



Exclusively for ISMS and CMS Members...

Enrollment Form for Accidental Death & Dismemberment Insurance Plan

PBT Insurance Office • 300 South Wacker Dr., Suite 700 • Chicago, IL 60606 • Ph: 1-800-621-0748 • Fax: 1-312-922-2849



Underwritten by: **Hartford Life Insurance Company 06098**
Simsbury, Connecticut
Physicians' Benefits Trust
Policy Number ADD-8485

Applicant's Name: _____ Date of Birth: ____/____/____

- I am currently a member of the Illinois State Medical Society/Chicago Medical Society.
- I am applying for membership in the Illinois State Medical Society/Chicago Medical Society.
- I am an employee of a member of the Illinois State Medical Society/Chicago Medical Society.

Name of Member: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Beneficiary: _____ Relationship: _____

You will be the Beneficiary for all Dependents' coverage

1. I hereby apply for the following coverage:
- Member /Employee Only Spouse Only Family Plan

2. Coverage Amount Desired (Principal Sum): \$ _____
(In \$25,000 units up to \$300,000)

3. If Family Coverage is desired, please complete the following:

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

PLEASE BILL ME (Send No Money Now)

- Semi Annual
- Annual

Dependent Child Name	Date of Birth

4. New Coverage Existing Coverage Increase

I hereby certify that the above statements are complete and true to the best of my knowledge.

Applicant's Signature: _____ Date: _____

HOW TO APPLY:

1. Complete the application form above.
2. Indicate coverage choices.
3. Mail your completed application form to the insurance

SEND NO MONEY NOW!

You will be billed when your certificate is issued.