Essential StaffCARE | **PLAN 1 - CHANGE FORM** | **208700-CEG**

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 __ __ /__ __ /__ __ __ __ Gender M F

Name Phone - -

Street Address City ST ZIP

Employer Hire Date __ __ /__ __ /__ __ __ __

Add / Change Dependent Information

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender
				M F
				M F
				M F
				M F

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 + Family ☐ Terminate Indemnity Plan

☐ Employee + 1 ☐ No Change

Benefit Bundle — Weekly Rates

The benefit bundle includes **dental, vision, and term life** benefits.

☐ ENROLL	$8.42	Employee Only
☐ CANCEL	$16.62	Employee + 1
☐ NO CHANGE	$26.18	Employee + Family

Fixed Indemnity Medical Plan — Weekly Rates

☐ ENROLL	$19.58	Employee Only
☐ CANCEL	$39.73	Employee + 1
☐ NO CHANGE	$53.06	Employee + Family

Add/Change Life/Accidental Death & Dismemberment Beneficiary

Primary Relationship

Secondary Relationship

Do you or any dependent to be enrolled currently have comprehensive health benefits from either an individual or group health insurance policy or an HMO or employer plan providing for essential health benefits?

☐ **YES** ☐ **NO** **(If No, you are not eligible for this plan.)**

If you did not answer YES to having comprehensive health benefits from either an individual or group health insurance policy, you may still enroll in dental, vision, or term life coverage.

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings. I understand that deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded. I understand that making no selection for a benefit means I do not wish to make a change to that benefit. **I understand that making no selection for a benefit means I do not wish to make a change to that benefit.**

▶ SIGNATURE _____ Date __ __ /__ __ /__ __ __ __