Physicians' Benefits Trust Life Insurance Company
Group Health Benefits Program

Employee Application & Change of Coverage Form
(For groups of 51 or more employees)

ALL ELIGIBLE EMPLOYEES MUST COMPLETE THIS APPLICATION WHETHER ELECTING TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR ELECTING TO WAIVE (DECLINE) COVERAGE IN THE HEALTH BENEFITS PROGRAM.

APPLICATION INSTRUCTIONS

This form must be completed by each Member, Non-member, and Employee who is regularly scheduled to work 20 or more hours per week and becomes eligible to participate in the Health Benefits Program. Please note, eligibility includes the completion of the Employer's waiting/probationary period.

Coverage will become effective the first of the month following the Employer's waiting period. A completed Application must be received by the Administrator within 30 days of the coverage eligibility date. After the 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.

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 within 60 days for Medicaid/CHIP Qualifying Event.

SECTION A – Indicate TYPE OF REQUEST by checking the applicable box.

- Check the applicable box for Type of Enrollment (New Applicant, Special or Late Enrollment) or if Waiving (Declining) Coverage, and complete each section of the form noted.

- Check the applicable box for the type of Change of Coverage(s) and complete each section noted.

PLEASE NOTE – Section H requires a Signature(s) and Date. If your spouse is applying for coverage, and any dependent child(ren) age 18 or older are applying for coverage, they must also sign and date these sections. Your signature confirms that all information provided is complete and true. Section H also authorizes the release of any necessary records regarding your medical history, or that of your spouse and dependents.

When referring to Spouse throughout this Application, this includes partners to a Civil Union. Domestic Partnership is subject to approval by PBT.

- Please print legibly.
- Please 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.

SECTION A – TYPE OF REQUEST (Check applicable box)

Effective Date of Request ______/________/_______

❑ New Applicant ❑ Special Enrollee ❑ Late Enrollee

❑ Waiver of Coverage - complete sections B, I and J only

Change of Coverage - Complete only the questions in Section B that are marked with an (*) and Sign/Date in Section H.

❑ Plan Change ❑ Name Change ❑ Address Change

❑ Add Spouse ❑ Add Dependent Child ❑ Terminate Insured Coverage

❑ Terminate Spouse ❑ Terminate Dependent Child ❑ COBRA or State Continuation of Coverage

❑ Conversion Privilege ❑ Change of Beneficiary Designation ❑ Other ____________________________

SECTION B – PERSONAL INFORMATION

*Name of Employer ____

*Employer Address ____
(Street) (City) (State) (Zip)

*Employer Phone Number (_______)________- _________

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

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

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

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

*Applicant Home Phone Number (________) _________-_________

Applicant Email Address ____

Applicant Date of Birth ______/_______/_________

Applicant Gender ❑ Male ❑ Female

Applicant Social Security Number ________-_______-_________

Is the Applicant a United States 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 ❑Single ❑Married ❑Divorced ❑Widowed

Applicant Membership Affiliation (check below)

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

Applicant's Specialty ____

Effective Date of PBT Coverage for New Enrollee _______/________/________ *(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).*

Are you currently, or have you been within the last 6 months, disabled or receiving treatment for any condition? (check box)

❑Yes ❑No

If 'Yes', what condition(s)? ____
____

SECTION C – DEPENDENT INSURANCE

If <u>applying</u> for coverage for your Spouse/Dependent(s) complete this section and section D, Dependent Information below.

Do You Want Health Insurance for Your Spouse? ❑Yes ❑No

Is Your Spouse Employed? ❑Yes ❑No

Name of Your Spouse's Employer ____

Is Your Spouse Insured In Another Health Plan? ❑Yes ❑No

If Yes, Please Provide Name of Health Insurance Carrier ____

Is Your Spouse Insured in Another Dental Plan? ❑Yes ❑No

If Yes, Please Provide the Name of Dental Insurance Carrier? ____

Do You Want Health Coverage for Your Child(ren)? ❑Yes ❑No

Are any of your dependents currently, or have been within the last 6 months, disabled or receiving treatment for any condition? (check box) ❑Yes ❑No

If 'Yes', what condition(s)? ____

SECTION D - DEPENDENT INFORMATION

This section should be completed if applying or terminating coverage for Spouse/Dependent(s).

List the name(s) of your Spouse and Dependent(s) if you are applying for or terminating coverage. If terminating coverage, check box B below and list name(s) of Spouse or Dependent(s) coverage is being terminated for. If applying for coverage, check box A below and list name(s), gender, date of birth, social security number, and full time student status for each Dependent listed. If you are applying for coverage for a child, all Eligible Dependent children must be covered. Attach a separate sheet if necessary to list additional Eligible Dependents. Eligible Dependents of each participating employee include a lawful spouse and children under age 26 regardless of marital status or financial dependency. Children are eligible if over age 26 if they are full time students and are unmarried and financially dependent on you. Children who are military veterans may be covered to age 30 subject to certain additional requirements.

A. ❑ Applying for Coverage for Spouse or Dependent(s) Effective Date of Coverage ______/______/_____

B. ❑ Terminating Coverage for Spouse or Dependent(s) Effective Date of Termination _____/_____/______

Type of Coverage Applying For (check one) ❑ Employee only ❑ Couple (Employee and Spouse) ❑ Employee and Child(ren) ❑ Family

	Name (Last/First/Middle Initial)	**Gender (M/F)**	**Date of Birth (month/day/year)**	**Social Security Number**	**Full Time Student (Y/N)**
Spouse					
Child					
Child					
Child					

Use additional paper if needed.

SECTION E - PLAN SELECTION

Please consult your employer on what plan(s) are available for your group. Then select your Health Benefits Plan and the desired deductible amount. Individual deductibles are listed below. *If available within your group, 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)** Plan **Select Plan and Deductible Option Below**

❑ **PPO Plan Option A** ❑ **PPO Plan Option B** ❑ **PPO Plan Option C**

Deductible choices for PPO Plans (circle one): $150 $300 $500 $750 $1,000 $2,000 $3,000

❑ **Preferred Choice Indemnity** Plan **Select Plan and Deductible Option Below**

❑ **Plan Option 1** ❑ **Plan Option 3**

Deductible choices for plans Option 1 and Option 3 (circle one): $150 $300 $500 $750 $1,000 $2,000 $3,000

❑ **Plan Option 5**

Deductible choices for plan Option 5 (circle one): $2,500 $5,000

❑ **Preferred Health Savings Account (HSA) Qualified Plan**	**Select Plan and Deductible Option Below**
Deductible and out-of-pocket maximum subject to change annually as the federal law requires.	

Deductible choices for HSA plan (circle one): **$1,200** **$1,800** **$2,700** **$5,250**

Other Coverage(s) Below ***Only for Groups that existed prior to December 31, 2013**

A. COMPREHENSIVE DENTAL PLAN (For ISMS/CMS members only and their dependents) - (circle) Yes No

Deductible Desired - (check one) □ $25 □ $50

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

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

SECTION F – 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.

Reason for Loss of Coverage (check one)

- ❑ Legal Separation or Divorce
- ❑ Reduction in Hours of Employment
- ❑ Termination of Employer Contributions
- ❑ MEDICAID/CHIP Ineligibility/Financial Assistance
- ❑ Death
- ❑ Termination of Employment
- ❑ Exhaustion of COBRA or state continuation

Other (describe) ______________________________

Date of Qualifying Event _____/______/_______ *Attach proof of your Qualifying Event*

A. Was Loss of Coverage Due to Failure to Pay Premiums When Due? ❑ Yes ❑ No
B. Was Loss of Coverage Due to Cause? ❑ Yes ❑ No

Reason for Gain of Dependent Status (check one) ❑ Birth ❑ Placement for Adoption ❑ Adoption ❑ Marriage

SECTION G – DESIGNATION OF BENEFICIARY *Only for Groups that existed prior to December 31, 2013

Beneficiary of $10,000 Term Life and AD&D Insurance for the Member, Non-Member, or Employee.

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 Employee/Member/Non-Member ____ Date __________________

SECTION H – 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 and Change of Coverage Form 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 Employee/Member/Non-Member ____ 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___________________

SECTION I – WAIVER OF COVERAGE

INDIVIDUALS OR DEPENDENTS OF INDIVIDUALS DECLINING COVERAGE MUST COMPLETE SECTION (I) WAIVER OF COVERAGE AND SECTION (J) NOTICE OF SPECIAL ENROLLMENT RIGHTS

Name of Employee, Member or Non-Member ____

I choose to WAIVE coverage for: □ Employee, Member, Non-Member □ Dependent Medical □ All Coverage

Reason for Waiver of Coverage (check one):

□ Other Health Insurance Coverage - Name of Insurer or Plan ____
□ Other Group or Individual Health Insurance Plan - Name of Insurer or Plan____
□ Other Group or Individual Health Insurance Plan (Spouse's Employer) - Name of Insurer or Plan ______________________
□ Other Reason - *Please Complete* ____

I have been given an opportunity to apply for the Group Health Benefits Program, and for myself and my Eligible Dependent(s), I (we) decline to participate.

Signature of Employee/Member/Non-Member____ **Date**_______________

Signature of Spouse ____ **Date**_______________

Signature of Dependent (if age 18 or over) ____ **Date** _______________

Signature of Dependent (if age 18 or over) ____ **Date**_______________

SECTION J – 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 Employee/Member/Non-Member ____**Date** _________________

Signature of Spouse ____ **Date** _________________

Signature of Dependent (if age 18 or over) ____ **Date**_________________

Signature of Dependent (if 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 received within your 30 day annual renewal period for your dependent's coverage to become effective.

Health insurance benefits for all covered individuals are payable for pre-existing conditions.

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.

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;: 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:
PBT Insurance Office
200 W. Adams Street, Suite 500, Chicago, IL 60606
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
pbt@alliedbenefit.com

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