Essential StaffCARE | Plan 1 - CHANGE FORM | 211200-TGG

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 and
4 Ever Life 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 Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Beneficiary Change ☐ Terminate Coverage

Reason for Termination (only select one)

☐ T1- Termination of Employment
☐ T2- Termination due to Retirement
☐ T3- Termination due to Employee's Medicare Entitlement
☐ T4- Deceased
☐ T5- Loss of Dependent Status
☐ T6- Reduction of Hours
☐ T7- Non FMLA Leave of Absence
☐ T8- Divorce/Legal Separation
☐ T9- USERRA/Military
☐ TU- Unknown
☐ TV- Voluntary Termination
☐ TS- Termination with Severance

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

PLAN CHANGES - Select a plan to change to. Leave blank for no change.

Medical/Rx — Weekly Rates

☐ $19.98 Employee Only
☐ $40.54 Employee + One
☐ $54.14 Employee + Family
☐ Terminate all coverage

- 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

$ 5.23 Employee Only
$10.46 Employee + One
$17.26 Employee + Family

Short-Term Disability — Weekly Rates

☐ ENROLL
☐ CANCEL

$4.20 Employee Only

Term Life — Weekly Rates

☐ ENROLL
☐ CANCEL

$0.60 Employee Only
$0.90 Employee + One
$1.80 Employee + Family

Add/Change Life/Accidental Loss of Life, Limb, and Sight Beneficiary

Primary ____________________ Secondary ____________________

Relationship ____________________ Relationship ____________________

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.

Signature Date