Essential StaffCARE	PLAN 2 - 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, 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 469-72-6521 Date of Birth 08/08/1959 Sex [X] M [ ] F

Name Michael Schwab Home Phone 320-363-0239

Street Address 11039 County Road 75 City St Joseph State MN Zip 56374

Employer CMG-ESSC Hire Date 10/14/2014

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 [X] 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 [X] 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.

Medical/Rx [1] — Weekly Rates

[ ] $20.91 Employee Only [ ] $56.67 Employee + Family [ ] No Change
[ ] $42.44 Employee + 1 [X] Terminate all coverage

- You **MUST** enroll in the Medical Insurance Plan before adding any additional benefits, except Dental.
- Your coverage level for Term Life will be identical to your medical plan selection.

Dental — Weekly Rates

[ ] $5.99 Employee Only
[ ] $11.98 Employee + 1
[ ] $19.77 Employee + Family
[ ] CANCEL
[ ] NO CHANGE

Short-Term Disability [2] — Weekly Rates

[ ] ENROLL
[ ] CANCEL $4.20 Employee Only
[ ] NO CHANGE

Term Life — Weekly Rates

[ ] ENROLL $0.60 Employee Only
[ ] 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/Accidental Death & Dismemberment

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 Michael Schwab Date

Form: ESC-NAV*SAD P2 v.15