Essential StaffCARE CHANGE FORM 221900-CMG

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
BCS 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

☐ **$21.32 per week for Employee Only**
☐ **$43.26 per week for Employee Plus 1**
☐ **$57.78 per week for Employee Plus Family**
☐ **Terminate all coverage**

- You MUST enroll in the Medical Insurance Plan before adding Dental, Vision, STD, or Term Life.
- Your coverage level for Dental, Vision and Term Life will be identical to your medical plan selection.

Dental

☐ **ENROLL**
☐ **CANCEL**

$5.23 /week for Employee Only
$10.46 /week for Employee Plus One
$17.26 /week for Employee Plus Family

Short-Term Disability

☐ **ENROLL**
☐ **CANCEL**

$4.20 /week for Employee Only

Vision

☐ **ENROLL**
☐ **CANCEL**

$2.35 /week for Employee Only
$4.00 /week for Employee Plus One
$5.64 /week for Employee Plus Family

Term Life

☐ **ENROLL**
☐ **CANCEL**

$0.60 /week for Employee Only
$0.90 /week for Employee Plus One
$1.80 /week for Employee Plus Family

Add/Change Life/AD&D Beneficiary

Primary _____ Secondary _____

Relationship _____ Relationship _____

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings. If canceling 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

Form: ESC-CF-10k-X