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 ___/___/___ 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 + Family ☐ Terminate Indemnity Plan

☐ Employee + 1 ☐ No Change

Benefit Bundle — Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$8.42 Employee Only
$16.62 Employee + 1
$26.18 Employee + Family

Fixed Indemnity Medical Plan — Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$19.58 Employee Only
$39.73 Employee + 1
$53.06 Employee + Family

Add/Change Life/AD&D Beneficiary

Primary Relationship

Secondary Relationship

This is a supplement to health coverage and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes. I hereby attest that I am purchasing this policy as a supplement or in addition to other major medical health insurance coverage. ☐ YES ☐ NO

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings. 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 deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded.

X Signature Date