Essential StaffCARE | Plan 2 - CHANGE FORM | 219301-EMP

Mail / Fax To: Planned Administrators, Inc.
PO Box 6702, Columbia, SC 29260

Telephone (866) 798-0803
Fax (803) 264-0772 6152

Underwritten by
BCS Insurance Company
Oakbrook Terrace, IL

Fill out this form ONLY if you are making changes in your coverage or terminating coverage.

EMPLOYEE INFORMATION (must be filled out) — **Address / Name Change**

Social Security Number 450-39-1832 Date of Birth 02/26/1972 Sex ☐ M ☐ F

Name Adnan Keith McGee Home Phone 979-481-7276

Street Address 2300 Ward Bend Rd #293B City Sealy State TX Zip 77474

Employer Hire Date / /

Add/Change Dependent Information

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender
Adnan K. McGee JR	636-76-7017	5/22/01	Son	M
Z'Ryan K. McGee	635-31-4441	6/15/11	daughter	F

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 ☐ T4- Deceased ☐ T7- Non FMLA Leave of Absence ☐ TU- Unknown
☐ T2- Termination due to Retirement ☐ T5- Loss of Dependent Status ☐ T8- Divorce/Legal Separation ☑ TV- Voluntary Termination
☐ T3- Termination due to Employee's Medicare Entitlement ☐ T6- Reduction of Hours ☐ T9- USERRA/Military ☐ TS- Termination with Severance

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

Select Coverage Level

You MUST select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.

☐ Employee Only ☐ Employee + 1 ☐ Employee + Family ☐ Terminate all Coverage

Medical/Rx[1] — Weekly Rates

☐ ENROLL ☐ NO CHANGE ☐ CANCEL
$20.91 Employee Only
$42.44 Employee + 1
$56.67 Employee + Family

Dental — Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE
$ 6.17 Employee Only
$12.34 Employee + 1
$20.36 Employee + Family

Short-Term Disability[2] — Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE
$4.20 Employee Only

Term Life — Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE
$0.60 Employee Only
$0.90 Employee + 1
$1.80 Employee + Family

[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/AD&D Beneficiary

Primary _____ Secondary _____

Relationship _____ Relationship _____

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.

Signature Adnan McGee Date 1/19/16

Form: ESC-UNAV P2 v.14