



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

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

For Resurrection Healthcare Physicians

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**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.**

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### 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(es) for the type of Change of Coverage(s) and complete each section of the form noted.

**PLEASE NOTE** – Sections I, J, and K require 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 I also authorizes the release of any necessary records regarding your medical history, or that of your spouse and dependents.

- **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.**

RHC-2011

**Section A** - (check applicable box)

- TYPE OF ENROLLMENT/WAIVE (DECLINE) COVERAGE** *OR*
- CHANGE OF COVERAGE**

**If Type of Enrollment/Waive (Decline) Coverage** - Check the applicable box and complete all required sections noted below.

- New Applicant - complete all sections of the form (excluding section F)
- Special Enrollee - complete all sections of the form
- Late Enrollee - complete all sections of the form (excluding section F)
- Waiver of Coverage - complete sections B, J and K

**If Change of Coverage(s)** - Check the applicable box for the type of change.

For Change(s) of Coverage, complete only the questions in Section B that are marked with an (\*). Also complete all required sections noted below.

- Plan Change – complete sections B, E, and I
- Name Change – complete sections B and I
- Address Change – complete sections B and I
- Add Spouse – complete sections B, C, D, E, F (if Special Enrollment), G, and I
- Add Dependent Child – complete same sections as above for ‘Add Spouse’
- Terminate Insured Coverage – complete sections B and I
- Terminate Spouse – complete sections B, D, and I
- Terminate Dependent Child – complete same sections as above for ‘Terminate Spouse’
- COBRA or State Continuation of Coverage – complete sections B and I
- Conversion Privilege – complete sections B and I
- Change of Beneficiary Designation – complete section B, H, and I
- Other \_\_\_\_\_

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

**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 Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_

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)? \_\_\_\_\_



	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					

**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. 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.*

<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"/> Preferred Health Savings Account (HSA) Qualified Plan		Select Your Plan Deductible Below		
<small>(Deductible and out-of-pocket maximum subject to change annually as the federal law requires)</small>				
	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>	
<small>(Deductible and out-of-pocket maximum subject to change annually as the federal law requires)</small>			
	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)**

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

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

**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 – CREDITABLE COVERAGE**

Creditable Coverage indicates whether prior insurance was in force. Check below for any individual(s) applying for the Health Plan.

Do you or your dependent(s) have prior coverage 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 PLAN(S) TO RECEIVE A REDUCTION IN YOUR PBT EXCLUSION PERIOD FOR PRE-EXISTING CONDITIONS.**

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## SECTION H – DESIGNATION OF BENEFICIARY

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

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

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## SECTION I – 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 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 \_\_\_\_\_

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

**SECTION J – WAIVER OF COVERAGE**

Name of Employee, Member or Non-Member \_\_\_\_\_  
(Last) (First) (Middle Initial)

I choose to WAIVE coverage as follows (check below) -

- Employee, Member, Non-Member       Dependent Medical       All Coverage

Reason for Waiver of Coverage (check)

- 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 \_\_\_\_\_

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

**SECTION K – 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 \_\_\_\_\_

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 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.

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 is the first day of the month coinciding with or next following receipt by the Administrator of his application for enrollment. All new insureds of a group currently covered under the PBT Group Health Benefits Program will be subject to the pre-existing condition limitation explained in this paragraph

## 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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