Physicians' Benefits Trust Life Insurance Company
Small Group Health Benefits Program
(For groups of 2-50 employees)

Employee Application & Change of Coverage Supplemental Form

This form must accompany your completed Illinois Standard Health Employee Application for Small Employers. Failure to submit both forms will delay the processing of your application.

Please print legibly or type information requested. Follow the instructions in each section and complete all appropriate sections in their entirety. ANY QUESTIONS LEFT UNANSWERED OR INCOMPLETE WILL DELAY OR PREVENT PROCESSING OF YOUR APPLICATION**.**

- This form must be completed by each employee 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 the Employer's stated waiting/probationary period, if any.

  ELECTING TO WAIVE PARTICIPATION IN THE HEALTH BENEFITS PROGRAM - Eligible employees and/or dependents electing to Waive Participation in the Health Insurance Plan must complete Section C of the Illinois Standard Health Employee Application for Small Employer and all other required sections regarding declination of coverage. In addition, complete Sections B and F of this form. Section F Notice of Special Enrollment Rights requires signature(s) of spouse and/or dependants if age 18 or older.

- Coverage will become effective the first of the month following the Employer's waiting period. A completed Application must be postmarked to 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 ENROLLMENT** in the **IMPORTANT INFORMATION SECTION** of this form. See Page 1 of ***THE*** **ILLINOIS STANDARD HEALTH EMPLOYEE APPLICATION FOR SMALL EMPLOYERS** to enroll Late and Special Enrollees.

  SPECIAL ENROLLMENT QUALIFICATION - Special Enrollment rights arise if 1) a Member, Non Member, 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, Non-Member, 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.

- **PLEASE REVIEW SECTION E AUTHORIZATION/RELEASE OF INFORMATION** *c*arefully, then sign and date where required. If your spouse is applying for coverage or, and any dependent child(ren) age 18 or older are applying for coverage, they 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 spouse and dependents.

❑ Section A – NEW APPLICANT

Complete Sections B, C, D, and E of this form. To enroll a Late Enrollee or Special Enrollee **complete designated section(s) on page 1 of the Illinois Standard Health Employee Application for Small Employers**.

❑ Section A1 – CHANGE OF COVERAGE

Check all that apply and complete required Sections B, C, D, and E of this form. Dependant information is required in Sections D and E of the Illinois Standard Health Employee Application for Small Employers.

❑ Plan Change	❑ Add Spouse	❑ Terminate Spouse
❑ Name Change	❑ Add Dependent Child	❑ Terminate Dependent Child
❑ Address Change	❑ Continuation of Coverage	❑ Change of Beneficiary Designation
❑ Conversion Privilege	❑ Terminate Applicant	❑ Other _____________________

Effective Date of Change_______/________/_______

Section B – PERSONAL INFORMATION

Name of Employer or Organization ____

Employer or Organization Address ____
(Street) (City) (State) (Zip)

Employer or Organization Phone Number (_______)_______- ________

Applicant Name____
(Last) (First) (Middle Initial)

If Requesting a Name Change, List New Name____
(Last) (First) (Middle Initial)

Effective Date of Name Change _______/_______/______

Applicant Home Address ____
(Street) (City) (State) (Zip)

If Changing Address, List New Address ____
(Street) (City) (State) (Zip)

Effective Date of Address Change _______/_______/_________ Applicant Home Phone Number (_____) _____-________

Applicant Email Address ____

Applicant Date of Birth: ______/_______/____ Applicant Gender (check one): ❑ Male ❑ Female

Applicant Social Security Number ________-_______-_________

Is the Applicant a United States (U.S.) Citizen? ❑ Yes ❑ No

If 'No', Please Provide Visa Status ____

Date of U.S. Entry ______/_______/______ Visa Expiration ______/_____/_____

Is the Applicant currently insured by another health plan? ❑ Yes ❑ No

If 'Yes', what is the name of the insurance carrier or current plan? ______________________________

If 'No', when were you last covered? ____

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

Applicant Membership Affiliation (check below)

❑ Illinois State Medical Society ❑ Chicago Medical Society ❑ Illinois State Dental Society

Applicant Specialty ____

Effective Date of Coverage _______/________/________ (Coverage will become effective the first of the month following the Employer's waiting period).

Termination Date of Current Coverage ______/_______/______ (Do not terminate your current coverage until you and your dependents are approved for PBT coverage).

Section C - PLAN SELECTION

Select the Health Benefits Plan and the desired deductible amount. Select the optional Comprehensive Dental Plan and the desired deductible amount. Please note, the Comprehensive Dental Plan is offered only to Illinois State Medical Society and Chicago Medical Society members and their dependents.

❑ **Preferred Provider Option (PPO)**	**Select Deductible and Plan Option Below**						
Deductible Options for All PPO Plans *(circle)*	$150	$300	$500	$750	$1,000	$2,000	$3,000

❑ ***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

❑ ***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

❑ ***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

❑ Preferred Choice Indemnity

Select Deductible and Plan Option Below

Plan Options 1 and 3 - Deductible Options (circle option) $150 $300 $500 $750 $1,000 $2,000 $3,000

❑ *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

❑ *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

❑ *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

❑ Preferred Health Savings Account (HSA) Qualified Plan

Select Your Plan Deductible Below

(Deductible and out-of-pocket maximum subject to change annually as the federal law requires)

Plan Deductible Options

$1,200	$1,800	$2,700	$5,250
❑ Individual $1,200 /Family $2,400	❑ Individual $1,800 /Family $3,600	❑ Individual $2,700 /Family $5,400	❑ Individual $5,250 /Family $10,500

OTHER COVERAGE(S)

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

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

Benefit Period? (Check one) □ 13 weeks □ 26 weeks □ Weekly Benefit Amount $____________
(Benefits available from $50 to $250 in $10 increments, can not exceed 60% of employee's annual salary)

Section D – DESIGNATION OF BENEFICIARY

Beneficiary of $10,000 Term Life and AD&D Insurance for Primary Insured.

Beneficiary: If no Beneficiary is designated, or if the designated Beneficiary does not survive the insured person, any Certificate 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. Designation of beneficiary with the latest effective date takes precedence.

❑ Check if Change of Beneficiary Designation

Name of Beneficiary ____

Beneficiary Address ____

Beneficiary Phone Number (______) _______-________

Relationship to Insured ____

Signature of Applicant ____

Date Signed____

Section E – 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.

By signing this form I authorize Physicians' Benefits Trust Life Insurance Company to gather individually identifiable health information, including medical records (excluding psychotherapy notes), lab records, and prescription records from sources including but not limited to physicians, clinics, hospitals, pharmacy benefit managers, and health plans. This information will be used for the purpose of evaluating and underwriting my insurance application. This authorization is valid until the time I receive a final determination on my application for coverage. I may revoke this authorization by notifying Physicians' Benefits Trust Life Insurance Company in writing. I understand that this information may be subject to re-disclosure, and once re-disclosed, may no longer be subject to federal rules governing privacy.

Signature of Applicant ____Date_____ /_____ /______

Signature of Spouse (if applying) ____Date_____ /____/_______

Signature of Dependent (if applying and age 18 or over) _________________________________Date_____/____ /_______

Signature of Dependent (if applying and age 18 or over) _________________________________Date_____/____ /_______

Signature of Dependent (if applying and age 18 or over) _________________________________Date_____/____ /_______

Section F – NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining coverage 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 for 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 (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 for 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 ______/____/______

Signature of Dependent (if applying and age 18 or over) ___________________________________ Date_____/_____/_______

Signature of Dependent (if applying and age 18 or over) _________________________________Date_____/____ /_______

Signature of Dependent (if applying and age 18 or over) _______________________________Date_____/____ /_______

IMPORTANT INFORMATION

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 lymph edemas.

Notice of Dependent Coverage

During the annual renewal of your certificate, you may add an eligible son or daughter who is under the age of 26 (an unmarried and financially dependent child 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.

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 return to us. This form must be postmarked within your 30 day annual renewal period for your dependent's coverage to become effective.

Health insurance benefits for individuals under age 19, are payable for pre-existing conditions. A pre-existing condition is a sickness or injury for which an individual has received medical care, advice or treatment within six months immediately preceding the effective date of coverage. These are not covered until 12 months have elapsed.

The 12-month period will be reduced by the amount of prior creditable coverage, if any, an individual has accrued. Prior creditable coverage is coverage without a 63-consecutive-day break under another group or individual health care plan, Medicare, Medicaid, and certain other state and federal programs. Effective date of coverage is the first day of the month coinciding with or next following receipt by the Administrator of his application for enrollment. All new insureds of a group currently covered under the PBT Group Health Benefits Program will be subject to the pre-existing condition limitation explained in this paragraph

Exclusions

The PBT Health Insurance Plan does not cover charges that are covered by Workers' Compensation or Employer's Liability laws. Occupational sickness or accidents covered under Workers' Compensation, unless the covered employee is not eligible for such compensation; cosmetic surgery, unless treatment is due to an accident sustained while covered; dental treatment other than to repair accidental damage to the jaw or natural teeth (within six months of the accident); oral surgery; including temporomandibular joint dysfunction (TMJ) and related disorders; hearing aids; eyeglasses or eye examinations for the correction of vision or fitting of eyeglasses; treatment of infertility for groups of less than 26 employees: medical care, services or supplies to the extent they are paid for, payable by or furnished under Medicare. Please refer to your Certificate of Insurance for a complete list of all exclusions.

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

Sponsored by:

PBTLIC is a wholly owned subsidiary of:

January 2011