



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

1. Please provide the following information:

Group Name: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____ E-Mail: _____

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

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. Please provide the following information for each eligible employee: (Attach additional page if needed)

Employee Name	Gender	Date of Birth	Type of Coverage Requested	Dental Coverage Y/N	

* S – Single (Employee Only) C – Couple (Employee, Spouse) EC – (Employee, Children) F – Family (Employee, Spouse, Children)

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

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

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

Preferred Choice Indemnity: Option 1 Option 3

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

Preferred Choice Indemnity: Option 5

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

Preferred Health Savings Account (HSA) Qualified Plan: (Subject to change annually as Federal law requires)

Deductibles: \$1,200 Individual/ \$2,400Family \$1,800 Individual/ \$3,600Family
 \$2,250 Individual/ \$4,500Family \$2,700 Individual/ \$5,400Family
 \$5,250 Individual/ \$10,500

6. Dental Insurance :

7. Term Life and AD&D Insurance:

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

Deductible Desired: \$25 \$50

Indicate optional dependent coverage in item#4.

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

8. Short Term Disability (STD) Insurance:

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

Benefit Period: 15 weeks 26 weeks

Weekly Benefit Amount Desired (\$50 to \$250 in increments of \$10): \$_____

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: dawnsterland@asg.aon.com

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

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