

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 467-47-0280 Date of Birth 03/13/70 Sex M F

Name Fredys VEGAS Home Phone 720) 296-4875

Street Address 16370 EAST LEAST 14th place City AURORA State CO Zip 80011

Employer _____ Hire Date 5/5/15

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 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/Rx¹

Weekly Rates

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

Dental

Weekly Rates

Short-Term Disability²

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 Arianna Marie Vegas Secondary _____

Relationship DAUGHTER 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 3/31/16