



Enhanced MEC Plan_Plan 1

MEDICAL BENEFITS CHANGE FORM

I am changing coverage for:

Myself

My spouse

My dependent(s)

I would like to:

Terminate coverage

Add/Change dependents covered

I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are adding dependents to your plan please complete an enrollment form as well.

OTIS Vaughn Hutchins

Employee Name

8/10/16

Date

[Handwritten Signature]

Employee Signature

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 Terminate Coverage

REQUIRED EMPLOYEE INFORMATION

MUST BE FILLED OUT

Address/Name Change

me <i>IS VAUGHN HUTCHINS</i>	Social Security # <i>466-35-5981</i>	Home Phone <i>832-428-3973</i>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
dress <i>.24 Wyatt St.</i>	City <i>Pasadena</i>	State <i>TX.</i>	Zip <i>77503</i>
Employer <i>Colarado Lighting - CLI</i>	Hire Date <i>/ /</i>	Date of Birth <i>11 10 1984</i>	

Additional/Change Dependent Information

me	Social Security #	Date of Birth	Gender	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

Weekly Rates

YOU MUST select a coverage level before adding any benefits in Section C. Your coverage level for the all benefits in Section C will be identical.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input checked="" type="checkbox"/>	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
Terminate All Plans <input type="checkbox"/>	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll
Change to Any Plan <input type="checkbox"/>	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel
	<input type="checkbox"/> No Change	<input type="checkbox"/> No Change	<input type="checkbox"/> No Change	<input type="checkbox"/> No Change	<input type="checkbox"/> No Change

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

Additional/Change Life/Accidental Death & Dismemberment Beneficiary

Primary <i>CARMEN DOMINGUEZ</i>	Relationship <i>FIANCEE</i>
Secondary <i>ASHLEY HUTCHINS</i>	Relationship <i>DAUGHTER</i>

REQUIRED SIGNATURE

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.

DATE *8 / 10 / 2016*

▶ SIGNATURE

