



Physicians' Benefits Trust Life Insurance Company

Group Health Benefits Program

Group Employer Application and Agreement

1. Practice Information

Application is submitted by: (full name of firm) _____

Address, Street, Suite#, City, State, Zip: _____

Federal Employer Identification Number: _____

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 Chicago Medical Society, Illinois State Medical Society, or Illinois State Dental Society.

Please check the appropriate box: CMS ISMS ISDS

For tax purposes, this business is considered an: Individual Proprietor Partnership Corporation Other

Will this Program replace another Group Plan currently in-force? Yes No

If 'Yes' please provide the name of the Insurer: _____

Reason for Change: _____

Date Current Coverage Will End: ___/___/___ Desired Effective Date of PBT Plan*: ___/___/___

* The effective date of 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 addition to the chosen Plan Deductible

<input type="checkbox"/> Plan A	In-Network	Out-of-Network
Hospital Co-Insurance Percentage	80%	60%
Individual Out of Pocket Maximum*	\$1,000	\$2,000
Deductible Choices:	<input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	

<input type="checkbox"/> Plan B	In-Network	Out-of-Network
Hospital Co-Insurance Percentage	80%	60%
Individual Out of Pocket Maximum*	\$5,000	\$10,000
Deductible Choices:	<input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	

<input type="checkbox"/> Plan C	In-Network	Out-of-Network
Hospital Co-Insurance Percentage	80%	60%
Individual Out of Pocket Maximum*	\$1,000	\$5,000
Deductible Choices:	<input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	

Preferred Choice Indemnity

Select Your Deductible for Option 1 or 3:	<input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000
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Select Your Deductible for Option 5:	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
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Select Your Preferred Choice Indemnity Plan Option Coverage:

<input type="checkbox"/> Option 1	Co-Insurance Percentage		Individual Out-of-Pocket Maximum*	
	In-Network	Out-Network	In-Network	Out-Network
	90%	80%	\$500	\$1,000

<input type="checkbox"/> Option 3	In-Network	Out-Network	In-Network	Out-Network
	70%	60%	\$3,750	\$5,000

<input type="checkbox"/> Option 5	In-Network	Out-Network	In-Network	Out-Network
	100%	90%	\$0	\$1,000

Preferred Health Savings Account (HSA) Qualified Plan (Deductible and out of pocket maximum subject to change annually as the federal law requires)

Individual/ Family Deductible Choices	<input type="checkbox"/> \$ 1,200 Individual	<input type="checkbox"/> \$ 2,400 Family
	<input type="checkbox"/> \$ 1,800 Individual	<input type="checkbox"/> \$ 3,600 Family
	<input type="checkbox"/> \$ 2,700 Individual	<input type="checkbox"/> \$ 5,400 Family
	<input type="checkbox"/> \$ 5,250 Individual	<input type="checkbox"/> \$ 10,500 Family

B. Term Life and AD&D

A benefit of \$10,000 Term Life and AD&D Coverage is required for each eligible employee and/or health plan applicant. Term Life 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.

C. Dental (for ISMS/CMS members only):

Yes No 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 Authorization

A. A completed **PBTLIC Group Health Benefits Employee Application** must be submitted for each eligible employee, physician, or dentist. Each applicant (including dependents) must complete a **Health History Questionnaire**.

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

* 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 and use a separate sheet if needed. Please attach the sheet to the application.

C. Participation Requirement:

D. Employer Contribution must be at least (%) of the lowest cost plan employee-only or single 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 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 UC-3 must be submitted with application.

G. Signature of designated person at Employer: _____

Print name of designated person at Employer: _____

Date: ___/___/___

Title: _____

Contact Person: _____

Phone Number: (_____) _____ Fax: (_____) _____

E-Mail Address: _____

Please return completed form to:
Return your completed application to:
PBT Insurance Office
200 East Randolph
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:

Fax 312-381-2795