Request for Quotation

Date (dd/mmm/yyyy)

Company Profile

Full Legal Business Name	City /Town
Province	Postal Code
SIC/Business Description	Length of time in business (minimum 6 months)
Current number of full time employees	Number of employees a year ago
Number of employees related to owner	Any employees involved in hazardous occupations? ☐ Yes ☐ No
Any employees not actively at work? ☐ Yes ☐ No	If yes, provide details:
Are all employees covered by Workers' Compensation? ☐ Yes ☐ No -- Is the group currently covered by an EP3? Are there any excluded certificates? (Y, N, TBD)	If no, who is not covered: -- If yes, is a copy of the prior carrier EP3 statement included?

Advisor Profile

Plan Advisor Name	Email Address
Business Address	Phone Fax
Commission Schedule ☐ Flat ____________% ☐ Graded (standard) ☐ 15-10 graded ☐ Other (please attach)	Mode of Delivery ☐ Email ☐ Hard copy

Existing Group Coverage

Does the group currently have coverage? ☐ Yes ☐ No	If yes, name of carrier:
Number of years with current carrier	

Proposed Plan

Proposed Effective Date	First Renewal ☐ 16 month
Percentage of premium paid by employer (minimum of 50%)	Termination Age ☐ 65 ☐ 70 ☐ 65/75 ☐ 70/75
Class A Description:	Class B Description (if applicable)

Request for Quotation

Plan Design – Class A

☑ **Life/AD&D** (minimum $10,000)

☐ Flat $ ______________ or ☐ Multiple of Salary: ________________________

Maximum: ________________________________

☐ **Dependent Life**

Spouse $ __________________________ Child Eligibility: ☐ Birth ☐ 14 days

Child – ½ of spousal amount

☐ **Long Term Disability**

Benefit %:

☐ Flat ____________% or ☐ Graded _____________________________________

Maximum: $ ____________________________ Elimination Period: ☐ 105 days ☐ 119 days ☐ 179 days

Benefit Period: ☐ 2 yrs ☐ 5 yrs ☐ to age 65 Definition of Disability: ☐ Any occ ☐ 2 year own occ

Taxability: ☐ Taxable ☐ Non-taxable COLA %: ☐ None ☐ 3% ☐ 4% ☐ 5%

☐ **Short Term Disability**

Benefit %: __________________ Maximum: $ __________________

Elimination Period (accident/sickness):
☐ 0/3 days ☐ 0/7 days ☐ 14/14 days

Benefit Period:
☐ 15 weeks ☐ 17 weeks ☐ 26 weeks

Occupational Coverage:
☐ Yes ☐ No

Taxability:
☐ Taxable ☐ Non-taxable

1st day hospital
☐ Yes ☐ No

☑ **Extended Health Care**

EHC Deductible (excl. Drug Card):
☐ 0/0 ☐ 25/25 ☐ 25/50 ☐ 50/50 ☐ 50/100

Other: ______________

EHC Coinsurance (excluding drugs, hospital and vision):
☐ 80% ☐ 90% ☐ 100% ☐ Other _____%

Drug Coverage

☐ Reimbursement
☐ Drug Card - Pay Direct Drugs
☐ Deferred Drugs

Drug Coinsurance:
☐ 80% ☐ 90% ☐ 100% ☐ Other _____%

Drug Card/Deferred Drugs:
☐ Per Prescription Deductible: $ ______
☐ Deductible equals dispensing fee
☐ Dispensing fee cap $ ___________

Drug Options:
☐ Prescription
☐ Prescription with exclusions

Drug Plan Basis:
☐ Mandatory Generic
☐ Generic
☐ Brand

Drug Maximum:
☐ $3,000 ☐ $5,000 ☐ $10,000 ☐ Unlimited

Paramedical Coverage

☐ Basic
☐ Standard
☐ Standard Plus
☐ Enhanced
☐ Enhanced Plus

Type of maximum: ☐ per practitioner ☐ combined

Calendar year maximum:
☐ $200 ☐ $300 ☐ $350 ☐ $400
☐ $450 ☐ $500 ☐ $750 ☐ $1000

Per Visit maximum $ __________________

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Plan Design – Class A

EHC - Other Services

☐ Optional Trip Cancellation Insurance ($1.25 per Plan Member per month)

☐ Hospital
  ☐ semi-private
☐ Vision
  ☐ $ ___________Maximum (every 2 calendar years) or ☐ eye exam only
☐ Surgical stockings
☐ Orthopaedic shoes and orthotics

☐ **Dental Care**

Deductible:
☐ 0/0 ☐ 25/25 ☐ 25/50 ☐ 50/100 ☐ 100/100 ☐ Other ________________

Basic

Coinsurance:
☐ 80% ☐ 90% ☐ 100% ☐ Other ______%

Maximum:
☐ 500 ☐ 1000 ☐ 1500 ☐ 2000 ☐ 3000
☐ Unlimited ☐ Combined with Major

Recall Exam:
☐ 2/year ☐ 6 months ☐ 9 months ☐ 12 months

Flouride treatment:
☐ Child only ☐ Adult and child

☐ **Major Restorative** *(minimum 3 lives)*

Coinsurance:
☐ 50% ☐ 60% ☐ 70% ☐ 80%

Maximum:
☐ 500 ☐ 1000 ☐ 1500 ☐ 2000 ☐ 3000
☐ Combined with Basic

☐ **Orthodontia** (*minimum 5 lives*)

Coinsurance: 50%

Maximum (lifetime):
☐ 1000 ☐ 1500 ☐ 3000

Fee Guide:
☐ Current ☐ Current – 1 yr ☐ Current – 2 yrs

Specialist fees: ☐ Yes ☐ No

Additional Services

☐ Health Care Spending Account (HCSA)
HCSA commission: _________________%

☐ Personal Benefits (member-billed Life Insurance and/or Critical Illness)

☐ **Deviations for Class B**

☐ **Additional Plan Design Options/Notes**

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Employee Data

	Name	Sex	Age or Date of Birth (mmm/yyyy)	Hire Date (mmm/yyyy)	Occupation	Prov	Coverage (S,F,W) EHC	Dental	Annual Salary	Hours per week
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2										
3										
4										
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