Physicians' Benefits Trust Life Insurance Company

Small Group Health & Dental Insurance Program
Application Supplement to Illinois Standard Health Employee Application
For groups of 2-50 employees

To be completed for New Enrollments, Late Enrollments, Special Enrollments and Waivers of Coverage.

This application accompanies your completed *Illinois Standard Health Employee Application for Small Employers*. In order to avoid processing delays, PBT must receive both forms with information PRINTED clearly and completely, including signatures where requested. The description of different types of Enrollments and Waiver of Coverage instructions are noted below. Once you determine your type of Enrollment or Waiver of Coverage, check the appropriate box in Section A and complete the required sections noted there. **THE EMPLOYER MUST COMPLETE THE TOP OF PAGE 2 WHERE REQUESTED.**

PBT requires that Physicians, Dentists and Employees must be scheduled to work 20 or more hours per week to be eligible for a PBT Health Plan.

The use of "Employee" in this application includes Physicians and Dentists.

- **New Enrollment** is an Employee who is newly eligible to enroll because the Employer's eligibility requirements have been satisfied. The employee's eligible dependents are able to enroll at the same time. Coverage will become effective on the first day of the month following the Employer's waiting period or probationary period, if any. Both completed Applications must be postmarked to the Administrator within 30 days of the coverage eligibility date. If received after this 30 day period, an eligible employee and their dependents will be considered a Late Enrollee. (Review the information outlined below for Late Enrollees and the Important Information section at the end of this application.) Dependents can be covered only if they enroll when the employee enrolls, unless they qualify as a Special Enrollee. Information on Special Enrollment is noted below.
- **Special Enrollment Qualification** is 1) An applicant (Eligible Employee, Spouse, Child(ren)) who initially declined coverage because they had other health coverage and now want to apply for PBT coverage because their other coverage has been lost; or 2) an Employee gains a new Spouse and/or Child(ren) through marriage, civil union, birth, adoption or placement for adoption. Special Enrollment must be submitted within 30 days of the qualifying event or 60 days for a Medicaid/CHIP Qualifying Event.
- **Late Enrollment** is an applicant (Eligible Employee, Spouse, Child(ren)) who did not enroll when first eligible and does not meet the conditions of being a Special Enrollee. A Late Enrollee is eligible for coverage the first day of the month after satisfaction of a 180-day waiting period following the date PBT receives the Application.
  Annual Enrollment for Certain Dependents occurs on the renewal date of your Employer's Health Plan. Certain Dependents up to age 26 and Military Veterans up to age 30 may enroll for coverage. Please review the "Important Information" section on the last page of this Application Supplement as to dependent eligibility.
- **Waiver of Coverage** is an Eligible Employee, Spouse, Child(ren) age 18 or over electing to waive participation in the Group Health Insurance Plan.

Section G, Authorization and Release of Information requires your signature as confirmation 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 child(ren). If your spouse and/or any child(ren) age 18 or over are applying for coverage, they must also sign and date where required in this section.

Mandatory $10,000 Term Life and Accidental Death and Dismemberment (AD&D) Benefit for Primary Insured - To designate a beneficiary for the mandatory $10,000 Term Life and AD&D benefit, see section H on the *Illinois Standard Health Employee Application for Small Employers*. 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. The beneficiary designation with the latest effective date takes precedence.

Employer Must Complete This Section

The employee enrolling in the PBT Group Insurance Program has met all eligibility requirements for the PBT Plan.

Employee Name: _____
Authorized Person (Print Name): _____
Authorized Person Signature: _____
Date: _____/_____/_____

SECTION A - TYPE OF ENROLLMENT OR WAIVER OF COVERAGE

Check the appropriate box below for type of requested enrollment or for waiver of coverage. Then complete the required sections noted below. If coverage is being requested, provide the requested effective date below.

Requested Effective Date of Coverage _____/_____/_____

- ❑ **New Enrollment** – Employee, Spouse, Child(ren) - Complete all sections of Illinois Standard Health Employee Application for Small Employers (except for Section C, Waiver of Coverage). Complete all sections of this form (except for Section E, Special Enrollment Qualification and Section F, Waiver of Coverage)
- ❑ **Special Enrollment** – Employee, Spouse, Child(ren) – Complete all sections of the Illinois Standard Health Employee Application for Small Employers (except for Section C, Waiver of Coverage). Complete all sections of this form (except for Section F, Waiver of Coverage). **The Illinois Standard Health Employee Application for Small Employers is <u>not</u> required for Newborn(s) if this application is submitted within 30 days of birth.**
- ❑ **Late Enrollment** – Employee, Spouse, Child(ren) - Complete the same sections as for a New Enrollment.
- ❑ **Waiver of Coverage** – Employee, Spouse, Child(ren) – Note, signatures for Spouse and/or Child(ren) age 18 or over are required if waiving coverage in Section F, Waiver of Coverage. The Employee also needs to sign this section. *Read and sign Section C Waiver of Coverage and Section I Acknowledgement & Signature on the Illinois Standard Health Employee Application for Small Employers.*

SECTION B - EMPLOYEE INFORMATION (Complete only if applying for coverage)

Employee Name (Last, First, MI) _____Phone # (_____) _____-_____

Are you a legal resident of the U.S.? ❑ Yes ❑ No If "No", provide Visa status _____ Visa expiration date ____/____/____

Marital Status (check one) ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Your Primary Physician's Name _____Phone # (_____) _____-_____

If you are a Physician or Dentist, what is your Membership Affiliation? (Check one)

❑ Illinois State Medical Society ❑ Illinois State Dental Society What is your Specialty? _____

SECTION C - SPOUSE AND CHILD(REN) INFORMATION (Complete only if applying for coverage)

If adding a Newborn ***only***, do not complete this section. Instead, complete Section E, Special Enrollment Qualification. Attach a separate sheet of paper if additional space is needed.

Spouse Name (Last, First, MI) _____

Is Spouse a legal resident of the U.S.? ❑ Yes ❑ No If "No", provide Visa status _____ Visa Expiration Date ____/____/____

Child Name (Last, First, MI) _____ Child Name (Last, First, MI) _____

Child Name (Last, First, MI) _____ Child Name (Last, First, MI) _____

Are Child(ren) legal resident(s) of the U.S.? ❑ Yes ❑ No If "No", provide Visa status _____ Visa Expiration Date ____/___/____

Spouse Primary Physician _____ Phone # (_____) _____

Child(ren) Primary Physician(s) _____Phone# (_____)_____

Child(ren) Primary Physician(s) _____Phone# (_____)_____

SECTION D - PLAN SELECTION

After reviewing your employer's PBT health and dental plan(s) and deductible option(s), check the box next to your chosen plan choice AND circle the deductible amount. All family members must be enrolled in the same plan and deductible.

❑ **Dental Plan**
Dental coverage is only available to ISMS and CMS members, their dependents and employees.

Deductible Options (circle one): $25 $50

❑ **PPO Health Plan Option A** ❑ **PPO Plan Option B** ❑ **PPO Plan Option C**

Deductible Options (circle one): $150 $300 $500 $750 $1,000 $2,000 $3,000
The Deductible amounts are per Individual. The Family Deductible is 2 times the Individual deductible amount; the $150 or $300 deductibles are 3 times the Individual deductible amount.

❑ **Preferred Choice Indemnity Health Plan Option 1** ❑ **Preferred Choice Indemnity Plan Option 3**

Deductible Options (circle one) : $150 $300 $500 $750 $1,000 $2,000 $3,000

❑ **Preferred Choice Indemnity Health Plan Option 5**

Deductible Options (circle one) : $2,500 $5,000
The Deductible amounts are per Individual. The Family Deductible is 2 times the Individual deductible amount; the $150 or $300 deductibles are 3 times the Individual deductible amount.

❑ **Health Savings Account (HSA) Qualified Health Plan**
Deductible and out of pocket maximums are subject to change annually as federal law requires.

Deductible Options (circle one): $1,250 Individual/$2,500 Family $1,800 Individual/$3,600 Family
$2,700 Individual/$5,400 Family $5,250 Individual/$10,500 Family

SECTION E - SPECIAL ENROLLMENT QUALIFICATION (FOR HEALTH PLAN)

If current coverage was lost, check the reason for the Qualifying Event in #1 and provide the date of the Loss of Coverage.

If a Dependent was gained due to a Qualifying Event stated in #2, check the type of Dependent.
Please Note: If a Dependent was gained due to an Adoption, proof of the Adoption is required. Attach proof to this application.

1. Loss of Coverage:
   ❑ Legal Separation or Divorce ❑ Death ❑ Reduction in Hours of Employment ❑ Termination of Employment
   ❑ Failure to pay premiums when due? ❑ Yes ❑ No For Cause? ❑ Yes ❑ No
   ❑ Termination of Employer Contributions ❑ Exhaustion of COBRA or State Continuation coverage
   ❑ MEDICAID/CHIP Ineligibility/Financial Assistance
   ❑ Other (describe) _____

   Date Loss of Coverage _____/_____/_____

2. Gained a Dependent:
   Gained a Spouse: ❑ Marriage/Civil Union Date _____/_____/_____
   Gained Child(ren): ❑ Placement for Adoption ❑ Adoption *(Attach proof*) Date _____/_____/_____
   ❑ Newborn Date of Birth _____/_____/_____ Name of Newborn: _____
   Gender of Newborn: ❑ Male ❑ Female SSN# of Newborn: (if available) _____-_____-_____

SECTION F - WAIVER OF HEALTH COVERAGE

The undersigned does hereby acknowledge receipt of the Notice of Special Enrollment Rights in the Waiver of Coverage section in the *Illinois Standard Health Employee Application for Small Employers*. Complete the section below for person(s) waiving coverage and sign where signature(s) are required for the Employee, Spouse and/or Child(ren) if age 18 or over waiving coverage. Attach a separate sheet of paper if additional space is needed.

Print Name of Employee _____ Print Name of Spouse _____

Print Name of Child(ren) _____

Signature of Employee _____Date _____

Signature of Spouse _____ Date_____

Signature of Child(ren) (if age 18 or over) _____ Date_____

SECTION G - AUTHORIZATION AND RELEASE OF INFORMATION

By signing this form, 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 rescinded. I further understand that there are pre-existing exclusions and/or limitations in the Certificate of Coverage which may apply to me, my spouse and my dependents.

I also 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 Employee _____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_____

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 Annual Enrollment of Certain Dependents (Illinois Age Expansion)
During the annual renewal of your group employer plan, 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 and is 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. To be added, eligible dependents must have been previously insured for a period of 90 continuous days and have not been uninsured for more than 63 days prior to the enrollment.

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 you wish to add an eligible dependent, please complete this application and *Illinois Standard Health Employee Application for Small Employers* and return both to us. This form must be postmarked within your 30 day annual renewal period for your dependent's coverage to become effective.

Pre-existing conditions are payable for health insurance benefits if a dependent is under age 19. If age 19 or older, a pre-existing condition coverage limitation applies. 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 of coverage 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 an application for enrollment. All new enrollees of a group currently covered under the PBT Group Health Benefits Program will be subject to the pre-existing condition limitation explained in the prior paragraph.

Return your completed application to:
PBT Administrator, 200 E. Randolph, 5th Floor, Chicago, IL 60601
If you have any questions:
Customer Service can be emailed at PBT@aon.com
Physician office 1-800-621-0748
Dentist office 1-866- 898-0926

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