

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 4 5 6 _ 6 5 _ 0 2 3 1 Date of Birth 05 / 15 / 1980 Sex M F

Name Fernando Moreno Home Phone 915-549-2172 -

Street Address 491 WinterSpring Place City El Paso State Tx Zip 79928

Employer Lake Region Hire Date 05/10/2015/

Add/Change Dependent Information

Dependent Name Social Security Number Date of Birth Relationship Gender

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

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/Rx1 Weekly Rates

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

Dental Weekly Rates Short-Term Disability 2 Weekly Rates

ENROLL \$6.17 Employee Only ENROLL CANCEL \$12.34 Employee + 1 CANCEL \$4.20 Employee Only NO CHANGE \$20.36 Employee + Family NO CHANGE

Term Life Weekly Rates

ENROLL \$0.60 Employee Only CANCEL \$0.90 Employee + 1 NO CHANGE \$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 Fernando Moreno (Jun 16, 2016)

Date Jun 16, 2016

ESG Healthcare Change Form

Adobe Sign Document History

06/16/2016

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By: Caitlin Scholl (Caitlin@corpmanagementgroup.com)

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“ESG Healthcare Change Form” History

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