Essential StaffCARE | PLAN 2 - CHANGE FORM | 2913900-DDI

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.

A. REASON FOR THE CHANGE

☐ Address Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Terminate Coverage

B. REQUIRED EMPLOYEE INFORMATION

MUST BE FILLED OUT **Address/Name Change**

Name	Social Security #	Phone		Gender M F
Address	City	State	Zip	Apt. #
Employer		Hire Date / /		Date of Birth / /

Add/Change Dependent Information

Name	Social Security #	Date of Birth / /	Gender M F	Relationship
			M F	
			M F	

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

Weekly Rates

	FIXED INDEMNITY MEDICAL[1]
Employee Only	☐ **$20.91**
Employee + Child(ren)	☐ **$34.71**
Employee + Spouse	☐ **$39.73**
Employee + Family	☐ **$52.90**
	☐ **Terminate** Plan
	☐ No Change

Premiums will be automatically deducted from your paycheck. For weekly payroll cycles the amount is shown above. For other payroll cycles the amount deducted will be calculated based on the weekly premium.

[1] This coverage is not available to residents of **NH, HI,** or **PR.**

Add/Change Accidental Loss of Life, Limb and Sight Beneficiary

Primary Relationship

Secondary Relationship

D. MEC PLAN CHANGES - Select the change you wish to make.

82913900-M-DDI **Monthly Rates**

MEC Wellness/Preventive [1] ☐ **Terminate** MEC Plan ☐ No Change

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

[1] *This coverage is not available to residents of HI, or PR.*

I understand that coverage may continue under my old elections until this form is received and processed by PAI. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. I understand that a change in elections will be effective the 1st of the month following your credit card draft. If canceling, your coverage will terminate on the last day of the month for which a payment has been made. **I understand that making no selection in Section C and D for a benefit means I do not wish to make a change to that benefit.**

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**