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 422-82-3514 Date of Birth 12/24/ Sex M F

Name Jerry Swank Home Phone

Street Address 119½ E. Saint Germin St. City St. Cloud State MN Zip 56304

Employer E.S.G. / CMG Hire Date 12/22/14

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 ☒ 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

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 ☐ Terminate all Coverage ←

Medical/Rx[1] — Weekly Rates

☐ ENROLL ☐ NO CHANGE ☒ CANCEL

$20.91 Employee Only
$42.44 Employee + 1
$56.67 Employee + Family

Dental — Weekly Rates

☐ ENROLL
☐ CANCEL
☒ NO CHANGE

$ 6.17 Employee Only
$12.34 Employee + 1
$20.36 Employee + Family

Short-Term Disability[2] — Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$4.20 Employee Only

Term Life — Weekly Rates

☐ ENROLL
☐ CANCEL
☐ NO CHANGE

$0.60 Employee Only
$0.90 Employee + 1
$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 Jerry L. Swank Date 12-01-2015

Form: ESC-UNAV PJv.14

employer solutions staffing group
Leveraging Resources in a Changing Market

Benefit Plan Administrators, Inc.

☐ New Employee
☐ Rehire *Rehire Date*________________

For Status Change Please Check: *You MUST provide a supporting Document*

☐ Change of Status Birth/
☐ Adoption
☐ Marriage
☐ Divorce

☐ Spouse Loss of Coverage Plan
☐ Change
☐ Cancel Employee/Dependents

Date of Status Change:

Benefits Enrollment Form

Employee Information

Name (Last, First, MI)	Date of Birth	Social Security Number	
Swank, Jerry	12/24/58	472-82-3514	
Address 119 1/2 E. Saint Germaine St.	**City** St. Cloud	**State** MN	**Zip Code** 56304

Gender	Marital Status	Phone Number:	Date of Hire
☒ Male ☐ Female	☐ Married ☒ Single ☐ Divorced	320-291-4155	12/22/14

Please Select Coverage Elected: Enhanced MEC Plan

Email Address:

Coverage Level :

☒ **Single - $24.00/Week** ☐ **Employee+Spouse - $38.00/Week** ☐ **Employee+Child(ren) - $38.00/Week** ☐ **Family - $63.00/Week**

Dependent Information

Dependent	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Dependent	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Dependent	Sex	Birth Date	Coverage Elected	Add (Enroll) Change, or Terminate
Last Name First Name M.I. Social Security #	☐ Male ☐ Female		☐ Medical	☐ Add ☐ Change ☐ Waive ☐ Terminate

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (LAST, FIRST, MI):

EFF. DATE

EFF. DATE

EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature Jerry L. Swank **Date** 12-01-2015

EMPLOYEES DECLINING ☐ **Declining due to other coverage.**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature **Date**

Employer Solutions Staffing Group Health Benefits Team
7301 Ohms Lane Suite 405
Edina, MN 55439
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com