Essential StaffCARE | PLAN 2 - CHANGE FORM | 276100-LGS

Mail / Fax to: Planned Administrators, Inc.
PO Box 6702
Columbia, SC 29260

Telephone (866) 798-0803
Fax (803) 264-0772

Underwritten by
BCS Insurance Company
Oakbrook Terrace, IL

Fill out this form ONLY if you are making changes in your coverage or terminating coverage.

A. REASON FOR THE CHANGE

☐ Address Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Terminate Coverage

B. REQUIRED EMPLOYEE INFORMATION

MUST BE FILLED OUT **Address/Name Change**

Name	Social Security #	Home Phone		Gender M F
Address	City	State	Zip	Apt. #
Employer		Hire Date / /		Date of Birth / /

Add/Change Dependent Information

Name	Social Security #	Date of Birth / /	Gender	Relationship
			M F	
			M F	
			M F	

C. INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

Weekly Rates

You **MUST** select a coverage level before adding any benefits in Section C. Your coverage level for all the benefits in Section C will be identical.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only ☐	**$20.91**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren) ☐	**$34.71**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse ☐	**$39.73**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family ☐	**$52.90**	**$20.52**	**$9.20**	**$1.80**	
Terminate **All** Plans ☐	☐ Enroll	☐ Enroll	☐ Enroll	☐ Enroll	☐ Enroll
No Change to Any Plan ☐	☐ Cancel	☐ Cancel	☐ Cancel	☐ Cancel	☐ Cancel
	☐ No Change	☐ No Change	☐ No Change	☐ No Change	☐ No Change

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

Add/Change Life/Accidental Loss of Life, Limb and Sight Beneficiary

Primary Relationship

Secondary Relationship

D. MEC PLAN CHANGES - Select the change you wish to make.

82761000-M-LGS **Monthly Rates**

MEC Wellness/Preventive ☐ **Terminate** MEC Plan ☐ No Change

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

I understand that coverage may continue under my old elections until this form is received and processed by PAI. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. I understand that a change in elections will be effective the 1st of the month following your credit card draft. If canceling, your coverage will terminate on the last day of the month for which a payment has been made. I understand that I have been offered an opportunity to become covered under the Essential StaffCARE plans, and I have chosen NOT to take advantage of this offer.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**