

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 6 4 5 - 1 6 - 7 4 8 5 Date of Birth 02 / 15 / 1990 Sex  M  F

Name James Salinas Home Phone 2105048580

Street Address 5450 rowley rd apt 701 City San antonio State Tx Zip 78240

Employer colorado lighting Hire Date 01-5-2015 /

**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  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<sup>1</sup>**

Weekly Rates

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

**Dental**

Weekly Rates

**Short-Term Disability<sup>2</sup>**

Weekly Rates

<input type="checkbox"/> ENROLL	\$ 6.17 Employee Only	<input type="checkbox"/>	<input type="checkbox"/> ENROLL	
<input checked="" type="checkbox"/> CANCEL	\$12.34 Employee + 1	<input type="checkbox"/>	<input checked="" type="checkbox"/> CANCEL	\$4.20 Employee Only
<input type="checkbox"/> NO CHANGE	\$20.36 Employee + Family	<input type="checkbox"/>	<input type="checkbox"/> NO CHANGE	

**Term Life**

Weekly Rates

ENROLL \$0.60 Employee Only   
 CANCEL \$0.90 Employee + 1   
 NO CHANGE \$1.80 Employee + Family

<sup>1</sup> This coverage is not available to residents of NH, HI, or PR. <sup>2</sup> STD is not available to persons who work in CA, HI, NJ, NY, or RI.

**Add/Change Life/AD&D Beneficiary**

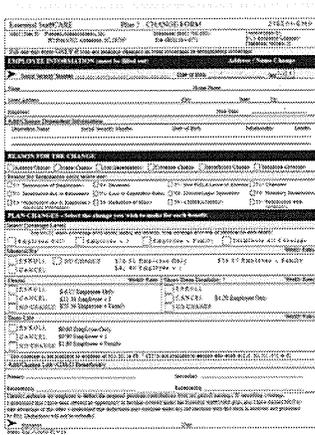
Primary \_\_\_\_\_ Secondary \_\_\_\_\_

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 James Salinas  
James Salinas (Jan 6, 2016)

Date Jan 6, 2016



# ESG Healthcare Change Form

Adobe Document Cloud Document

January 06, 2016

## History

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