



Exclusively for ISMS and CMS Members...

# Enrollment Form for Accidental Death & Dismemberment Insurance Plan

PBT Insurance Office • 200 East Randolph, 5th Floor • Chicago, IL 60601 • Ph: 1-800-621-0748 • Fax: 1-312-381-2795



Underwritten by: **Hartford Life Insurance Company 06098**  
Simsbury, Connecticut  
Physicians' Benefits Trust  
Policy Number ADD-8485

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

- I am currently a member of the Illinois State Medical Society/Chicago Medical Society.
- I am applying for membership in the Illinois State Medical Society/Chicago Medical Society.
- I am an employee of a member of the Illinois State Medical Society/Chicago Medical Society.

Name of Member: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

**You will be the Beneficiary for all Dependents' coverage**

1. I hereby apply for the following coverage:
- Member /Employee Only     Spouse Only     Family Plan

2. Coverage Amount Desired (Principal Sum): \$ \_\_\_\_\_  
(In \$25,000 units up to \$300,000)

3. If Family Coverage is desired, please complete the following:

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE BILL ME (Send No Money Now)

- Semi Annual
- Annual

Dependent Child Name	Date of Birth

4.  New Coverage     Existing Coverage Increase

I hereby certify that the above statements are complete and true to the best of my knowledge.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### HOW TO APPLY:

1. Complete the application form above.
2. Indicate coverage choices.
3. Mail your completed application form to the PBT Insurance Office

**SEND NO MONEY NOW!**

*You will be billed when your certificate is issued.*