



**Physicians' Benefits Trust Life Insurance Company
Group Health Benefits Program
Supplement to Employer Application & Agreement Form**

Resurrection Healthcare Physicians

*Indicate N/A (Not Applicable) in any sections that do not apply to your Employer.
Please Print Clearly*

1. Name of Employer _____

Employer Address _____ Suite # _____

City _____ State _____ Zip Code _____

Name of Contact Person? _____ Title _____

Phone Number (_____) _____ Fax Number (_____) _____ Email _____

Federal Employer Tax ID # _____

2. Type of health coverage currently offered by Employer? (circle) PPO HMO HSA-Qualified
Other (specify) _____

3. Is the Employer's current health plan funding arrangement fully insured? (circle) Yes No

4. Does the Employer offer any of the program(s) referred to below? (circle) Yes No

If 'Yes', check the type of program(s) offered below -

Health Reimbursement Arrangement (HRA) Flexible Spending Account (FSA) Health Savings Account (HSA)

Will the Program be continued? (circle) Yes No

5. Has the Employer ever had group health coverage with (PBTLIC)? (circle) Yes No

If 'Yes', indicate cancellation date ____/____/____

6. Provide names and anticipated coverage termination dates for Qualified Beneficiaries currently covered under COBRA or State Continuation.

Name of Insured	Coverage Type (Individual, Couple, Employee with Children or Family)	Anticipated Termination Date	Type of Plan (circle)
			Health Dental
			Health Dental
			Health Dental

Use a separate sheet if necessary.

7. List below the names of covered Employees not actively at work due to: 1) layoff; 2) leave of absence; 3) confinement in a health care facility; 4) maternity leave; 5) disability; 6) worker’s compensation; 7) illness; 8) injury, 9) other (specify) _____

Employee Name	Age	Reason for Absence (1-9)	Plan Type (PPO, HMO, Other)	Date Last Worked	Coverage Type (Individual, Couple, Employee with Children or Family)

Use a separate sheet if necessary.

8. List below all disabled Dependent Spouses and Dependent Children who are currently covered by the Employer’s plan.

Employee Name	Age	Dependent Name	Plan Type (PPO, HMO, Other)	Date of Disability	Medicare Eligible (Y or N)

Use a separate sheet if necessary.

9. Total Number of Eligible Employees Waiving Coverage:

	Class A*	Class B*	Class C*
• Due to Spousal Coverage	_____	_____	_____
• Due to Other Coverage	_____	_____	_____

* Class is determined by the employer based on its desire to offer different benefits to different classes of employees.

Please consult your business advisors regarding potential discrimination concerns.

10. Is it the intent of the Employer to offer plans insured by other carriers concurrently with PBTLIC? (circle)
 Yes No

If 'Yes', circle type of plan(s) PPO HMO HSA-Qualified Other (specify) _____

11. MEDICAL QUESTIONNAIRE FOR EMPLOYEES AND THEIR DEPENDENTS

Please indicate Yes or No to each question below. If 'Yes' is indicated, list the number of individuals in the space provided before each question AND provide details below in Section 14.

YES	NO	Number of Individuals	
			1. Has anyone had a claim of \$10,000 or more in the past 12 months?
			2. Has anyone been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years?
			3. Has anyone been advised, diagnosed or treated by a physician in the past 5 years for:
			A. Stroke, heart, circulatory, vascular disease or disorder?
			B. Cancer, tumors, leukemia, lupus or any other systemic disease?
			C. Multiple sclerosis, paralysis?
			D. Diabetes, pancreas, growth disorder or endocrine disorder?
			E. AIDS, tested positive for HIV, immune system disorders?
			F. Kidney disorder or hepatitis/liver disorder?
			G. Nervous system or brain/seizure disorder, mental/emotional disorders, alcohol/drug/substance abuse or dependency?
			H. Organ transplant or bone marrow transplant?
			I. Other? _____
			4. Are any employees or dependents currently pregnant?
			5. Have any employees missed 7 or more consecutive work days in the past 12 months due to injury or illness?
			6. Has the Employer needed to make any ADA-required workplace modifications due to the medical condition of any current employees?

If you have answered 'Yes' to any of the questions above, please provide details below. Use an additional page if needed. We reserve the right to require a Health History Questionnaire be completed and/or a personal telephone interview take place for each individual for whom a 'Yes' answer pertains.

12. DETAILS OF MEDICAL HISTORY

Question No.	Name (optional)	Employee, Spouse or Child (circle one)	Age	Sex M/F	Condition/ Diagnosis	Treatment & Medications	Dates of Treatment	Degree of Recovery
		Employee, Spouse, Child						
		Employee, Spouse, Child						
		Employee, Spouse, Child						
		Employee, Spouse, Child						
		Employee, Spouse, Child						

13. CURRENT COVERAGE INFORMATION

The following information is needed to comply with Public Act 86-537, as amended, which regulates the Discontinuation and Replacement of Group Insurance policies. PBTLIC further reserves the right to change the quoted rates or withdraw the proposal if any of the above information changes, was omitted, or has been reported inaccurately.

What is the provision in the current insurance carrier’s group policy for **coverage during lay off, leave of absence and disability**?

What is the current insurance carrier’s extension of benefits provision for medical services in the event of employer group cancellation?

Has the Employer’s **medical coverage ever been cancelled**, or applications for coverage been declined or withdrawn? (circle)
 Yes No

If ‘Yes’, explain _____

If additional space is needed for any of the above, please attach a separate sheet with the required information.

14. HISTORICAL COVERAGE INFORMATION

Provide the information requested below for all insurance companies and/or alternative funding arrangements in effect during the current and preceding four years. A separate sheet is necessary to provide information on the preceding four years if the premium rates, plan types, and/or benefit levels have changed.

Insurance Company Name		Coverage Period
Current:		
Current Premium Rates for:	Plan Type (circle)	Benefit Levels (Deductible and Coinsurance)
Employee	HMO PPO Other (specify): _____	Deductible: _____ Coinsurance: _____
Employee and Spouse	HMO PPO Other (specify): _____	Deductible: _____ Coinsurance: _____
Employee and Children	HMO PPO Other (specify): _____	Deductible: _____ Coinsurance: _____
Family	HMO PPO Other (specify): _____	Deductible: _____ Coinsurance: _____
Total Monthly Health Premium		

15. AUTHORIZATION

To the best of our knowledge and belief, all information on this application is true and complete. PBTLIC may rely upon this information in deciding whether to provide coverage. If the application is not complete, PBTLIC reserves the right to reject it. We understand that coverage will not be effective prior to the effective date determined by PBTLIC.

Employer Representative's Signature and Title

Date

Print Employer Representative's Name and Title

Date

Producer Signature

Date

Return your completed application to:

200 E. 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 1-312-381-2795

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