Essential StaffCARE | MEC - CHANGE FORM | 82973900-M-AYC

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.

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 M F	Relationship
			M F	
			M F	
			M F	
			M F	
			M F	

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

Weekly Rates

MEC Wellness/Preventive

☐ **$13.42** Employee Only

☐ **$15.18** Employee + Child(ren)

☐ **$16.38** Employee + Spouse

☐ **$18.66** Employee + Family

☐ **Terminate** MEC Plan

☐ No Change

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings for the MEC Plan. 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 for a benefit means I do not wish to make a change to that benefit.**

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**