Physicians' Benefits Trust Life Insurance Company

Group Health Benefits Program

APPLICATION & CHANGE OF COVERAGE FORM
(including Term Life and AD&D Coverage)

INSTRUCTIONS:

The Group Health Benefits Program Application & Change of Coverage Form is used for new applicants as well as to make changes to an existing election. The form must be completed by each individual who is regularly scheduled to work 20 or more hours per week and becomes eligible to participate in the Health Benefits Program. Eligibility includes the completion of a stated waiting/probationary period, if any. **Coverage will become effective the first of the month following the Group Employer's waiting period. A completed Application must be received by the Administrator within 30 days of the coverage eligibility date.** After this 30 day period, an eligible individual will be a Late Enrollee and subject to the procedures outlined for Late Enrollees.

NOTE: All eligible individuals must complete an Application, whether or not they elect to participate in the Plan.

Please follow the steps outlined below to ensure an efficient application procedure.

For Individuals Applying for Participation in the Health Benefits Program

1. Complete Sections A, B, C, D, E, G, H and I of the Group Health Benefits Program Application.
2. Review Section I, then sign and date. If your spouse is applying, he/she must also sign and date this section. Your signature confirms that all information provided is complete and true. It also authorizes the release of any necessary records regarding your medical history, or that of your dependents.
3. All eligible individuals and each of their dependents applying for coverage in the Plan must complete a Health History Questionnaire.
4. Dental coverage is offered only to Illinois State Medical Society and Chicago Medical Society members.

For Changes in Coverage

Changes can include: Adding or terminating coverage for a spouse or dependent child, changing plan selection or changes in name or address.

1. When adding a spouse or dependent child, complete Sections A, B, C, D, E, G and I. Each individual being added must complete a Health History Questionnaire.
2. When terminating coverage for a spouse or dependent child, complete Sections A, B and C.
3. When changing name or address information, complete Sections A and B.

For Individuals Waiving Enrollment in the Health Benefits Program

1. If you are eligible to apply to the Health Insurance Plan but choose to decline coverage, you must complete Sections A, B, J and K of the Application.
2. The *Waiver of Coverage,* Section J, must be completed in its entirety. The reason for the declination of coverage must be stated on the form. You (and your spouse, if applicable) must sign and date the *Waiver of Coverage* section.
3. The *Notice of Special Enrollment Rights*, Section K, must be signed and dated as acknowledgment of the Special Enrollment Rights available under the Health Insurance Plan.
4. If you are applying only for the Term Life Plan, you must state this in Section D on the Application. A Health History Questionnaire must be completed for Term Life Coverage.

For Individuals Applying for Participation in the Health Benefits Program with Dependents Waiving Coverage

1. Follow the steps outlined above For Individuals Applying for Participation in the Health Benefits Program.
2. For Dependents who are waiving coverage, follow the steps outlined For Individuals Waiving Enrollment in the Health Benefits Program.

Application & Change of Coverage Form

Refer to instructions before completing this form.
Please print or type information requested.

SECTION A - TYPE OF ACTIVITY (Please check appropriate boxes)

❑ **NEW APPLICATION:** ❑ New Employee ❑ Late Enrollee ❑ Waiver of Coverage Desired Effective Date: ______/______/_______

For all primary insured participants in the medical plan, coverage includes $10,000 of Term Life and AD&D benefits.

❑ **CHANGE – Check all that apply**

❑ Terminate Spouse ❑ Add Spouse ❑ Change Plan
❑ Terminate Dependent Child ❑ Add Dependent Child ❑ Name Change
❑ Terminate Applicant ❑ Address Change

SECTION B - PERSONAL INFORMATION

Name of Employer or Organization:______________________________

Address: (Street/City/State/Zip) ______________________________ Telephone #:(   )__________

Name: (Last, First, Middle Initial) ______________________________ S.S. #: ___/___/___/___/___/___/___/___/___/

Medicare Health Insurance Claim # (on your Medicare Card): ___/___/___/___/___/___/___/___/___/___/

Home Address: (Street, City, State, Zip)______________________________ Home Phone #:__________

Are you currently insured by another health plan? ❑ Yes ❑ No

If "Yes", state name of insurer or plan: ______________________________ Termination date:_____/_____/_____

Are you an ISMS/CMS or ISDS member? ❑ Yes ❑ No What is your specialty? ______________________________

Date of Birth:_____/_____/_____ Employment Date:_____/_____/_____ Coverage Eligibility Date:_____/_____/_____ Gender: ❑ Male ❑ Female

Marital Status: (check one) ❑ Single ❑ Married ❑ Widowed ❑ Divorced

SECTION C - DEPENDENT INFORMATION (DO NOT LEAVE BLANK)

List Individuals for whom you are adding/changing/terminating coverage. Please select one of these actions **(A/C/T)** for each name listed below. Attach a separate sheet if necessary to list additional Eligible Children: (An Eligible Child is a child who is naturally born, legally adopted, a stepchild, or placed for adoption, under age 26 unless a full-time student.)

*** Action Legend:** (**A**)dd (**C**)hange (**T**)erminate TYPE OF CONTRACT: ❑ Single ❑ Couple ❑ Adult & Child(ren) ❑ Family

	Action*	Last Name, First Name, M.I.	Gender	Date of Birth (mm/dd/yyyy)	Social Security #
Spouse			❑ M ❑ F	/ /	
Child			❑ M ❑ F	/ /	
Child			❑ M ❑ F	/ /	
Child			❑ M ❑ F	/ /	
Child			❑ M ❑ F	/ /	

SECTION D - PLAN SELECTION

1. ❑ 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

Select Deductible Desired:
❑ $150 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000 ❑ $2,000 ❑ $3,000

2. ❑ 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

Select Deductible Desired for Option 1 or 3:
❑ $150 ❑ $300 ❑ $500 ❑ $750 ❑ $1,000 ❑ $2,000 ❑ $3,000
Select Deductible for Option 5: ❑ $2,500 ❑ $5,000

3. ❑ Health Savings Account (HSA) Qualified Plan*
❑ **Individual Deductible Desired:** ❑ $1,150 ❑ $1,800 ❑ $2,700 ❑ $5,250
❑ **Family Deductible Desired:** ❑ $2,300 ❑ $3,600 ❑ $5,400 ❑ $10,500 ***Subject to change annually as law requires.**

4. Dental (ISMS and CMS members only): ❑ Yes ❑ No Deductible desired: ❑ $25 ❑ $50

5. Term Life: ❑ Yes ❑ No

6. Weekly Disability: ❑ Yes ❑ No

SECTION E - DEPENDENT HEALTH INSURANCE

Is Spouse Health Coverage desired? ❑ Yes ❑ No Is Spouse employed? ❑ Yes ❑ No Name of Spouse's Employer:__________

Is Spouse insured in another health plan? ❑ Yes ❑ No Is Spouse insured in another dental plan? ❑ Yes ❑ No

If Yes, Name of Health Insurer: ______________ If Yes, Name of Dental Insurer?______________

Is Child(ren) Health Coverage desired? ❑ Yes ❑ No

Are you or any dependent currently (or within the last six (6) months) disabled or receiving treatment for any condition? ❑ Yes ❑ No

If "YES", what condition(s)?______________________________

SECTION F - SPECIAL ENROLLMENT QUALIFICATION

Special Enrollment rights arise if 1) a Member Physician, Non-Member Physician, Member Dentist, Non-Member Dentist, Employee, or Dependent who initially declined coverage because of other health coverage wants to apply for coverage after losing other coverage; or 2) a Member Physician, Non-Member Physician, Member Dentist, Non-Member Dentist or Employee gains a new Dependent through marriage, birth, adoption or placement for adoption. Special Enrollment must be requested on this form within 30 days of the qualifying event or 60 days for MEDICAID/CHIP Qualifying Event.

Provide Special Enrollment information below:

1) Loss of coverage is due to: ❑ Legal Separation or Divorce ❑ Reduction in Hours of Employment ❑ MEDICAID/CHIP Ineligibility/Financial Assistance ❑ Death ❑ Termination of Employer Contributions ❑ Termination of Employment ❑ Exhaustion of COBRA or state coverage ❑ Other (describe) ______________
   Date of Qualifying Event: ________/________/________ ***PBT reserves the right to request proof of the qualifying event.***
2) Was loss of coverage due to failure to pay premiums when due? ❑ Yes ❑ No For Cause? ❑ Yes ❑ No
3) Gained Dependent Status due to: ❑ Birth ❑ Placement for Adoption ❑ Adoption ❑ Marriage Date of Qualifying Event: _____/_____/_____

SECTION G - CREDITABLE COVERAGE

Do you or your dependent(s) have prior coverage under another group health plan, individual health coverage, Medicare, Medicaid, Tricare, State Health Benefits Risk Pool, Federal Employee's Health Program, public health plan or a health plan under the Peace Corps Act? ❑ Yes ❑ No

If "Yes" you must provide Certificate(s) of Creditable Coverage from prior plans to receive a reduction in your exclusion period for pre-existing conditions.

SECTION H - DESIGNATION OF TERM LIFE AND AD&D INSURANCE BENEFICIARY FOR PRIMARY INSURED

BENEFICIARY: If no Beneficiary is designated, or if the designated Beneficiary does not survive the insured person, any Policy Benefits will be paid to the surviving Spouse, or if none, to the surviving child or children (including legally adopted child or children) equally. If none exist, benefits will be paid to the executor or administrator of the insured person's estate.

Name of Beneficiary: ______________________________

Address: ______________________________

Telephone Number: ( ) ______________________ Relationship to Insured: ______________________

Signature of Applicant: ______________________ Date Signed: ______________________

SECTION I - AUTHORIZATION/RELEASE OF INFORMATION

I agree that to the best of my knowledge and belief all statements and answers to the questions in this Application are complete, accurate and true and I agree that they are the basis for the issuance of coverage. If it should be determined later that any answer is incomplete or false, coverage may be denied. I further understand that there are pre-existing exclusions and/or limitations in the Certificate of Coverage which may apply to me, my spouse or my dependents.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, self-insured health plan, the Medical Information Bureau, or other organization, institution or person that has records or knowledge of me, my spouse, or my dependents, to furnish Physicians' Benefits Trust Life Insurance Company, including any reinsurers, with such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Applicant: ______________________ **Date:** ____/____/____

Home Phone #: ( ) ______________________

Signature of Spouse (if applying): ______________________ **Date:** ____/____/____

IF YOU DECLINE COVERAGE, YOU MUST COMPLETE THE WAIVER OF COVERAGE AND NOTICE OF SPECIAL ENROLLMENT RIGHTS SECTIONS.

SECTION J - WAIVER OF COVERAGE

Name of Employee, Physician or Dentist: **(Last, First, Middle Initial)** ______________________

I choose to WAIVE coverage as follows: ❑ Employee Medical ❑ Dependent Medical ❑ All Coverage

Reason for Waiver of Coverage:
- ❑ Other Health Insurance Coverage — Name of Insurer or Plan: ______________________
- ❑ Other Group Health Plan — Name of Insurer or Plan: ______________________
- ❑ Other Group Plan (spouse's employer) — Name of Insurer or Plan: ______________________
- ❑ Other Reason - *Please Complete:* ______________________

Name of Current Insurer or Plan Sponsor: ______________________

I have been given an opportunity to apply for the Group Health Benefits Program, and for myself and my Eligible Dependent(s), I (we) decline to participate.

Signature of Applicant: ______________________ **Date:** ______________________

Signature of Spouse: ______________________ **Date:** ______________________

(Spouse signature is only required if employee is applying for coverage but the spouse is not applying.)

SECTION K - NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining application for yourself or your dependents (including your spouse) because you are covered under another group health plan or have other health insurance coverage (including MEDICAID/CHIP), you may be able to apply yourself or your dependents in the Group Health Benefits Program in the future. You must request enrollment within thirty (30) days after your other coverage ends involuntarily (60 days for MEDICAID/CHIP). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to apply yourself and your dependents provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

The undersigned does hereby acknowledge receipt of this Notice of Special Enrollment Rights.

Signature of Applicant: ______________________ **Date:** ______________________

Signature of Spouse: ______________________ **Date:** ______________________

For Office/Employer Use Only: Health Plan Options: __________ Preferred Choice Indemnity: __________ PPO: __________ HSA: __________
Health Deductible Amount: $ __________ Dental Deductible Amount: $ __________ Indicated Desired Effective Date: ____/____/____
Gross Weekly Salary: $ __________ (Disability Plan) Client #: __________ (if applicable)

IMPORTANT INFORMATION

As a part of our on-going commitment in keeping insured members up-to-date on any changes that impact the Physicians' Benefits Trust Health Insurance Plans, we wanted to inform you of two new laws that might be of benefit to you, your family, or your employees.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, you are hereby notified of the availability of certain benefits under your health insurance program. If you elect to receive breast reconstruction in connection with a mastectomy, you will have coverage (subject to customary annual deductibles and co-insurance provisions) for: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to provide a symmetrical appearance; and (c) prostheses and physical complications for all stages of the mastectomy, including lymphedemas.

NOTICE OF DEPENDENT COVERAGE

During the annual renewal of your policy, you may add an eligible son or daughter who is unmarried, financially dependent on you, and under the age of 26 (an unmarried dependent that is a full time student may continue coverage beyond age 26) provided you pay the applicable premium. If your son or daughter is a military veteran, an Illinois resident, unmarried, financially dependent on you, and under the age of 30, you may add him/her to your certificate provided you pay the applicable premium.

An eligible dependent must have 90 days or more of prior continuous coverage and not have had a gap of coverage of more than 63 days. A dependent military veteran must also have: (a) served in the active or reserve components of the United States Armed Forces, including the National Guard; (b) received a release or discharge other than a dishonorable discharge; and (c) submit proof to the Administrator using Form DD 2-14 (Member 4 or 6) otherwise known as a Certificate of Release or Discharge from Active Duty. This form is issued by the Federal government to all veterans. For information on how to obtain a copy of the DD 2-14, your dependent veteran may call the Illinois Department of Veteran Affairs at 1-800-437-9824 or the U.S. Department of Veterans Affairs at 1-800-827-1000. If added during this period, Pre-existing condition limitations and creditable coverage rules will not be applicable for health coverage and waiting periods will not be applicable for dental coverage.

If you wish to add an eligible dependent, please complete this form and the Health History Questionnaire and return to us. These forms must be postmarked within your 30 day annual renewal period for your dependent's coverage to become effective.

Late Enrollment

A Health Benefits Program Late Enrollment is one which has been submitted more than 30 days following the date the individual first became eligible to apply for the Plan. Eligibility includes the completion of the groups' stated waiting/probationary period, if any.

Follow the steps outlined For Individuals Applying for the Health Benefits Program. A completed Application and Health History Questionnaire must be submitted for each late enrollee. The effective date of coverage after receipt of the application will be the first of the month following a six-month waiting period. Premiums are not charged during this waiting period.

Special Enrollment

An individual who is eligible but did not apply in the Health Benefits Program when first eligible may qualify as a Special Enrollment if:

1. Coverage was declined when the individual was first eligible because there was coverage under another plan and that coverage was involuntarily lost due to:
   - Legal Separation or Divorce
   - Termination of Employer Contributions
   - MEDICAID/CHIP Eligibility
   - MEDICAID/CHIP Financial Assistance
   - Death
   - Reduction in Hours of Employment
   - Termination of Employment
   - Exhaustion of COBRA Coverage
2. There was a dependent status change due to: • Birth • Marriage • Adoption • Placement for Adoption
3. A completed Application & Change of Coverage Form and the necessary Health History Questionnaires was submitted within **30 days (60 days for MEDICAID/CHIP)** of the event.
4. Complete Sections A, B, C, D, E, F, G, H and I of the Group Health Benefits Program Application.

Instructions and Definitions by Section

SECTION A • Type of Activity - Provide all information that applies to the reason you are completing this Application & Change of Coverage Form.

New Applicant – New Employee and New Group: Complete Sections B, C, D, E, G, H and I and provide a Health History Questionnaire for each individual listed in Section C.

Late Enrollee – Complete Sections B through G and provide a Health History Questionnaire for each individual listed in Section C.

Waiver of Coverage – Complete Sections B, G, H, J and K.

SECTION B • Personal Information - Complete all personal information in order for your application to be processed.

SECTION C • Dependent Information - Use "A", "C" or "T" to indicate whether you are adding, changing, or terminating coverage for an individual. Print your full name along with the name(s) of your dependents, if applicable. Indicate Gender, Date of Birth, and Social Security Number for each individual listed.

SECTION D • Plan Selection - Select Health and Dental Plan desired; including deductible amount. Dental coverage is offered only to Illinois State Medical Society and Chicago Medical Society members.

SECTION E • Dependent Health Insurance - Provides coverage information. Complete this Section for all new applications or coverage changes.

SECTION F • Special Enrollee Qualification - Complete this Section for Special Enrollees.

SECTION G • Creditable Coverage– Indicates whether prior insurance was in force. Complete for any individual(s) applying for the Health Plan.

SECTION H • Designation of Term Life Insurance Beneficiary - Provide Beneficiary information for Term Life and AD&D coverage.

SECTION I • Authorization / Release of Information - This section must be completed for all applications, coverage changes and terminations. Application & Change of Coverage Form must be signed in order for it to be processed. Authorized Employer signature and date required.

Return completed application to:

PBT Insurance Office • 200 East Randolph Street • 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
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