Essential StaffCARE | VALUE PLAN - CHANGE FORM | 2949000-AJV

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 #	Home Phone		Sex 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

Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical** Insurance Plan before adding any additional benefits in Section C.
Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection.

	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only	☐ **$18.76**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren)	☐ **$31.16**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse	☐ **$35.64**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family	☐ **$47.48**	**$20.52**	**$9.20**	**$1.80**	
	☐ **Terminate** Plan	☐ Enroll	☐ Enroll	☐ Enroll	☐ Enroll
	☐ No Change	☐ Cancel	☐ Cancel	☐ Cancel	☐ Cancel
		☐ No Change	☐ No Change	☐ No Change	☐ No Change

[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

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

82949000-M-AJV **Monthly Rates**

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

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

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, however, coverage will continue as long as you have a paycheck deduction.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**