

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

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

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

REASON FOR THE CHANGE

Address Change Name Change Add Dependent(s) Coverage Change 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 _____ ST _____ ZIP _____

Employer _____ Hire Date ____ / ____ / _____

Add / Change Dependent Information

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F
				<input type="checkbox"/> M <input type="checkbox"/> F

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

MEC Wellness/Preventive

Monthly Rates

- \$58.19 Employee Only
- \$69.53 Employee + 1
- \$80.87 Employee + Family
- No Change
- Terminate MEC Wellness/Preventive

If electing benefits, I hereby authorize my employer to send request to PAI for enrollment into the coverage. If cancelling coverage, I understand that I have been offered an opportunity to become covered under the Essential StaffCARE plan, and I have chosen NOT to take advantage of this offer. I understand that the change will be effective the 1st of the month after the request date.

▶ SIGNATURE _____ Date ____ / ____ / _____