

Mail / Fax to: Planned Administrators, Inc.  
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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	<input type="checkbox"/> M <input type="checkbox"/> F
Address	City	State	Zip	Apt. #
Employer		Hire Date	Date of Birth	
		/ /	/ /	

**Add/Change Dependent Information**

Name	Social Security #	Date of Birth	Gender	Relationship
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> M <input type="checkbox"/> F	

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

**Weekly Rates**

You **MUST** enroll in the **Fixed Indemnity Medical** Insurance Plan before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection.

	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>
Employee Only	<input type="checkbox"/> \$22.76	\$5.40	\$2.42	\$0.60	\$4.20
Employee + Child(ren)	<input type="checkbox"/> \$37.78	\$14.58	\$6.54	\$0.90	
Employee + Spouse	<input type="checkbox"/> \$43.24	\$10.80	\$4.84	\$0.90	
Employee + Family	<input type="checkbox"/> \$57.58	\$20.52	\$9.20	\$1.80	
	<input type="checkbox"/> Terminate Plan	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll	<input type="checkbox"/> Enroll
	<input type="checkbox"/> No Change	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel	<input type="checkbox"/> Cancel
		<input type="checkbox"/> No Change	<input type="checkbox"/> No Change	<input type="checkbox"/> No Change	<input type="checkbox"/> No Change

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>STD is not available to persons who work in CA, HI, NJ, NY, or RI.

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

Primary	Relationship
Secondary	Relationship

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

**82960300-M-AQL Weekly Rates**

**MEC Wellness/Preventive**  **Terminate MEC Plan**  **No Change**  
 \$13.42 Employee Only  \$15.18 Employee + Child(ren)  \$16.38 Employee + Spouse  \$18.66 Employee + Family

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings for the Fixed Indemnity Plan and ancillary benefits. I understand that deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded, however, coverage will continue as long as you have a paycheck deduction. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. **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