



**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

Membership Affiliation: \_\_\_ CMS    \_\_\_ ISMS    \_\_\_ ISDS    \_\_\_ Other \_\_\_\_\_  
(Indicate Group Name)

**2. Please indicate the desired effective date of coverage:     1<sup>st</sup> of the Month     15<sup>th</sup> 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, 5<sup>th</sup> 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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