Essential StaffCARE CHANGE FORM 219301-EMP

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 ☒

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

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

Social Security Number 609-49-1534 Date of Birth __/__/____ Sex M ☒

Name Ana Gloria Salinas Duarte Home Phone 651-450-0317

Street Address 215 20th Ave S. City S. Saint Paul State MN Zip 55075

Employer CMG | ESSG Hire Date 04/23/2009

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

☒ $18.82 per week for Employee Only
☐ $38.19 per week for Employee Plus 1
☐ $51.00 per week for Employee Plus Family
☐ Terminate Medical, STD and Term Life coverage

Dental

☒ $ 5.99 per week for Employee Only
☐ $11.98 per week for Employee Plus 1
☐ $19.77 per week for Employee Plus Family
☐ Terminate Dental coverage

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

Term Life

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

Short-Term Disability

☐ ENROLL ☐ CANCEL
$4.20 /week for Employee Only

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 Ana Gloria Salinas Duarte Date 11/30/09

Form: ESC-CF-10k-ECD0808