



**Group Health Benefits Program**  
*For Members, Their Employees and Families*  
**REQUEST FOR QUOTE • CENSUS - EMPLOYEE DATA SHEET**

PBT INSURANCE OFFICE • 300 South Wacker Drive, Suite 700 • Chicago, IL 60606  
 Phone: 1-800-621-0748 • Fax: 1-312-922-2849 • www.pbtinsurance.com

Name	Sex	Birthdate	Dependent Coverage*				Life Ins. Only	Dental Ins. Only
			S	CO	EC	FA		
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								

\*Key: S: Single, CO: Employee + Spouse, EC: Employee + Children, FA: Employee, Spouse + Children

**Circle the Health and Dental Plan Options and Deductible Amounts for your Group below:**

**Health Plan(s):**

<b>Preferred Provider Option (PPO) -</b>	Deductible:	\$150	\$300	\$500	\$750	\$1,000	\$2,000	\$3,000
	Option:	A	B	C				
<b>Preferred Choice Indemnity -</b>	Deductible:	\$150	\$300	\$500	\$750	\$1,000	\$2,000	\$3,000
	Option:	1	3					
<b>Indemnity Option 5 -</b>	Deductible:	\$2,500	\$5,000					
<b>Health Savings Account (HSA) -</b>	Individual Deductible:	\$1,100	\$1,800	\$2,700	\$5,250			
	Family Deductible:	\$2,200	\$3,600	\$5,400	\$10,500			

**Dental Plan:**

<b>Dental -</b>	Deductible:	\$25	\$50
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Name of Group: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone: (        ) \_\_\_\_\_ Fax: (        ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

How would you prefer to receive your proposal:  E-mail       Fax       Mail

**To request a proposal, fax this completed form to 1-312-922-2849 today!**

SC - \_\_\_\_\_