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 471-55-8474 Date of Birth 06/04/1985 Sex M ☒

Name Chamroeun Ouk Home Phone 507-202-0564

Street Address 4518 22nd Ave NW City Rochester State MN Zip 55901

Employer ESG Hire Date 03/31/2011

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
☑ CANCEL MEDICAL, TERM LIFE and STD

$20.91 /week for Employee Only
$42.44 /week for Employee Plus One
$56.67 /week for Employee Plus Family

Dental

☐ ENROLL
☐ CANCEL

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

Term Life

☐ ENROLL
☐ CANCEL

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

Short-Term Disability (STD)

☐ ENROLL
☐ CANCEL

$4.20 /week for Employee Only

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 _____ Date 12-16-11