Selectpac

Benefits proposal for groups with 3 to 35 plan members

Proposal

Selectpac Proposal

Advisor Name ______________________________

Advisor Company ______________________ Advisor Email ______________________

Advisor Phone Number ______________________ Advisor Fax Number ______________________

Advisor Address ______________________________

Client Name ______________________ Client Postal Code ______________________

Section A

1. What is the exact nature of your business? ______________________
2. How many years has your company been in business? ______________________
3. Are there any subsidiaries or affiliates to be covered? ☐ Yes ☐ No

   If "Yes", provide name(s): ______________________
4. To be eligible, employees must work at least 20 hours per week (24 if group of 3 or 4). Are all eligible employees participating in this plan? ☐ Yes ☐ No
5. In the last 3 years, have any employees been absent from work due to disability or other leaves of absence?
   ☐ Yes ☐ No If "Yes", please explain:

   ____
6. Are your employees covered by Workers' Compensation? ☐ Yes ☐ No

   If no, which employees are not covered and why?

   ____
7. Are any of your employees seasonal? ☐ Yes ☐ No (A seasonal employee must work at least 9 full months over a 12-month period. If "Yes", indicate on the Employee Data sheet.)
8. What percentage of your employees are related? ________% (If applicable, indicate on the Employee Data sheet.)
9. Are there any independent contractors seeking coverage? ☐ Yes ☐ No (If "Yes", indicate on the Employee Data sheet.)
10. Are any employees regularly working or travelling outside Canada? ☐ Yes ☐ No
11. Are you, the employer, willing to contribute at least 25% toward the cost of this plan? ☐ Yes ☐ No
12. Will this plan include employees age 65 or over that live and work in the province of Quebec and have opted out of RAMQ coverage? ☐ Yes ☐ No

Section B

What is the most important aspect of a group benefit plan to you?

☐ Price ☐ Service ☐ Financial stability of insurance company ☐ Technology/ease of use

What areas of protection are most significant to you and your employees?

☐ Death ☐ Disability ☐ Healthcare ☐ Dentalcare ☐ Confidential counselling

☐ HCSA ☐ Other ______________________

Section C (complete only if group benefits currently exist)

Who is your current insurance carrier?* ______________________

When did your coverage begin with your current insurance carrier? ______________________

Have you been with any other insurance carriers in the last five years? ______________________

What is the primary reason for requesting a proposal? ______________________

**If available, please include benefit plan booklet, rate history and claims experience.*

Employee Data Listing for: ______________________________

Coverage: Type of coverage required,
(S) Single
(F) Family
(W) Waive due to spousal coverage

Salary: Please provide approximate yearly salary if you would like Long- or Short-Term Disability coverage, or Life as a function of earnings.

Class: You can have more than one group or class of employees with different coverage limits, e.g. owners, management, sales, other employees, etc.

	Employee Name	Date of Birth	Date of Hire	Gender	Coverage	Occupation	Salary	Class	Prov
	Doe, John	*2-Mar-54*	*9-Aug-98*	*M / F*		*Project Manager*		*A*	*ON*
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S - Single
F - Family (any employees who have dependant(s) – spouse, common law spouse, same sex spouse, dependent children)
W - Waive (employees may refuse Health / Dental coverage if they have similar coverage through their spouse)

PLAN DESIGN (Refer to the back cover)

Company Name: **Advisor:**

Plan Design #1 Or Class 1	Plan Design #2 Or Class 2
☐ Quote based on industry benchmark	☐ Quote based on industry benchmark
Life Insurance & AD&D Salary-based or Flat Max Other	**Life Insurance & AD&D** Salary-based or Flat Max Other
Dependant Life (Spouse/Child)	**Dependant Life** (Spouse/Child)
Critical Illness Salary-Based or Flat Max Other	**Critical Illness** Salary-Based or Flat Max Other
Dependant CI (Spouse/Child)	**Dependant CI** (Spouse/Child)
STD Benefit Coverage Benefit Period Waiting Period Accident Waiting Period Illness ☐ First-Day Hospital ☐ Taxable Max **LTD** Benefit Coverage Waiting Period Benefit Period COLA ☐ Taxable Max	**STD** Benefit Coverage Benefit Period Waiting Period Accident Waiting Period Illness ☐ First Day-Hospital ☐ Taxable Max **LTD** Benefit Coverage Waiting Period Benefit Period COLA ☐ Taxable Max
Healthcare Coinsurance Deductible **Paramedical** Max Paramedical Coins Per Visit max **Vision** ☐ Eye Exams Only Coverage (glasses, contacts) Hospital Private Duty Nursing Diagnostic Services	**Healthcare** Coinsurance Deductible **Paramedical** Max Paramedical Coins Per Visit max **Vision** ☐ Eye Exams Only Coverage (glasses, contacts) Hospital Private Duty Nursing Diagnostic Services
Prescription Drugs Reimbursement Coinsurance Maximum Drug Type Deductible Dispensing Limit ☐ Smoking Cessation Included ☐ Vaccines included Formulary Pharmacy Network Value Plan ☐ Therapeutic Class Pricing	**Prescription Drugs** Reimbursement Coinsurance Maximum Drug Type Deductible Dispensing Limit ☐ Smoking Cessation Included ☐ Vaccines included Formulary Pharmacy Network Value Plan ☐ Therapeutic Class Pricing
Dentalcare Deductible Routine Coinsurance Routine Max Major Coinsurance Major Max Orthodontic Coinsurance* Orthodontic Max* Recall Exams Scaling Units *Minimum # of employees required	**Dentalcare** Deductible Routine Coinsurance Routine Max Major Coinsurance Major Max Orthodontic Coinsurance* Orthodontic Max* Recall Exams Scaling Units *Minimum # of employees required
Add EAP	**Add EAP**
☐ Cost Plus ☐ Health SolutionsPlus ☐ Medical Reimbursement Plan	☐ Cost Plus ☐ Health SolutionsPlus ☐ Medical Reimbursement Plan

Comments:

PLAN DESIGN

Plans for **three to 35** plan members must include:

- Employee Life
- At least one of the following:
  - Short-term Disability (STD)
  - Long-term Disability (LTD)
  - Dentalcare
  - Healthcare
  - Critical Illness

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