



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
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Return completed application to:

PBT Insurance Office
 300 South Wacker Drive, Suite 700
 Chicago, IL 60606
 1-800-621-0748 • Fax: 312-922-2849
 www.pbtinsurance.com