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

☐ **$62.00** Employee Only ☐ **$81.80** Employee + Child(ren) ☐ **$89.00** Employee + Spouse ☐ **$107.90** 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.

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