

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  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

EMPLOYEE INFORMATION (must be filled out)

Address / Name Change

Social Security Number 480085187 Date of Birth 06/20/1974 Sex  M  F  
 Name HEATHER SWENSON Home Phone \_\_\_\_\_  
 Street Address 444 PAWNEE RD City MCPHERSON State KS Zip 67460  
 Employer CORPORATE MANAGEMENT GROUP Hire Date \_\_\_\_\_

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.

Employee Only  Employee Plus 1  Employee Plus Family

Medical/Rx: You MUST enroll in the Medical Insurance Plan before adding Term Life or Short-Term Disability.

ENROLL \$20.91 /week for Employee Only  
 CANCEL MEDICAL, TERM LIFE and STD \$42.44 /week for Employee Plus One  
 \$56.67 /week for Employee Plus Family

Dental

ENROLL \$5.99 /week for Employee Only  
 CANCEL \$11.98 /week for Employee Plus One  
 \$19.77 /week for Employee Plus Family

Term Life

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

Short-Term Disability (STD)

ENROLL \$4.20 /week for Employee Only  
 CANCEL

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 canceling 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.

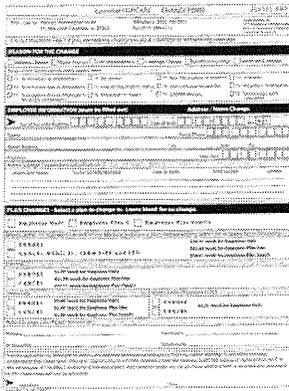
Signature HEATHER H. SWENSON  
 HEATHER M. SWENSON (Jul 21, 2015)

Date Jul 21, 2015

# Healthcare Change Form

Adobe Document Cloud Document  
History

July 21, 2015



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