



Physicians' Benefits Trust Life Insurance Company Group Health Benefits Program

Employer Application & Agreement Form

SECTION A – EMPLOYER INFORMATION

Name of Employer _____

Employer Address _____ Suite # _____

City _____ State _____ Zip Code _____

Name of Contact Person at Employer _____ Title _____

Phone Number (____) _____ Fax Number (____) _____ Email _____

How long has Employer been in business? _____

Federal Employer Tax ID# _____

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 Chicago Medical Society, Illinois State Medical Society, or Illinois State Dental Society. Please check Membership Affiliation below.

Illinois State Medical Society Chicago Medical Society Illinois State Dental Society

For tax purposes, this business is considered: (check one)

Individual Proprietor Partnership Corporation Other _____

Does the Employer have Workers' Compensation Coverage? Yes No
If 'yes', are any employees not covered by Workers' Compensation? Yes No
If 'yes', list employee names: _____

Will this Program replace another Group Plan currently in-force? Yes No

If 'Yes' please provide the name of the Insurance Carrier _____

Reason for Change _____

Date Current Coverage Will End ____/____/____

Desired Effective Date of PBT Plan* ____/____/____ * The effective date of coverage may not be earlier than the first of the month following the acceptance of this application by PBTLIC.

SECTION B - PLAN SELECTION

Group Health Insurance - The number of plan options that may be offered to the firm's employees is based on participation level and group size.

<input type="checkbox"/> Preferred Provider Option (PPO)		Select Deductible and Plan Option Below						
<i>Deductible Options for all PPO Plans (circle option)</i>		\$150	\$300	\$500	\$750	\$1,000	\$2,000	\$3,000

<input type="checkbox"/> Plan Option A	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	80%	60%	\$1,000 + Deductible	\$2,000 + Deductible

<input type="checkbox"/> Plan Option B	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	80%	60%	\$5,000 + Deductible	\$10,000 + Deductible

<input type="checkbox"/> Plan Option C	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	80%	60%	\$1,000 + Deductible	\$5,000 + Deductible

<input type="checkbox"/> Preferred Choice Indemnity		Select Deductible and Plan Option Below					
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Plan Option 1 or 3 - Deductible Options (circle option) \$150 \$300 \$500 \$750 \$1,000 \$2,000
\$3,000

<input type="checkbox"/> Plan Option 1	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	90%	80%	\$500 + Deductible	\$1,000 + Deductible

<input type="checkbox"/> Plan Option 3	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	70%	60%	\$3,750 + Deductible	\$5,000 + Deductible

Plan Option 5 - Deductible Options (circle option) \$2,500 \$5,000

<input type="checkbox"/> Plan Option 5	Co-Insurance Percentage		Annual Out-of-Pocket	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	100%	90%	\$0 + Deductible	\$1,000 + Deductible

<input type="checkbox"/> Preferred Health Savings Account (HSA) Qualified Plan (Deductible and out-of-pocket maximum subject to change annually as the federal law requires)		Select Your Plan Deductible Below	
Plan Deductible Options			
\$1,200	\$1,800	\$2,700	\$5,250
<input type="checkbox"/> Individual \$1,200 /Family \$2,400	<input type="checkbox"/> Individual \$1,800 /Family \$3,600	<input type="checkbox"/> Individual \$2,700 /Family \$5,400	<input type="checkbox"/> Individual \$5,250 /Family \$10,500

SECTION C – OTHER COVERAGE(S)

A. TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

A benefit of \$10,000 Term Life and AD&D Coverage is required for each eligible employee and/or health plan applicant. The Term Life and AD&D benefit 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.

B. COMPREHENSIVE DENTAL PLAN (circle) Yes No
 (The Comprehensive Dental Plan is available to ISMS/CMS members only and their dependents)

Deductible Desired (check one) \$25 \$50

C. WEEKLY DISABILITY INCOME (Must work a minimum of 20 hours per week and participate in the Group Health Benefits Program) (circle) Yes No

Benefit Period? (check one) 13 weeks 26 weeks Weekly Benefit Amount \$ _____
 (Benefits available from \$50 to \$250 in \$10 increments, cannot exceed 60% of employee's annual salary)

SECTION D – ADDITIONAL DETAILS

A. For a Small Group of 2-50 employees the Illinois Standard Health Employee Application for Small Employers and the PBT Small Group Application & Change of Coverage Supplemental Form must be submitted for each eligible employee, physician, or dentist.

For a Group of 51 or more employees the Group Health Benefits Program Employee Application & Change of Coverage Form must be submitted for each eligible employee, physician, or dentist.

Number of Employees per Class (if applicable):

	Class A*	Class B*	Class C*
B. 1. Total number of employees _____ (including self-employed individuals)	_____	_____	_____
2. Total number of eligible employees _____	_____	_____	_____
3. Total number participating _____	_____	_____	_____
4. Your group's eligibility requirements _____ (i.e., hourly requirements and other conditions)			

* Class is determined by the employer based on its desire to offer different benefits to different classes of employees. Please provide a description of each class and use a separate sheet if needed. Attach the sheet to the Application.

Please consult your business advisors regarding potential discrimination concerns.

- C. Participation Requirement: {75% of all eligible employees}
- D. Employer Contribution must be at least {50%} of the lowest cost plan employee-only or single rate.
- E. Employer Waiting Period for new employees to be covered (check one)
 - 30 Days
 - 60 Days
 - 90 Days
 - Other (specify) _____

If an employer does not have any waiting period, an Application must be received by PBT at least 15 days prior to the requested effective date and approved by PBT. 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, but it may not be changed to less than a 30 day waiting period.

SECTION E – EMPLOYER AUTHORIZATION

- A. A copy of the Employer’s most recent Wage & Tax Statement, Illinois UC-3 must be submitted with application.
- B. Signature of designated person at Employer _____
 Print name of designated person at Employer _____ Title _____
 Date ____/____/_____
 Phone Number (____) _____ Fax (____) _____
 Email Address _____

Return your completed application to:

**200 E. Randolph
5th Floor
Chicago, IL 60601**

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

You can also fax your questions to 1-312-381-2795

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