

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	Relationship
		/ /	☐ M ☐ F	
			☐ 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

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