



Physicians' Benefits Trust Life Insurance Company

# Individual Health Benefits Program

Change of Coverage Form For: Resurrection Health  
Care Physicians

## Instructions:

The Individual Health Benefits Program Change of Coverage Form is used for those wishing to make changes to an existing election including Term Life Insurance and Accidental Death & Dismemberment coverage.

Please follow the steps outlined below, provide all the information requested, and write legibly to ensure that your change of coverage request proceeds without any delay.

**If you are requesting a change in coverage which can include adding or terminating coverage for a spouse or dependent child, changing plan selection, changes in name or address, continuation of coverage, or conversion privilege, and to change Term Life beneficiary designation, please follow these steps:**

Questions left unanswered or incomplete may delay or prevent processing of the Change of Coverage Form.

- 1.** Complete Sections A, B, C, D, E, F, and H to add a spouse or dependent child. You must also complete a **Health History Questionnaire** for each individual being added.
- 2.** Complete Sections A, B, C, and H to terminate coverage for a spouse or dependent child.
- 3.** Complete all Sections (except G) to apply for a change of coverage or to elect the conversion privilege.
- 4.** Complete Sections A, B, and H to request name or address change.
- 5.** Complete Sections A, B, G, and H to change the Term Life and Accidental Death & Dismemberment beneficiary designation.

## Return your completed Change of Coverage Form to:

PBT Insurance Office: 200 E. Randolph Street  
5th Floor  
Chicago, IL 60601

# Change of Coverage Form

Please read the instructions in each section before completing this form.  
Please print legibly or type information requested.

## PLEASE PRINT LEGIBLY OR TYPE INFORMATION REQUESTED

### Section A – ACTIVITY:

Please provide all information that applies to the reason you are completing this Change of Coverage Form. Please be sure to complete all Sections and provide a **Health History Questionnaire** for each individual who appear in Section C.

#### Change Coverage – Please check all that apply

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Change Plan                    | <input type="checkbox"/> Terminate Spouse          | <input type="checkbox"/> Name Change                    |
| <input type="checkbox"/> Add Spouse                     | <input type="checkbox"/> Terminate Dependent Child | <input type="checkbox"/> Address Change                 |
| <input type="checkbox"/> Add Spouse Add Dependent Child | <input type="checkbox"/> Conversion Privilege      | <input type="checkbox"/> Change Beneficiary Designation |

### Section B – PERSONAL INFORMATION:

Complete all personal information in order for your application to be processed as quickly and efficiently as possible.

Your name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Your home address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Your home Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_ Gender:  Male  Female Your Social Security Number: \_\_\_\_\_

United States Citizen:  Yes  No  
If 'No' please provide Visa Status: \_\_\_\_\_ Date of U.S. Entry: \_\_\_/\_\_\_/\_\_\_ Visa Expiration: \_\_\_/\_\_\_/\_\_\_

Your Marital Status (check one):  Single  Married

Membership Affiliation:  Illinois State Medical Society/Chicago Medical Society  Illinois State Dental Society  
Your Specialty: \_\_\_\_\_

Are you currently insured by another health plan?  Yes  No

If yes, state the name of the insurer or plan \_\_\_\_\_

If no, when were you last covered? \_\_\_\_\_

Have you or your spouse ever been covered by or applied for coverage through PBT?  Yes  No

What was the outcome of your application? \_\_\_\_\_

Have you, your spouse, or any of your dependent children ever been declined coverage for individual medical insurance?  Yes  No

If yes, please state when you applied and why coverage was declined: \_\_\_\_\_

Your Desired Effective Date of PBT Coverage \_\_\_\_\_

Termination Date of Current Coverage\* \_\_\_\_\_

**\* Do not terminate your current coverage until you and your dependents are approved for PBT coverage.**

## Section C - DEPENDENT INFORMATION :

Please be sure to print the name(s) of your dependents. You must indicate Gender, Date of Birth, Social Security Number, and Full Time Student Status for each individual 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 all additional Eligible Children (An Eligible Child is a child who is naturally born, legally adopted, a stepchild, or placed for adoption, under age 26 unless a full-time student).

**Type of Contract:**     Single     Couple     Adult and Child(ren)     Family

	Name (Last/First/Middle Initial)	Date of Birth (mm/dd/yyyy)	Social Security Number	Full Time Student Y/N
Spouse				
Child				
Child				
Child				

## Section D - PLAN SELECTION:

Select the Health and Dental Plan desired including the deductible amount.

**I would like to apply to change coverage ...**

### Preferred Provider Option (PPO)

<input type="checkbox"/> Plan A	In-Network RHC Facility	In-Network	Out-of-Network
Hospital Co-Insurance Percentage	80%	60%	50%
Physician Co-Insurance Percentage	N/A	80%	60%
Individual Out of Pocket Maximum	\$1,000	\$1,000	\$5,000
Deductible Choices:	<input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000		

<input type="checkbox"/> Plan B	In-Network RHC Facility	In-Network	Out-of-Network
Hospital Co-Insurance Percentage	90%	80%	50%
Physician Co-Insurance Percentage	N/A	90%	80%
Individual Out of Pocket Maximum	\$500	\$500	\$1,000
Deductible Choices:	<input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000		

<input type="checkbox"/> Plan C	In-Network RHC Facility	In-Network	Out-of-Network
Hospital Co-Insurance Percentage	100%	90%	50%
Physician Co-Insurance Percentage	N/A	100%	90%
Individual Out of Pocket Maximum	Deductible	Deductible	\$1,000
Deductible Choices:	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000		

**Health Savings Account (HSA) Qualifying High Deductible Plan\*}**

Individual Deductible Choices:	<input type="checkbox"/> \$1,800	<input type="checkbox"/> \$2,900
Family Deductible Choices:	<input type="checkbox"/> \$3,600	<input type="checkbox"/> \$5,600

\*Subject to change annually as the Federal law requires.

**Dental (Available to only ISMS and CMS members and their dependents):**

Deductible desired:  \$25  \$50

**(Conversion option not available for Dental)**

**Section E - DEPENDENT HEALTH INSURANCE :**

- Do you want health coverage 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 the name of Health Insurer: \_\_\_\_\_
- Is your spouse insured in another dental plan? .....  Yes  No
- If "YES", please provide the name of Dental Insurer? \_\_\_\_\_
- Do you want Health Coverage for your Child(ren).....  Yes  No

**Section F – CREDITABLE COVERAGE**

Indicates whether prior insurance was in force. Complete for any individual(s) applying for the Health Plan.

Have you or your dependent(s) had prior coverage within the last 63 days under another group health plan, individual health coverage, Medicare, Medicaid, Tricare, State Health Benefits Risk Pool, and Federal Employee's Health Program, public health plan or a health plan under the Peace Corps Act? .....  Yes  No

If "YES" you must provide Certificate(s) of Creditable Coverage from prior plans to receive a reduction in your exclusion period for pre-existing conditions.

**Section G – CHANGE OF DESIGNATION OF \$10,000 TERM LIFE AND AD&D INSURANCE BENEFICIARY FOR PRIMARY INSURED**

**Beneficiary:** If no Beneficiary is designated, or if the designated Beneficiary does not survive the insured person, any Policy 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 date takes precedence.

Name of Beneficiary: \_\_\_\_\_

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

Telephone Number: ( \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ) Relationship to Insured \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

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 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. I understand that signing this form is voluntary and that I need not sign it to assure eligibility.

My employer will not directly or indirectly pay any portion of the premium applicable to this coverage (not applicable to self-employed person, sole proprietorship, or family-owned business that has no employees other than members of the applicant's immediate family – spouse or dependent children).

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone Number: (\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_)

Signature of Spouse (if applying): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dependent Child (if older than 17): \_\_\_\_\_

Signature of Dependent Child (if older than 17): \_\_\_\_\_

### IMPORTANT INFORMATION

As a part of our on-going commitment in keeping insured members up-to-date on any changes that impact the Physicians' Benefits Trust Health Insurance Plans, we wanted to inform you of two laws that might be of benefit to you, your family, or your employees.

#### 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 lymphedemas.

#### Notice of Dependent Coverage (Health and Dental Plans)

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

An eligible dependent must have 90 days or more of prior continuous coverage and not have had a gap of coverage of more than 63 days. 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 the Health History Questionnaire and return to us. These forms must be postmarked within your 30 day annual renewal period for your dependent's coverage to become effective.

## Return your completed Change of Coverage Form to:

PBT Insurance Office  
200 E. Randolph Street • 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**

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