Essential StaffCARE | **CHANGE FORM** | **220000-SIG**

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.

Medical/Rx [1] Weekly Rates

☐ $22.76 Employee Only ☐ $61.67 Employee + Family ☐ Terminate Indemnity Plan
☐ $46.18 Employee + 1 ☐ No Change

- You **MUST** enroll in the Medical Insurance Plan before adding any additional benefits.
- Your coverage level for the additional benefits will be identical to your medical plan selection.

Dental Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$5.40	Employee Only
$10.80	Employee + 1
$17.82	Employee + Family

Short-Term Disability [2] Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$4.20 Employee Only

Vision Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$2.42	Employee Only
$4.92	Employee + 1
$6.56	Employee + Family

Term Life Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$0.60	Employee Only
$0.90	Employee + 1
$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. — 82200000-M-SIG

MEC Wellness/Preventive Monthly Rates

☐ $60.00 Employee Only ☐ $111.29 Employee + Family ☐ Terminate MEC Wellness/Preventive
☐ $90.87 Employee + 1 ☐ No Change

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