Essential StaffCARE | **CHANGE FORM** | **2935900-AAL**

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.

REASON FOR THE CHANGE

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

EMPLOYEE INFORMATION (must be filled out) — Address / Name Change

Social Security Number___ ___ ___-___ ___- ___ ___ ___ ___ Date of Birth ___/___/___ Sex M F

Name Home Phone - -

Street Address City State Zip

Employer Hire Date ___/___/___

Add/Change Dependent Information

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender

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

Select Coverage Level

You **MUST** select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.

☐ Employee Only ☐ Employee + Spouse
☐ Employee + Child(ren) ☐ Employee + Family
☐ Terminate all coverage

Medical/Rx [1] — Weekly Rates

☐ ENROLL	$18.76	Employee Only
☐ CANCEL	$31.16	Employee + Child(ren)
☐ NO CHANGE	$35.64	Employee + Spouse
	$47.48	Employee + Family

Dental — Weekly Rates

☐ ENROLL	$5.40	Employee Only
☐ CANCEL	$14.58	Employee + Child(ren)
☐ NO CHANGE	$10.80	Employee + Spouse
	$20.52	Employee + Family

Short-Term Disability [2] — Weekly Rates

☐ ENROLL		
☐ CANCEL	$4.20	Employee Only
☐ NO CHANGE		

Vision — Weekly Rates

☐ ENROLL	$2.42	Employee Only
☐ CANCEL	$6.54	Employee + Child(ren)
☐ NO CHANGE	$4.84	Employee + Spouse
	$9.20	Employee + Family

Term Life — Weekly Rates

☐ ENROLL	$0.60	Employee Only
☐ CANCEL	$0.90	Employee + Child(ren)
☐ NO CHANGE	$0.90	Employee + Spouse
	$1.80	Employee + Family

[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

MEC PLAN CHANGES - Select the change you wish to make. 82935900-M-AAL

MEC Wellness/Preventive — Monthly Rates

☐ $60.00 Employee Only ☐ $87.00 Employee + Spouse ☐ No Change
☐ $79.80 Employee + Child(ren) ☐ $105.90 Employee + Family ☐ Terminate MEC Wellness/Preventive

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings for the Fixed Indemnity Plan and ancillary benefits. I understand that deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. I understand that the change will be effective the 1st of the month after the request date. If canceling coverage, 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.

X Signature Date