

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 0 2 0 1 7 1 7 Date of Birth 01 / 26 / 1991 Sex [X] F

Name Jose Gutierrez Home Phone 602-639-0430

Street Address 11959 W Calle Hermosa Lane City Avondale State Az Zip 85323

Employer Colorado Lighting Hire Date 09-16-2013 /

Add/Change Dependent Information

Dependent Name Social Security Number Date of Birth Relationship Gender

REASON FOR THE CHANGE

[X] Address Change [] Name Change [] Add Dependent(s) [] Coverage Change [] Beneficiary Change [X] Terminate Coverage

Reason for Termination (only select one)

[X] T1- Termination of Employment [] T4- Deceased [] T7- Non FMLA Leave of Absence [X] 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 [X] Terminate all Coverage

Medical/Rx¹

Weekly Rates

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

Dental

Weekly Rates

Short-Term Disability²

Weekly Rates

[] ENROLL \$ 6.17 Employee Only [] ENROLL
[X] 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 []
[X] 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 Jose Gutierrez (Jan 7, 2016)

Date Jan 7, 2016

The image shows a thumbnail of the 'ESG Healthcare Change Form'. It is a complex form with multiple sections, including a header with 'ESG HEALTHCARE CHANGE FORM', a section for 'PERSONAL INFORMATION', a 'REASON FOR THIS CHANGE' section with various checkboxes, and a 'PLANNING' section. The form is densely packed with text and checkboxes.

ESG Healthcare Change Form

Adobe Document Cloud Document

1/7/16

History

Created:	1/6/16
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“ESG Healthcare Change Form” History

-  Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)
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