Physicians' Benefits Trust Life Insurance Company

Small Group Health Insurance Program
Insured Change Form

Section A – CHECK TYPE OF CHANGE(S)

❑ Plan Change
❑ Name Change
❑ Address Change
❑ Terminate Employee
❑ Terminate Spouse/Domestic Partner
(Contact your Employer for additional required forms if terminating coverage for a Domestic Partner)
❑ Terminate Child(ren) – List Names of Children Terminating Coverage: _____, _____, _____, _____
❑ Other _____

❑ Conversion Privilege (Preferred Choice Indemnity Plan 3 $3,000 deductible)
❑ Change of Beneficiary Designation for Term Life and AD&D Plan
❑ Election of COBRA
❑ Election of Illinois Continuation

Requested Effective Date of Change and/or Termination _____/_____/_____

Section B – PERSONAL INFORMATION

Employer Name _____PBT Group#_____

Employer Address (Street, City, State, Zip) _____ Phone # (_____)_____- _____

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

Current Employee Home Address (Street, City, State, Zip) _____

If Requesting a Name Change, List New Name (Last, First, MI) _____

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

If Terminating Coverage for Spouse and/or Child(ren), List Names: _____
If additional space is required, attach a separate sheet of paper and sign and date.

Section C - PLAN CHANGE SELECTION

After reviewing your Employer plan(s) and deductible option(s), check the box next to your chosen health plan choice AND circle the deductible amount. All family members must be enrolled in the same plan and deductible. **If you are a group of 2-50 employees and upgrading your plan, the *Illinois Standard Health Employee Application for Small Employers* is also required to be completed with this form.**

Dental Plan: **Deductible Options** ❑ $25 ❑ $50
Dental coverage is only available to ISMS and CMS members, their dependents and employees.

PBT PPO Health Plan Options: ❑ **Option A** ❑ **Option B** ❑ **Option C**
Deductible Options: $150 $300 $500 $750 $1,000 $2,000 $3,000
The Deductible Amounts are Per Individual. The Family Deductible is 3 times the Individual amount if the $150 or $300 deductibles are chosen, or 2 times the Individual amount if the other deductibles are chosen.

PBT Preferred Choice Indemnity Health Plan Options: {❑ **Option 1** ❑ **Option 3** **See below for Option 5**
Deductible Options: $150 $300 $500 $750 $1,000 $2,000 $3,000
The Deductible Amounts are Per Individual. The Family Deductible is 3 times the Individual amount if the $150 or $300 deductibles are chosen, or 2 times the Individual amount if the other deductibles are chosen.
❑ **Option 5** **Deductible Options:** $2,500 $5,000

❑ **PBT Health Savings Account (HSA) Qualified Health Plan:**

Deductible and out of pocket maximum subject to change annually as the federal law requires

Deductible Options: $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 D – CHANGE OF BENEFICIARY DESIGNATION

This is regarding $10,000 Term Life and Accidental Death & Dismemberment 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. The beneficiary designation with the latest effective date takes precedence.

Name of New Beneficiary _____Relationship to Primary Insured_____

New Beneficiary Address (City, State, Zip) _____Phone # (_____) _____-_____

Signature of Applicant _____Date _____/_____/_____

Section E – AUTHORIZATION AND RELEASE OF INFORMATION

I agree that to the best of my knowledge and belief all statements and answers to the questions in this Change 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 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 or my dependents.

By signing this form I authorize Physicians' Benefits Trust Life Insurance Company to gather, if necessary, 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 _____Date_____ /_____ /_____

Signature of Dependent (age 18 or over) _____ _____Date_____ /_____ /_____

Signature of Dependent (age 18 or over) _____ _____Date_____ /_____ /_____

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
Physicians and their office staff please call 1-800-621-0748
Dentists and their office staff please call 1-866-898-0926

Sponsored by:

PBTLIC is a wholly owned subsidiary of:

ISMIE Mutual Insurance Company