

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.

### A. REASON FOR THE CHANGE

☐ Address Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Terminate Coverage

### B. REQUIRED EMPLOYEE INFORMATION

#### MUST BE FILLED OUT

#### Address/Name Change

Name	Social Security #	Phone	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
Address	City	State	Zip	Apt. #
Employer	Hire Date / /		Date of Birth / /	

### Add/Change Dependent Information

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

### C. INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

#### Weekly Rates

You **MUST** select a coverage level before adding any benefits in Section C. Your coverage level for all the benefits in Section C will be identical.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL <sup>1</sup>		DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>	CRITICAL ILLNESS
	Plan 1	Plan 2					
Employee Only <input type="checkbox"/>	\$15.98	\$19.98	\$5.40	\$2.42	\$0.60	\$4.20	\$2.71
Employee + Child(ren) <input type="checkbox"/>	\$26.54	\$33.17	\$14.58	\$6.54	\$0.90		\$2.75
Employee + Spouse <input type="checkbox"/>	\$30.36	\$37.96	\$10.80	\$4.84	\$0.90		\$4.99
Employee + Family <input type="checkbox"/>	\$40.44	\$50.55	\$20.52	\$9.20	\$1.80		\$5.04
NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No Medical Plan		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>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

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

#### 82994000-M-BGV Weekly Rates

MEC Wellness/Preventive ☐ Terminate MEC Plan ☐ No Change

☐ \$13.42 Employee Only ☐ \$15.18 Employee + Child(ren) ☐ \$16.38 Employee + Spouse ☐ \$18.66 Employee + Family

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, however, coverage will continue as long as you have a paycheck deduction. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. **I understand that making no selection in Section C and D for a benefit means I do not wish to make a change to that benefit.**

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

► SIGNATURE