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
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 521-73-7016 Date of Birth 9/24/1985 Sex [X] M [ ] F

Name Barry Kappius Home Phone 720-938-1772

Street Address 10887 Grange Creek Dr. City Thornton State CO Zip 80233

Employer Colorado Lighting Hire Date 1/2/2008

Add/Change Dependent Information

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender
Holly Nelson	524-69-4581	1-28-1985	Fiance	F

REASON FOR THE CHANGE

[ ] Address Change [ ] Name Change [ ] Add Dependent(s) [X] Coverage Change [ ] Beneficiary Change [ ] Terminate Coverage

Reason for Termination (only select one)

[ ] T1- Termination of Employment [ ] T4- Deceased [ ] T7- Non FMLA Leave of Absence [X] 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 [X] Employee + 1 [ ] Employee + Family [ ] Terminate all Coverage

Medical/Rx[1] — Weekly Rates

[ ] ENROLL [ ] NO CHANGE [X] CANCEL
$20.91 Employee Only
$42.44 Employee + 1
$56.67 Employee + Family

Dental — Weekly Rates

[ ] ENROLL [ ] CANCEL [X] NO CHANGE
$ 6.17 Employee Only
$12.34 Employee + 1
$20.36 Employee + Family

Short-Term Disability[2] — Weekly Rates

[ ] ENROLL [X] CANCEL [ ] NO CHANGE
$4.20 Employee Only

Term Life — Weekly Rates

[ ] ENROLL [X] 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 [signature] Date 3-28-16

Form: ESC-UNAV-P2 v.14

employer solutions staffing group
Leveraging Resources in a Changing Market

Benefit Plan Administrators, Inc.

☐ New Employee
☐ Rehire *Rehire Date*_____

For Status Change Please Check: *You MUST provide a supporting Document*
☐ Change of Status Birth/ ☐ Spouse Loss of Coverage Plan
☐ Adoption ☐ Change
☐ Marriage ☒ Cancel Employee/Dependents
☐ Divorce Date of Status Change:

Benefits Enrollment Form

Employee Information

Name (Last, First, MI)	Date of Birth	Social Security Number
Kapprus, Barry	9-24-85	521-73-7016

Address	City	State	Zip Code
10887 Grange Creek Dr,	Thornton	CO	80233

Gender	Marital Status	Phone Number:	Date of Hire
☒ Male ☐ Female	☐ Married ☐ Single ☐ Divorced		1-2-08

Please Select Coverage Elected: Enhanced MEC Plan

Email Address:

Coverage Level :

☐ Single - $24.00/Week ☐ Employee+Spouse - $38.00/Week ☐ Employee+Child(ren) - $36.00/Week ☐ Family - $63.00/Week

Dependent Information

Dependent	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate
Dependent	**Sex**	**Birth Date**	**Coverage Elected**	**Add (Enroll) Change, or Terminate**
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature Date

EMPLOYEES DECLINING ☐ Declining due to other coverage.

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature [signature] Date 3-28-16

Employer Solutions Staffing Group Health Benefits Team
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Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com