



# Physicians' Benefits Trust Life Insurance Company Individual Health Benefits Program

Individual Application and Change of Coverage Supplemental Form  
For: Resurrection HealthCare Physicians

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**This form must accompany your completed Illinois Standard Health Application for Individual and Family Health Insurance Coverage. Failure to submit both forms will delay the processing of your application.**

Please print legibly or type information requested. 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**

- **New Applicants** – Please check **Section A** and complete **ALL** sections of the form and applicable sections of the Illinois Standard Health Application for Individual and Family Health Insurance Coverage form.
- **Change of Coverage** – Please check **Section A1** and all requested changes of coverage and complete applicable sections of this form. In addition, please complete applicable sections of the Illinois Standard Health Application for Individual and Family Health Insurance Coverage form.
- **Sign and date where required in Section D. Please review Section E carefully.** 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 where required in Section E.** Your signature confirms that all information provided is complete and true. It also authorizes the release of any necessary records regarding your medical history, or that of your spouse and dependents.

Section A – NEW APPLICANT

Check if a New Applicant and complete ALL sections of the form and sign/date where required. In addition, please complete applicable sections of the Illinois Standard Health Application for Individual and Family Health Insurance Coverage form.

Section A1 – CHANGE OF COVERAGE

Check all that apply and complete applicable sections of this form and sign/date where required. In addition, please complete applicable sections of the Illinois Standard Health Application for Individual and Family Health Insurance Coverage form.

- Plan Change       Add Spouse       Terminate Spouse
- Name Change       Add Dependent Child       Terminate Dependent Child
- Address Change       Continuation of Coverage       Change of Beneficiary Designation
- Other \_\_\_\_\_

Effective Date of Change \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Section B – PERSONAL INFORMATION**

Applicant Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

If Requesting a Name Change, List New Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Effective Date of Name Change \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Applicant Current Home Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

If Changing Address, List New Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Effective Date of Address Change \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone Number (\_\_\_\_\_) \_\_\_\_\_

Applicant Email Address \_\_\_\_\_

Applicant Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Applicant Gender (check one)  Male  Female

Applicants Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is the Applicant a United States (U.S.) Citizen? (Check one):  Yes  No

If 'No', please provide Visa Status \_\_\_\_\_

Date of U.S. Entry \_\_\_\_/\_\_\_\_/\_\_\_\_ Visa Expiration \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the Applicant currently insured by another health plan? (Check one):  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 Specialty \_\_\_\_\_

Applicants Desired Effective Date of PBT Coverage (Date must be the 1<sup>st</sup> or 15<sup>th</sup> of the month) \_\_\_\_/\_\_\_\_/\_\_\_\_

Termination Date of Current Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_ (Do not terminate your current coverage until you and your dependents are approved for PBT coverage).

**Section C - PLAN SELECTION**

Select the Individual Health Benefits Plan and the desired deductible amount. 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.

<input type="checkbox"/> Preferred Provider Option (PPO)		Select Deductible and Plan Option Below	
<input type="checkbox"/> Plan A	In-Network (RHC Facility)	In-Network	Out-of-Network
Facility Co-Insurance Percentage	80%	60%	50%
Physician's Co-Insurance Percentage	NA	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"/> \$5,000 <input type="checkbox"/> \$10,000		
<input type="checkbox"/> Plan B	In-Network (RHC Facility)	In-Network	Out-of-Network
Facility Co-Insurance Percentage	90%	80%	50%
Physician's Co-Insurance Percentage	NA	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"/> \$5,000 <input type="checkbox"/> \$10,000		
<input type="checkbox"/> Plan C	In-Network (RHC Facility)	In-Network	Out-of-Network
Facility Co-Insurance Percentage	100%	90%	50%
Physician's Co-Insurance Percentage	NA	100%	90%
Individual Out of Pocket Maximum	Deductible Amount	\$1,000	\$1,000
Deductible Choices:	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000		

<input type="checkbox"/> <b>Preferred Health Savings Account (HSA) Qualified Plan</b>		<b>Select Your Plan Deductible Below</b>	
(Deductible and out-of-pocket maximum subject to change annually as the federal law requires)			
	In-Network (RHC Facility)	In-Network	Out-of-Network
Facility Co-Insurance Percentage	100%	80%	60%
Physician's Co-Insurance Percentage	NA	100%	80%
Out of Pocket Maximum	Deductible Amount	For \$1,800 Deductible: \$3,150 Individual/\$6,300 Family For \$2,900 Deductible: \$3,500 Individual/\$6,800 Family	
Individual/ Family Deductible Choices	<input type="checkbox"/> \$1,800 Individual/ <input type="checkbox"/> \$3,600 Family <input type="checkbox"/> \$2,900 Individual/ <input type="checkbox"/> \$5,600 Family		

<input type="checkbox"/> <b>Alternate Health Savings Account (HSA) Qualified Plan</b>		<b>Select Your Plan Deductible Below</b>	
(Deductible and out-of-pocket maximum subject to change annually as the federal law requires)			
	In-Network (RHC Facility)	In-Network	Out-of-Network
Facility Co-Insurance Percentage	80%	60%	50%
Physician's Co-Insurance Percentage	NA	80%	50%
Out of Pocket Maximum	Deductible Amount	For \$1,800 Deductible: \$3,150 Individual/\$6,300 Family For \$2,900 Deductible: \$3,500 Individual/\$6,800 Family	
Individual/ Family Deductible Choices	<input type="checkbox"/> \$1,800 Individual/ <input type="checkbox"/> \$3,600 Family <input type="checkbox"/> \$2,900 Individual/ <input type="checkbox"/> \$5,600 Family		

**OTHER COVERAGE(S)**

**COMPREHENSIVE DENTAL PLAN** - (circle)      Yes      No  
 (The Comprehensive Dental Plan is available to ISMS/CMS members only and their dependents)

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

**SECTION D – DESIGNATION OF BENEFICIARY**

**Beneficiary of \$10,000 Term Life and AD&D Insurance for Primary Insured.**

**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 Applicant \_\_\_\_\_

Date Signed \_\_\_\_\_

**SECTION E – 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.

Signature of Applicant \_\_\_\_\_ 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Dependent (if applying and age 18 or over) \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## **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 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, 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. These forms must be postmarked within your 30 day annual renewal period for your dependent's coverage to become effective.

Health insurance benefits for individuals under age 19, are payable for pre-existing conditions. A pre-existing condition is a sickness or injury for which an individual has received medical care, advice or treatment within six months immediately preceding the effective date of coverage. These are not covered until 12 months have elapsed.

Except for the Major Medical High Deductible Plan and the Individual Health Care Program (Value Plan), the 12 month period will be reduced by the amount of prior creditable coverage, if any an individual has accrued. Prior creditable coverage is coverage without a 63 consecutive day break under another group or individual health care plan, Medicare, Medicaid and certain other state and Federal programs. Effective date of coverage means, for a regular enrollment, the first day of month following acceptance by the Administrator.

### **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; treatment of infertility for groups of less than 26 employees; 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:

200 E. Randolph

5<sup>th</sup> 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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