



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

1. Please provide the following information:

Name: _____

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 Individual Census Sheet found at the end of this document. Be sure to include yourself and all eligible family members.

5. Please check the Health Plan (A through F) 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. Please 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: (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

D. Value Plan (PPO) : Plan Option 1 Plan Option 2

Deductible for Option 1: \$1,000 per Individual/ \$2,000 per Family

Deductible for Option 2: \$2,000 per Individual/ \$4,000 per Family

Prescription Drug Coverage: First Option – No Deductible Second Option – \$250 Deductible
 Third Option - \$500 Deductible Fourth Option – No Coverage

Maternity Coverage: Yes No Benefit (Treatment for complications due to pregnancy is covered even if the optional maternity coverage is not chosen).

E. Value Plan Health Savings Account (HSA) Qualified Plan (Subject to change annually as Federal law requires).

Individual Plan Deductibles: \$1,500 \$3,000 \$4,000 \$5,000

Maternity Coverage: Yes No Benefit (Treatment for complications due to pregnancy is covered even if the optional maternity coverage is not chosen).

Family Plan Deductibles: \$3,000 per Individual /\$6,000 per Family
 \$4,000 per Individual /\$7,000 per Family
 \$5,000 per Individual/\$8,000 per Family

Maternity Coverage: Yes No Benefit (Treatment for complications due to pregnancy is covered even if the optional maternity coverage is not chosen).

F. Major Medical High Deductible Plan

Option 1 - \$10,000 Deductible In-Network

Option 2- \$27,500 Deductible In-Network

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

* Term Life and AD&D Insurance in the amount of \$10,000 is automatically included with all medical plans for the primary applicant.

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:



Individual Census Sheet

Primary Applicant/Employee				Spouse				Dependent Child(ren)		
Name	Gender	DOB	Tobacco use in the last 12 months? Y/N	Name	Gender	DOB	Tobacco use in the last 12 months? Y/N	Name	Gender	DOB