Essential StaffCARE — Plan 2 - CHANGE FORM — 220300-GEO

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 ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth ___/___/___ Sex M F

Name _____ Home Phone ___ - ___ - ____

Street Address _____ City _____ State _____ Zip _____

Employer Geotemps, Inc. Hire Date ___/___/___

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]

Bi-Weekly Rates

☐ ENROLL ☐ NO CHANGE ☐ CANCEL

$41.82 Employee Only
$84.88 Employee + 1
$113.34 Employee + Family

Dental

Bi-Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE

$10.80 Employee Only
$21.60 Employee + 1
$35.64 Employee + Family

Short-Term Disability [2]

Bi-Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE

$8.40 Employee Only

Vision

Bi-Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE

$4.84 Employee Only
$9.84 Employee + 1
$13.12 Employee + Family

Term Life

Bi-Weekly Rates

☐ ENROLL ☐ CANCEL ☐ NO CHANGE

$1.20 Employee Only
$1.80 Employee + 1
$3.60 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/Accidental Loss of Life, Limb, and Sight 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 _____ Date _____

Form: ESC-USb P2 v.15.1