



Physicians' Benefits Trust Life Insurance Company

MediCap

MediCap Medicare Supplement Personal Application

This application is for one applicant only. If you wish to obtain coverage for your spouse, please complete a separate form. Do not send money. We will bill you later.

PLEASE PRINT:

Name: _____ Date of Birth: ____/____/____

Address: _____ Gender: Male Female

City: _____ State: _____ Zip: _____ Social Security Number: _____

Telephone: _____ Email: _____

Please check appropriate box: I am a member of ISMS CMS ISDS

PLEASE CHECK THE APPROPRIATE BOXES:

- I am age 65 or older with coverage effective with Medicare Parts A & B Yes No
I currently have health coverage through Physicians' Benefits Trust Life Insurance Company Yes No
I wish to enroll in PBTLIC MediCap Plan: A G J
Bill me: Quarterly Semi-Annually
Do you have another Medicare Supplement policy or certificate in force (including health care service contract or health maintenance organization contract)? Yes No
If so, with which company? _____
Do you have any other health insurance policy providing benefits which this Medicare Supplement would duplicate? Yes No

I understand that if I have had 6 or more months of health coverage with PBTLIC or another Medicare Supplement Plan, I am not subject to a Pre-Existing Condition Limitation.

If I am not currently insured under a PBTLIC Health Care Plan or another Medicare Supplement Plan, I am subject to the MediCap Plan Pre-Existing Condition Limitation stated in the Certificate of Coverage.

Applicant Signature _____ Date ____/____/____

Desired Effective Date (must be first day of the month) ____/____/____

Return completed application to:

PBT Insurance Office • 300 South Wacker Drive, Suite 700 • Chicago, IL 60606

For Physicians and Office Staff contact us at:
Ph: 1-800-621-0748 • Fax: 1-312-922-2849
www.pbtinsurance.com

For Dentists and Office Staff contact us at:
Ph: 1-866-898-0926 • Fax: 1-312-922-2849
www.isdsinsurance.com