



# Physicians' Benefits Trust Life Insurance Company

## Employer Application and Agreement

### For RESURRECTION HEALTH CARE

#### 1. PRACTICE INFORMATION

Application is submitted by: (full name of firm) \_\_\_\_\_

Address, Street, Suite #, City, State, Zip: \_\_\_\_\_

Type of Business and/or Specialty: \_\_\_\_\_

In order to participate in the Physicians' Benefits Trust Life Insurance Company (PBTLIC) Group Health Benefits Program, one health plan participant must be a member of the Illinois State Medical Society, Chicago Medical Society, or Illinois State Dental Society.

Member Name: \_\_\_\_\_

Member of:     ISMS     CMS     ISDS

For tax purposes, this business is considered an:     Partnership     Corporation     Other \_\_\_\_\_

Will this program replace another Group Plan?     YES     NO

If "Yes," provide Name of Insurer: \_\_\_\_\_

Reason for Change: \_\_\_\_\_

Date Current Coverage Ends: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Desired Effective Date of PBT Plan\*: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*\* The effective date of this coverage may not be earlier than the first of the month following the acceptance of this application by PBTLIC.*

#### 2. PLAN SELECTION

**A. Group Health Insurance:** The number of options from the PPO/Indemnity plans combined that may be offered to the firm's employees is based on participation level and size.

**Preferred Provider Option (PPO)**

	In-Network RHC Facility	In-Network	Out-of-Network
<input type="checkbox"/> <b>Plan A</b>			
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"/> <b>Plan B</b>			
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"/> <b>Plan C</b>			
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) Qualified Plan\***

**Deductible**             \$1,800 Individual / \$3,600 Family

**Desired:**              \$2,900 Individual / \$5,600 Family

\*Subject to change annually as Federal law requires.

**B. TERM LIFE and AD&D:**

A benefit of \$10,000 Term Life and AD&D Coverage is required for each employee and/or applicant. Term Life coverage reduces from \$10,000 to \$6,500 at age 65, to \$5,000 at age 70, to \$3,000 at age 75 and to \$2,000 at age 80.

**Additional Supplemental Term Life:**  YES  NO

ADDITIONAL TERM LIFE benefit requested \$ \_\_\_\_\_ (Available in \$1,000 increments up to \$40,000)

**Dependent Term Life:** \$2,500 Benefit. (Children age 2 weeks to 6 months benefit is \$250)  YES  NO

**C. DENTAL (for ISMS/CMS members only):**  YES  NO or  Individually Selected

Deductible desired:  \$25  \$50

**D. WEEKLY DISABILITY INCOME:** (Must work a minimum of 20 hours per week and participate in the Group Health Benefits Program)

YES  NO Benefit Period:  13 weeks  26 weeks  Weekly Benefit Amount \$ \_\_\_\_\_

(Benefits available from \$50 to \$250 in \$10 increments, cannot exceed 60% of employee's annual salary)

**3. EMPLOYER INFORMATION AND AUTHORIZATION**

**A.** A completed **PBT LIC Group Health Benefits Program Application** must be submitted for each eligible employee and/or physician/dentist. Each applicant (including dependents) must complete a Health History Questionnaire.

	Number of Employees per Class:		
	Class A*	Class B*	Class C*
<b>B. 1.</b> Total number of employees: _____ (including self-employed individuals)	_____	_____	_____
2. Total number of eligible employees: _____	_____	_____	_____
3. Total number participating: _____	_____	_____	_____
4. Your group's eligibility requirements _____ (i.e., hourly requirements and other conditions)	_____		

\*Class is determined by the employer based on its desire to offer different benefits to different classes of employees. Please provide a description of each class. You can use a separate sheet if needed. Please attach the sheet to the application.

**C.** Participation Requirement: N/A

**D.** Employer Contribution must be at least (N/A) of the lowest cost plan employee-only rate.

**E.** Employer Waiting Period for new employees to be covered:

30 Days  60 Days  90 Days  Other (if other state here) \_\_\_\_\_

Note: If an employer does not have any waiting period, a Health History Questionnaire and Application must be received by PBT at least 15 days prior to the requested effective date and approved by PBT. Coverage will become effective on the first day of the month coinciding with or next following the date of hire.

A group may change the Employer Waiting Period once per Plan Year, but it may not be changed to less than a 30 day waiting period.

**F.** A copy of the Employer's most recent **Wage & Tax Statement, Illinois Form UC-3** must be submitted with application.

**G.** Signature of Employer: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: \_\_\_\_\_

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

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

E-mail Address: \_\_\_\_\_

**Please return completed form to:**

**PBT Insurance Office**

200 East Randolph, 5th Floor, Chicago, IL 60601

Ph: 1-800-621-0748 • Fax: 1-312-381-2795

www.pbtinsurance.com