THEbenefitsHUB

Delivering Instant Access to Your Employee Benefits

Home

THEbenefitsHUB

Check FSA

Contact Us

Click the plan year you would like information for.

Plan Years

- 2012-2013
- 2011-2012

Benefits 2012-2013

- MEDICAL
- MEDICAL SUPPLEMENT
- DENTAL
- VISION
- DISABILITY
- CANCER
- BASIC LIFE
- VOLUNTARY GROUP LIFE
- AD&D
- IDENTITY THEFT
- REIMBURSEMENT PLANS

We encourage you and your family to become familiar with this website. Inside, you will find detailed information about your employee benefits program including benefit summaries, claim forms, insurance, and product information. Direct links to the employee benefit information are provided.

Click the plan name to view specific information for a plan.

Things To Remember

Welcome to BirdvilleISDBenefits.com, the central source for all your benefit needs. Protecting your family and assets is an important and complicated task. Birdville ISD offers you a comprehensive benefits package to achieve this goal....read more.

Quick Links

- Be In The Know



Financial Benefit Services, LLC
 2121 N Glenville Dr
 Richardson, TX 75082
 Phone: (469) 385-4640
 Toll Free: (800) 583-6908
 www.FBSBenefits.com

Your Username Is:

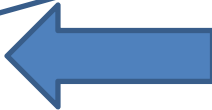
The first Six (6) characters of your last name, followed by the first letter of your first name, followed by the last Four (4) digits of your Social Security Number.

Your Password Is:

Last Name (Excluding punctuation) followed by the last four (4) digits of your Social Security Number.

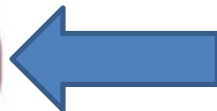
If you have previously logged in this year, you will

If you need login assistance, click this link to watch a video of how to login.



Username

Password



[Click here](#) to download enrollment instructions.

Forgotten your username or password? [Click here](#).

EMPLOYEE USAGE AGREEMENT

Please review and accept to proceed.

When electronic signatures are used, federal law requires that we inform you of the following:

By clicking I accept below, I consent to electronic processing of this application to include use of my electronic signature.

I acknowledge that Electronic Signature means that I am the person identified on this application as the applicant, that I voluntarily accept all the terms and conditions as stated in this application, and that I agree to the electronic processing of this record. I acknowledge that my electronic signature will have the same legal effect as a signature on paper.

I acknowledge that I have the right to print and keep this application on paper.

I acknowledge that I have the right to withdraw my consent to the electronic signature on this application. I understand I must notify my benefit providers in writing of my withdrawal of consent and that such withdrawal will not affect actions already taken by my benefit providers.

I acknowledge that my consent to the use of my electronic signature applies to this application only and not to any other transactions with my benefit providers.

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby declare all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. Furthermore, I understand that this application must be updated by me to include any condition or disease which may occur between the date of my application and the Effective Date of Coverage. I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified for the Effective Date.

By clicking the "Continue" button, I hereby agree to the terms of the Employee Usage Agreement above.

Do not show this page again

Review usage agreement
and click continue.

Continue

Cancel

PERSONAL INFORMATION

Please complete the 5-section enrollment process.

Please edit/view your profile information.

Click the "Sign & Continue" button at the bottom of the page after you've entered the profile information.

Fields in bold are required

General Information

First Name	<input type="text" value="New Hire"/>
Middle Initial	<input type="text" value=""/>
Last Name	Test
Title	<input type="text" value="No Title"/>
Social Security No.	000000075
Government Visa No.	0
EEO Job Category	<input type="text" value="Select EEO Job Category"/>
Gender	<input type="text" value="Female"/>
Date of Birth	<input type="text" value="10/6/1975"/> <small>date in format, mm/dd/yyyy</small>

Contact Information

Street Address	<input type="text" value="6125 East Belknap"/>
Street Address 2	<input type="text" value=""/>
City	<input type="text" value="Haltom City"/>
State	<input type="text" value="TX - Texas"/>
County	<input type="text" value=""/>
Zip Code	<input type="text" value="76117"/>
Home Phone	<input type="text" value="817-547-5700"/>
Work Phone	<input type="text" value="817-547-5700"/> Ext. <input type="text" value=""/>
Email Address	<input type="text" value="newhire@birdvilleschools.net"/>
Alternate Email	<input type="text" value=""/>

Please add your email address.

Other Information

Marital Status

- Single date in format, mm/dd/yyyy
- Married
- Separated
- Divorced
- Widowed

Tobacco User

No ▼

Additional Information

Answer Additional Information questions for health insurance eligibility and effective date.

Are you currently a TRS member?

- No
- Yes

Select an option that indicates which effective date your TRS Medical coverage will begin.

- Actively at Work Date
- First of the Month Following Actively at Work Date

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Save & Continue

DEPENDENT INFORMATION

Please complete the 5-section enrollment process.

Please enter your dependent information.

Please verify all dependent information as benefit eligibility is based on this information. This is including: Gender Types, Dates of Birth, Social Security Number, and Student Status. If there is any information that is inaccurate, it may cause some dependents to show ineligible for some benefits.

To add a spouse or child to the system, click the Add Spouse/Child Link.

Spouse

Test, Spouse 

Children

Test, Child 

 Add a child 

Back

Save & Continue

DEPENDENT INFORMATION

Please add your child's information.

Click the "Save" button at the bottom of the page after you've entered the child's information.

Fields in bold are required.

Name Information

First Name

Kid

Initial

Last Name

Test

Title

No Title

Social Security No.

000000018

nine digits - no dashes or spaces

Gender

Female

Date of Birth

01/01/2010

date in format, mm/dd/yyyy

Contact Information

Residing Address

6125 East Belknap

City

Haltom City

State

TX - Texas

County

Postal Code

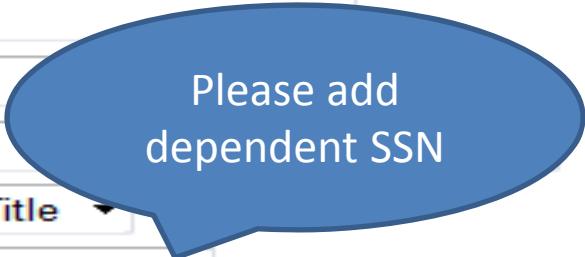
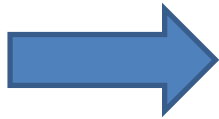
76117

Child has resided here since

01/01/2010

date in format, mm/dd/yyyy

Please add dependent SSN



Legal Information

Has there been a court decree issued regarding Financial Support?

Has there been a court decree issued regarding Insurance Coverage?

Qualified Medical Support Order

Support Information

What percentage of support do you provide this child?

As of what date?

Is child claimed on Federal Taxes?

School Information

Indicate whether **college aged** child is a student

School/University

School Address

City

State

Postal Code

Click to add another child

Indicate full time student status for children age 18 & up.



Save

Cancel

Acceptance

AUTHORIZATION:

I agree this election form cannot be revoked or changed during the plan year, unless there is a change in my family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of spouse's employment) which justifies the revocation or change as authorized by the Internal Revenue Code and Regulations. I understand that any moneys that I allocate in these accounts and do not spend by the end of the Plan Year cannot be returned to me as TAX FREE compensation.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE. I ALSO UNDERSTAND THAT THE PREMIUMS FOR DEDUCTION DOES NOT CONSTITUTE COVERAGE OR APPROVAL BY THE CARRIER. COVERAGES THAT REQUIRE HEALTH QUESTIONS ARE NOT IN FORCE UNTIL APPROVED BY THE INSURING CARRIER.

• I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) afforded by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas with HMO benefits provided by SHA, LLC dba FirstCare, Legacy Health Solutions, Inc., Mercy Health Plans of Missouri, Inc., Scott and White Health Plan, and Valley Baptist Insurance Company dba Valley Baptist Health Plans. On behalf of myself and any dependents listed on the Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.

- If I am enrolling a grandchild in my residence and the grandchild is my primary residence, that I provide natural parents reside in my home regarding the child's medical coverage.

• Only those coverage(s) and amount if this Enrollment Application and Change Form in accordance with the provisions of the TRS Rules.

• I understand that the health coverage exclusion (not applicable to HMO coverage).

• I understand that by enrolling for coverage and Change Form that any TRS-ActiveCare coverage provided by a participating district/entity will be terminated under TRS Rules.

• I authorize necessary payroll deduction for my health insurance. I agree that my Employer acts as my agent for the purpose of this enrollment.

• I state that the information given is true and correct. I understand and agree that any incorrect information will invalidate my coverage(s).

May 10, 2012

Date

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Finished

Print This Page

If you elect health insurance to be effective on your date of hire, you will be directed to the medical screen to choose your coverage and then to this screen.

Click on the Finished button to continue.

If you elect not to have health insurance effective on your date of hire, you will be directed to this screen since you are waiving the date of hire benefit.

Click on the Finished button to continue.

Message from webpage



You have completed new hire enrollment for benefits for the current plan year. However, your company is in open enrollment for the upcoming plan year. You will now complete open enrollment for upcoming plans.

Click 'OK' and you will be redirected to walk through the system again for all other new hire benefit elections.

OK

Current Medical Plan Election

You are not currently enrolled in any Medical plans.

Click the box next to the name of every person you want to cover.

Available Medical Plans

Coverage

<input checked="" type="radio"/> ActiveCare 1 HD View Plan Outline Provided by TRS Eligible on 9/1/2012 Select Tax Election Pre-tax	<input checked="" type="checkbox"/> You <input type="checkbox"/> Dirk [spouse] <input type="checkbox"/> Child [child]	73.00
<input type="radio"/> ActiveCare 1 View Plan Outline of Benefits Provided by TRS Eligible on 9/1/2012 Select Tax Election Pre-tax	<input type="checkbox"/> You <input type="checkbox"/> Dirk [spouse] <input type="checkbox"/> Child [child]	
<input type="radio"/> ActiveCare 2 View Plan Outline of Benefits Provided by TRS Eligible on 9/1/2012 Select Tax Election Pre-tax	<input type="checkbox"/> You <input type="checkbox"/> Dirk [spouse] <input type="checkbox"/> Child [child]	
<input type="radio"/> ActiveCare 3 View Plan Outline of Benefits Provided by TRS Eligible on 9/1/2012 Select Tax Election Pre-tax		
<input type="radio"/> I waive enrollment in all available Medical plans		

Helpful Hint:
If you elected medical coverage effective on date of hire, you also must re-elect for the 9/1/12 plan year as well.

Medical
\$ 73.00

Dental
[ENROLLED] \$47.16

Vision
[WAIVED]

Long Term Disability
[ENROLLED] \$46.86

Cancer
[WAIVED]

Employee Life
[ENROLLED] \$16.20

Spouse Life
[ENROLLED] \$0.90

Child(ren) Life
[ENROLLED] \$1.20

AD&D
[ENROLLED] \$6.96

Identity Theft
[WAIVED]

HealthCare Reimbursement

Dependent Care Reimbursement

Monthly Payroll Deduction
192.28

TRS - ActiveCare DECLINATION PAGE

By clicking the "Accept" button I, the employee, certify that the available medical coverage has been explained and offered to me. I have been given the opportunity to apply for the medical coverage offered to me and my eligible dependents. The voluntary election, as indicated below, reflects either enrollment or waiver in the medical coverage by myself, the employee. If I have waived the medical coverage and decide to apply for the coverage at a later date, I understand there may be a delay in the effective date of the medical coverage as well as a pre-existing condition exclusion period (not applicable to HMO coverage).

*Effective September 1, 2014, the waiting period is not applicable for any individual under the age of 19.

* If you are declining coverage for any dependent, please contact your Benefits Administrator.

List the reason you are declining health insurance for all dependents. You can add dependents you have not entered into the system

		Members of your family	
		Name	Reason for Declining
Covered		Amanda Test	None
Declining Member	Spouse	Dirk Test	Other Group Coverage
Declining Member	Child	Child Test	Other Reason don't want

+ Add a Child

If everything is correct on this screen







Accept

or [Back](#)

Current Long Term Disability Plan Election

The employee is not currently enrolled in any Long Term Disability plans.

Available Long Term Disability Plans

- Plan A - Injury 0 / Sickness 7** 
View Plan Outline of Benefits
Provided by Unum
Eligible on 10/1/2012
Cost is deducted on a post-tax basis
- Plan A - Injury 60 / Sickness 60** 
View Plan Outline of Benefits
Provided by Unum
Eligible on 10/1/2012
Cost is deducted on a post-tax basis
- Plan A - Injury 90 / Sickness 90** 
View Plan Outline of Benefits
Provided by Unum
Eligible on 10/1/2012
Cost is deducted on a post-tax basis
- Plan A - Injury 180 / Sickness 180** 
View Plan Outline of Benefits
Provided by Unum
Eligible on 10/1/2012
Cost is deducted on a post-tax basis
- Plan B - Injury 0 / Sickness 7** 
View Plan Outline of Benefits
Provided by Unum
Eligible on 10/1/2012
Cost is deducted on a post-tax basis
- Plan B - Injury 14 / Sickness 14** 
View Plan Outline of Benefits
Provided by Unum
Eligible on 10/1/2012
Cost is deducted on a post-tax basis

Click the Radial Button next to the plan option you wish to elect.

Monthly Benefit

Monthly Benefit	Cost
Select Coverage...	
Select Coverage...	
\$3,300.00	Cost: \$156.09
\$3,200.00	Cost: \$151.36
\$3,100.00	Cost: \$146.63
\$3,000.00	Cost: \$141.90
\$2,900.00	Cost: \$137.17
\$2,800.00	Cost: \$132.44
\$2,700.00	Cost: \$127.71
\$2,600.00	Cost: \$122.98
\$2,500.00	Cost: \$118.25
\$2,400.00	Cost: \$113.52
\$2,300.00	Cost: \$108.79
\$2,200.00	Cost: \$104.06
\$2,100.00	Cost: \$99.33
\$2,000.00	Cost: \$94.60
\$1,900.00	Cost: \$89.87
\$1,800.00	Cost: \$85.14
\$1,700.00	Cost: \$80.41
\$1,600.00	Cost: \$75.68
\$1,500.00	Cost: \$70.95

Cost

Election Summary

Costs shown are as of 10/1/2012

- Basic Life**
[ENROLLED] \$0.00
- Medical**
[ENROLLED] \$732.00
- MEDLink**
[ENROLLED] \$69.00
- Dental**
[ENROLLED] \$108.20
- Vision**
[ENROLLED] \$26.32
- Long Term Disability**
\$
- Cancer**
[WAIVED]
- Employee Life**
[WAIVED]
- AD&D**
[WAIVED]
- Identity Theft**
[WAIVED]
- HealthCare Reimbursement**
[WAIVED]

When you have multiple coverage options to choose from, click the drop down arrow to select your desired coverage.

Current Cancer Plan Election

You are not currently enrolled in any Cancer plans.

Available Cancer Plans	Coverage	Your Cost
<input type="radio"/> Low Option View Plan Outline of Benefits Provided by American Public Life Eligible on 10/1/2012 Select Tax Election Pre-tax ▾	<input type="checkbox"/> You <input type="checkbox"/> Dirk [spouse] <input type="checkbox"/> Child [child]	<input type="text"/>
<input type="radio"/> Low Option w / ICU View Plan Outline of Benefits Provided by American Public Life Eligible on 10/1/2012 Select Tax Election Pre-tax ▾	<input type="checkbox"/> You <input type="checkbox"/> Dirk [spouse] <input type="checkbox"/> Child [child]	<input type="text"/>
<input type="radio"/> High Option View Plan Outline of Benefits Provided by American Public Life Eligible on 10/1/2012 Select Tax Election Pre-tax ▾	<input type="checkbox"/> You <input type="checkbox"/> Dirk [spouse] <input type="checkbox"/> Child [child]	<input type="text"/>
<input type="radio"/> High Option w / ICU View Plan Outline of Benefits Provided by American Pu Eligible on 10/1/2012 Select Tax Election Pre-tax ▾	<input type="checkbox"/> You	<input type="text"/>

Election Summary
Costs shown are as of 10/1/2012

Basic Life
[ENROLLED] \$0.00

Medical
[WAIVED]

Dental
[WAIVED]

Vision
[WAIVED]

Long Term Disability
[WAIVED]

Cancer
\$ 0.00

Employee Life
[ENROLLED] \$16.20

Spouse Life
[ENROLLED] \$0.90

Child(ren) Life
[ENROLLED] \$1.20

AD&D
[ENROLLED] \$6.96

Identity Theft
[WAIVED]

HealthCare Reimbursement

Dependent Care Reimbursement

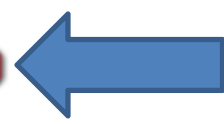
Monthly Payroll Deduction
\$ 25.26

To decline a benefit, click the "I waive enrollment" radial button (located at the bottom of each available plan screen).



Back

Sign & Continue



Current HealthCare Reimbursement Plan Election

The employee is not currently enrolled in any HealthCare Reimbursement plan

Enter your monthly contribution amount.

Available HealthCare Reimbursement Plan

HealthCare Reimbursement with Flex Card ⓘ **Monthly Contribution**

[View Plan Outline of Benefits](#)

Provided by National Benefit Services

Allowed range of contributions is \$25.00 min to \$208.33 max.

Effective period is

Click this link to view plan information.

Cost is deducted on

Employee waives enrollment in the available HealthCare Reimbursement plan

Please enter the Effective Date for this new enrollment: mm/dd/yyyy

Save

Cancel

Election Summary
Results shown are as of 10/1/2012

Basic Life
[ENROLLED] \$0.00

Medical
[WAIVED]

Dental
[WAIVED]

Vision
[WAIVED]

Long Term Disability
[WAIVED]

Cancer
[WAIVED]

Employee Life
[WAIVED]

AD&D
[WAIVED]

Identity Theft
[WAIVED]

HealthCare Reimbursement
\$

Dependent Care Reimbursement
[WAIVED]

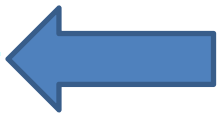
Monthly Payroll Deduction
\$

BENEFICIARY INFORMATION

Please add beneficiaries in step 1. Once all beneficiaries have been added, proceed to step 2 to create beneficiary allocations.

Step 1 - Create Beneficiary

+ Add a Beneficiary



Step 1: Click Add a Beneficiary for each beneficiary you wish to add to the system.

Step 2 - Beneficiary Allocations

Apply Allocations to all coverages equally ▼

The Following allocation applies to all applicable coverages.

Cancel

Finished

Add A Beneficiary



Select Dependent to add as a Beneficiary

Select Dependent ▾

Or enter beneficiary info below

Select a name from dependents in the system or enter beneficiary information below and save.

Relation:

Select Relation ▾

First Name:

Last Name:

Address:

City:

State:

AK - Alaska ▾

Postal Code:

Phone:

Gender:

Male ▾

Date of Birth:

Social Security No:

nine digits - no dashes or spaces



Save

Cancel



BENEFICIARY INFORMATION

Please add beneficiaries in step 1. Once all beneficiaries have been added, proceed to step 2 to create beneficiary allocations.

Step 1 - Create Beneficiary

Test, Spouse [Spouse]

Test, Child [Child]

[+ Add a Beneficiary](#)

Step 2 - Beneficiary Allocations

Apply Allocations to all coverages equally

You can choose to apply the same beneficiaries to all benefits or choose to allocate differently for each benefit.

The Following allocation applies to all applicable coverages.

Beneficiary Name	Percentage	
	Primary	Contingent
Test, Spouse	<input type="text" value="100"/>	<input type="text" value="0"/>
Test, Child	<input type="text" value="0"/>	<input type="text" value="100"/>

Primary and/or Contingent percentages must equal 100%

Please complete the 5-section enrollment process.

Please print this form for your records, and then you MUST click the finish button to confirm your Enrollment.

Personal Information [Click here to edit](#)






Test, Amanda 2121 N Glenville Drive Richardson, TX 75082	Social Security No. ###-##-0075
	Government Visa No. 0
	Date of Employment 8/24/2012
	Date of Birth 10/6/1975
972-881-2255 [home]	Gender Female
972-881-2255 Ext. 120 [work]	Marital Status Married
aadams@thebenefitshub.com	Tobacco User No
Are you currently a TRS member?	Yes

Review personal information and benefit elections for accuracy.

Election Information

Below is the list of the elections effective as of greatest new hire eligibility date 10/1/2012.

To edit an existing benefit plan election, click the corresponding name of the benefit plan type. To view the outline of benefits of any existing election, click the corresponding icon next to the plan type.

Effective 10/1/2012		
Benefit Plan	Coverage	Your Cost
Basic Life - Basic Life  Effective on 10/1/2012 Provided by MetLife Policy Number: - Cost is deducted on a post-tax basis	\$10,000.00	\$0.00
Dental - High PPO  Effective on 10/1/2012 Provided by MetLife Policy Number: 00422991 Cost is deducted on a pre-tax basis	Test, Amanda Test, Dirk [Spouse] Test, Child [Child]	\$108.20
Employee Life - Employee  Effective on 10/1/2012 Provided by MetLife Policy Number: - Cost is deducted on a post-tax basis	\$180,000.00	\$16.20
Spouse Life - Spouse  Effective on 10/1/2012 Provided by MetLife Policy Number: - Cost is deducted on a post-tax basis	\$15,000.00 Test, Dirk [Spouse]	\$0.90
Child(ren) Life - Child(ren)  Effective on 10/1/2012 Provided by MetLife Policy Number: - Cost is deducted on a post-tax basis	\$10,000.00 Test, Child [Child]	\$1.20

I agree this election form cannot be revoked or changed during the plan year, unless there is a change in my family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of spouse's employment) which justifies the revocation or change as authorized by the Internal Revenue Code and Regulations. I understand that any moneys that I allocate in these accounts and do not spend by the end of the Plan Year cannot be returned to me as TAX FREE compensation.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE. I ALSO UNDERSTAND THAT THE PREMIUMS FOR DEDUCTION DOES NOT CONSTITUTE COVERAGE OR APPROVAL BY THE CARRIER. COVERAGES THAT REQUIRE HEALTH QUESTIONS ARE NOT IN FORCE UNTIL APPROVED BY THE INSURING CARRIER.

• I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) afforded by the TRS-ActiveCare program which is administered by Blue Cross and Blue Shield of Texas with HMO benefits provided by SHA, LLC dba FirstCare, Legacy Health Solutions, Inc., Mercy Health Plans of Missouri, Inc., Scott and White Health Plan, and Valley Baptist Insurance Company dba Valley Baptist Health Plans. On behalf of myself and any dependents listed on the Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.

- If I am enrolling a grandchild in Section 5, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes.
- If I am enrolling a child as an "other child" in Section 5, I certify that my household is the child's primary residence, that I provide at least 50% of the child's support, that neither of the child's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.

- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions of the TRS-ActiveCare program.
- I understand that the health coverage I am applying for may be subject to a preexisting condition exclusion (not applicable to HMO coverage).
- I understand that by enrolling for coverage with the Employer named in this Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating Employer will be terminated under TRS Rules.
- I authorize my Employer to deduct from my pay the amount of my contribution to the cost of my coverage(s). I agree to pay the amount of my contribution to the cost of my coverage(s) through my Employer. All notices given to my Employer are binding upon me. I also agree that my coverage(s) is subject to any future amendments.
- I understand that the information on this Enrollment and Change Form is true and correct. I understand that any false or incorrect statements material to the risk and knowingly made by me will invalidate my coverage.

Print a copy for your records and click the Finished button.

May 9, 2018

Date

Signature of Test, Amanda [Applicant]

Back

Finished

Print This Page



Welcome, Amanda Test. Please select an option or choose from the menu below:

Make elections in upcoming plans during your company's open enrollment.

Click this icon to change password.



Personal Information

Click this icon to view dependents



Dependent Information

Click this icon to view benefit elections



Benefit Plan Information



Company Communication

Click Logout when you are finished.

