Physicians' Benefits Trust Life Insurance Company

Employer Application and Agreement

1. PRACTICE INFORMATION

Application is submitted by: (full name of firm) ____________________

Address, Street, Suite #, City, State, Zip: ____________________

____

Type of Business and/or Specialty: ____________________

In order to participate in the Physicians' Benefits Trust Life Insurance Company (PBTLIC) Group Health Benefits Program, one health plan participant must be a member of the Illinois State Medical Society, Chicago Medical Society, or Illinois State Dental Society.

Please check appropriate box: ❑ ISMS ❑ CMS ❑ ISDS

For tax purposes, this business is considered an: ❑ Individual Proprietor ❑ Partnership ❑ Corporation ❑ Other________

Will this program replace another Group Plan? ❑ YES ❑ NO

If "Yes" provide Name of Insurer: ____________________

Reason for Change: ____________________

Date Current Coverage Will End: ____/____/____ Desired Effective Date of PBT Plan*: ____/____/____

* *The effective date of this coverage may not be earlier than the first of the month following the acceptance of this application by PBTLIC.*

2. PLAN SELECTION

A. Group Health (You may choose up to 4 options from the PPO/Indemnity plans combined):

Check Option(s) Requested:

Preferred Provider Option(PPO)

	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-Network	In-Network	Out-Network
❑ Option A	80%	60%	$1,000	$2,000
❑ Option B	80%	60%	$5,000	$10,000
❑ Option C	80%	60%	$1,000	$5,000

Preferred Choice Indemnity

	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-Network	In-Network	Out-Network
❑ Option 1	90%	80%	$500	$1,000
❑ Option 3	70%	60%	$3,750	$5,000
❑ Option 5	100%	90%	$0	$1,000

CHOOSE YOUR DEDUCTIBLE *(You may choose up to 3 deductibles. Check all that apply.)*

Deductible(s) Desired: ❑ $150 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000 ❑ $2,000 ❑ $3,000

Deductible(s) for Option 5: ❑ $2,500 ❑ $5,000

Health Savings Account (HSA) Qualified Plan* ❑ Yes ❑ No

CHOOSE YOUR DEDUCTIBLE

❑ **Individual Deductibles desired:**	❑ $1,100	❑ $1,800	❑ $2,700	❑ $5,250
❑ **Family Deductibles desired:**	❑ $2,200	❑ $3,600	❑ $5,400	❑ $10,500

**Subject to change annually as law requires.*

(Application continues on reverse side)

B. TERM LIFE:

A benefit of $10,000 Term Life and AD&D Coverage is required for each employee and/or applicant. Term Life coverage reduces from $10,000 to $6,500 at age 65, to $5,000 at age 70, to $3,000 at age 75 and to $2,000 at age 80.

Additional Supplemental Term Life: ❑ YES ❑ NO

ADDITIONAL TERM LIFE benefit requested $____________________ (Available in $1,000 increments up to $40,000)

Dependent Term Life: $2,500 Benefit. (Children age 2 weeks to 6 months benefit equals $250) ❑ YES ❑ NO

C. DENTAL: ❑ YES ❑ NO or ❑ Individually Selected Deductible desired: ❑ $25 ❑ $50

(Available to Illinois State Medical Society and Chicago Medical Society members only)

D. WEEKLY DISABILITY INCOME: ❑ YES ❑ NO Benefit Period: ❑ 13 weeks ❑ 26 weeks

(Must work a minimum of 20 hours per week and participate in the Group Health Benefits Program)

3. EMPLOYER INFORMATION AND AUTHORIZATION

A. A completed **PBTLIC Group Health Benefits Program Application** must be submitted for each eligible employee, physician or dentist. Each applicant (including dependents) must complete a Health History Questionnaire.

B. 1. Total number of employees: ________________

2. Total number of eligible employees: __________

3. Your group's eligibility requirements (i.e., hourly requirements and other conditions) ________________________

4. Total number participating: ________________

C. Employer Waiting Period for new employees to be covered:

❑ 30 Days ❑ 60 Days ❑ 90 Days ❑ Other (if other) state here________________________

Note: *If no waiting period is specified, coverage will become effective on the first day of the month coinciding with or next following the date of hire.*

A group may change the Employer Waiting Period once per Plan Year.

D. A copy of the Employer's most recent **Wage & Tax Statement, Illinois Form UC-3** must be submitted with application.

E. Signature of Employer:______________________________________ Date: _____/_____/_____

Title:____

Contact Person:____

Phone Number: (   )____________________ Fax Number: (   )____________________

E-mail Address:____

Return completed application to:

PBT Insurance Office • 200 East Randolph, 5th Floor • Chicago, IL 60601

IF YOU HAVE ANY QUESTIONS:

For Physicians and Office Staff contact us at:	For Dentists and Office Staff contact us at:
Ph: 1-800-621-0748 • Fax: 1-312-381-2795	Ph: 1-866-898-0926 • Fax: 1-312-381-2795
www.pbtinsurance.com	www.isdsinsurance.com