Essential StaffCARE | Plans 1 & 2 - CHANGE FORM | 2994001-BGV-1

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 M F
Address	City	State	Zip	Apt. #
Employer		Hire Date / /		Date of Birth / /

Add/Change Dependent Information

Name	Social Security #	Date of Birth / /	Gender	Relationship
			M F	
			M F	
			M F	

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

Semi-monthly 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 [1] Plan 1	FIXED INDEMNITY MEDICAL [1] Plan 2	DENTAL [1]	VISION [1]	TERM LIFE [1]	SHORT-TERM DISABILITY [1, 2]	CRITICAL ILLNESS [1]
Employee Only ☐	**$34.62**	**$43.29**	**$11.70**	**$5.24**	**$1.30**	**$9.10**	**$5.87**
Employee + Child(ren) ☐	**$57.50**	**$71.86**	**$31.59**	**$14.17**	**$1.95**		**$5.96**
Employee + Spouse ☐	**$65.78**	**$82.25**	**$23.40**	**$10.49**	**$1.95**		**$10.81**
Employee + Family ☐	**$87.62**	**$109.52**	**$44.46**	**$19.93**	**$3.90**		**$10.92**
NO to ALL Benefits ☐	☐ Plan 1 ☐ Plan 2 ☐ No Medical Plan		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NH, 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.

82994001-M-BGV-1 **Semi Monthly Rates**

MEC Wellness/Preventive ☐ **Terminate** MEC Plan ☐ No Change

☐ **$29.10** Employee Only ☐ **$32.90** Employee + Child(ren) ☐ **$35.51** Employee + Spouse ☐ **$40.44** 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**