

Employer Use Only Retire Rehire Date

EMPLOYEE INFORMATION (MUST BE FILLED OUT)

*219301-EMP

USE BLACK or BLUE INK ONLY

Social Security Number 471-55-8474 Date of Birth 06/04/1985 Sex M F

Name Chamroen A. Ouk Home Phone 507-319-5758

Street Address 5000 25th Ave NW City Rochester State MN Zip 55901

Do you or any dependents have Medicare? Yes No If Yes:

Medicare Health Insurance Claim Number (HICN) Medicare Effective Date

Names of Covered Person(s) 1. 2. 3. 4.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no medical selection is a declination of coverage.

Signature [Signature] Date 03/31/2010

MEDICAL BENEFIT SELECTION - 10k

Weekly Rates

- \$18.82 Employee Only
- \$38.19 Employee +1
- \$51.00 Employee + Family
- No to Medical.

For Term Life and Accidental Death & Dismemberment please write in your Beneficiary information. TERM LIFE / AD&D INSURANCE BENEFICIARY

RELATIONSHIP

AD&D is part of the Medical Benefits

- You MUST enroll in the Medical Insurance Plan before adding Short-Term Disability & Term Life coverage.
- Your coverage level for Term Life will be identical to your Medical plan selection.
- For questions regarding benefits, please call Essential StaffCARE Customer Service at 1-866-798-0803.

SUPPLEMENTARY BENEFITS

Weekly Rates

DENTAL Employee Only \$5.99 Employee +1 \$11.98 Employee + Family \$19.77 No

TERM LIFE Yes No Employee Only \$0.60 Employee +1 \$0.90 Employee + Family \$1.80

SHORT-TERM DISABILITY Yes No \$4.20 STD is an Employee Only plan

Short-Term Disability (STD) is not available to persons who work in California, Hawaii, New Jersey, New York, and Rhode Island.

Required Dependent Information

Name Chamroen Ouk Relationship: Spouse Domestic Partner Child
 Social Security Number 472-41-0270 Date of Birth 11/13/1986 Sex M F

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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: Chamdeun Ouk Home Phone: 507-202-0564

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

Employer: ESG Hire Date: 03/31/2010

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/BC 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 PAL Deductions will not be refunded.

Signature: 

Date: 12-16-11