



# Physicians' Benefits Trust Life Insurance Company

## Application for Dental Protection Plan

**As a member of the Illinois State Medical Society or Chicago Medical Society, I wish to apply for Dental Coverage provided by Physicians' Benefits Trust Life Insurance Company.**

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

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

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

Business Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Desired Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CHOOSE YOUR DEDUCTIBLE:**

\$25.00  \$50.00

Is Spouse Coverage Desired?  YES  NO

If so, is spouse employed?  YES  NO

Name of Spouse's Employer: \_\_\_\_\_

Is spouse currently insured?  YES  NO

Name of Spouse's Insurer: \_\_\_\_\_

**If you wish to cover your spouse and/or eligible dependent children, complete this section.**

Full Name (Last, First, Middle Initial)	Social Security #	Gender	Date of Birth Mo/Day/Yr
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

I hereby apply for coverage. I agree that the copy of my signature on a copy of this form may be accepted as my signature.

I agree that, to the best of my knowledge and belief, all statements in this Application are complete and true and agree that they will be a basis of the issuance of coverage by Physicians' Benefits Trust Life Insurance Company.

Signature of Applicant  <div style="font-size: 2em; font-weight: bold; margin-top: 10px;">X</div>	Date Signed
---	-------------

**Return completed application to:**

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