Essential StaffCARE	MEC - CHANGE FORM	82087000-M-CEG

Mail / Fax to: Planned Administrators, Inc.
PO Box 6702
Columbia, SC 29260

Telephone (866) 798-0803
Fax (803) 264-0772

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 ☐ Terminate Coverage

EMPLOYEE INFORMATION (must be filled out) — Address / Name Change

Social Security Number __ __ __ - __ __ - __ __ __ __ Date of Birth __ __ /__ __ /__ __ __ __ Gender M F

Name Phone - -

Street Address City ST ZIP

Employer Hire Date __ __ /__ __ /__ __ __ __

Add / Change Dependent Information

Dependent Name	Social Security Number	Date of Birth	Relationship	Gender
				M F
				M F
				M F
				M F
				M F
				M F

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

MEC Wellness/Preventive Monthly Rates

☐ $58.19 Employee Only

☐ $69.53 Employee + 1

☐ $80.87 Employee + Family

☐ No Change

☐ Terminate MEC Wellness/Preventive

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

If electing benefits, I hereby authorize my employer to send request to PAI for enrollment into the coverage. I understand that the change will be effective the 1st of the month after the request date. I understand that making no selection for a benefit means I do not wish to make a change to that benefit. **I understand that making no selection for a benefit means I do not wish to make a change to that benefit.**

▶ SIGNATURE _____ Date __ __ /__ __ /__ __ __ __