



**PHYSICIANS' BENEFITS TRUST HEALTH AND DENTAL BENEFITS PROGRAM
EMPLOYER GROUP PLAN PREMIUM
REQUEST FOR QUOTE**

1. Please provide the following information:

Group Name: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Membership Affiliation: ISMS CMS ISDS Other _____
(Please indicate group name)

2. Please indicate the desired effective date of coverage: 1st of the Month 15th of the Month

3. How would you prefer to receive your quote: Mail E-Mail Fax

4. To provide you with an accurate quote, please complete and submit the Group Census Sheet found at the end of this document for each eligible employee.

5. Please check the Health Plan (A through C) and Deductible option(s) for which you would like to receive a quote. There is no limit to the number of quotes you can request. Refer to the brochure for Plan details.

A. Preferred Provider Option (PPO): Option A Option B Option C

Deductibles: \$150 \$300 \$500 \$750 \$1,000 \$2,000 \$3,000

B. Preferred Choice Indemnity: Option 1 Option 3 Option 5

Deductibles for Options 1 & 3: \$150 \$300 \$500 \$750
 \$1,000 \$2,000 \$3,000

Deductibles for Option 5: \$2,500 \$5,000

C. Preferred Health Savings Account (HSA) Qualified Plan: (Options are subject to change annually as Federal law requires)

Individual Deductibles: \$1,200 \$1,800 \$2,700 \$5,250

Family Deductibles: \$2,400 \$3,600 \$5,400 \$10,500

6. Dental Insurance (Available only to members of ISMS or CMS):

Please indicate if you would like a quote for Dental Insurance: Yes No

Deductible Desired: \$25 \$50

7. Term Life and AD&D (Term Life and AD&D Insurance in the amount of \$10,000 is automatically included with all medical plans for the primary applicant). If an additional level of coverage is desired, please indicate on the Group Census Sheet.

Please indicate if you would like a quote for Dependent Term Life insurance: Yes No.

8. Short Term Disability (STD) Insurance:

Please indicate if you would like to receive a quote for STD insurance: Yes No

Benefit Period: 13 weeks 26 weeks

Weekly Benefit Amount Desired (\$50 to \$250 in increments of \$10): \$____ (60% of Gross Weekly Income)

Mail completed form to: PBT Insurance Office, 200 East Randolph, 5th Floor, Chicago, IL 60601
Fax completed form to: 312-381-2795
E-mail completed form to: dawn.sterland@aon.com
(To e-mail your completed form, you'll need to save the form and attached it to your e-mail).

If you have any questions:

Physicians and their office staff please call: 1-800-621-0748

Dentists and their office staff please call: 1-866-898-0926

Sponsored by:



PBTLIC is a wholly owned subsidiary of:



