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 09 / 24 / 1985 Sex ☑ M ☐ F

Name Barry Kappius Home Phone 7209381772 -

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

Employer Colorado lighting Hire Date 1/2/2007 /

Add/Change Dependent Information

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

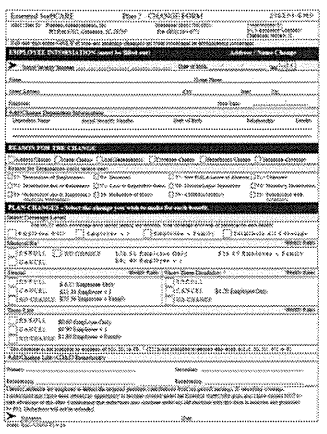
Primary _____ Secondary _____

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 Barry Kappius (Feb 3, 2016) Date Feb 3, 2016

Form: ESC-UNAV P2 v.14



ESG Healthcare Change Form

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