

**Essential StaffCARE CHANGE FORM**

209600-GRN

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  
In 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 -- Date of Birth // Sex  M  F

Name  Home Phone -

Street Address  City  State  Zip

Employer  Hire Date //

**Add/Change Dependent Information**

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender

**Medical/RX PLAN CHANGES - Select a plan to change to. Leave blank for no change.**

Plan 1: \$5,000	Plan 2: \$10,000	Plan 1: \$5,000	Plan 2: \$10,000
<input type="checkbox"/> \$18.88/week	<input type="checkbox"/> \$19.76/week - Employee Only	<input type="checkbox"/> \$51.10/week	<input type="checkbox"/> \$53.55/week - Family
<input type="checkbox"/> \$38.31/week	<input type="checkbox"/> \$40.10/week - Employee + 1	<input type="checkbox"/> Terminate all coverage	

- You MUST enroll in the Medical Insurance Plan before adding Dental, STD, or Term Life.
- Your coverage level for Dental and Term Life will be identical to your medical plan selection.

Dental	STD
<input type="checkbox"/> ENROLL \$5.23 /week for Employee Only	<input type="checkbox"/> ENROLL \$4.20 /week for Employee Only
<input type="checkbox"/> CANCEL \$10.46 /week for Employee Plus One	<input type="checkbox"/> CANCEL
<input type="checkbox"/> CANCEL \$17.26 /week for Employee Plus Family	

Term Life
<input type="checkbox"/> ENROLL \$0.60 /week for Employee Only
<input type="checkbox"/> CANCEL \$0.90 /week for Employee Plus One
<input type="checkbox"/> CANCEL \$1.80 /week for Employee Plus Family

**Add/Change Life/AD&D Beneficiary**

Primary \_\_\_\_\_ Relationship \_\_\_\_\_  
 Secondary \_\_\_\_\_ 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 \_\_\_\_\_ Date \_\_\_\_\_