Request for Quotation

Date (dd/mmm/yyyy) _____

You may complete this form electronically. Use the 'tab' key to move through the form or you may click on each field.
Remember to save a copy of the completed form before sending it for quotation.
To complete a hard copy, simply print the form.

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	If no, who is not covered:

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 ☐ 12 month ☐ 16 month ☐ Other _____
Percentage of premium paid by employer (minimum of 50%)	Termination Age ☐ 65 ☐ 70 ☐ 65/85 ☐ 70/85
Class A Description	Class B Description (if applicable)

NEXT

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 - 1/2 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:
☐ 5 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 (Quebec only)

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:
☐ Brand
☐ Generic
☐ Formulary

Drug Maximum:
☐ $1,000 ☐ $5,000
☐ $10,000 ☐ Unlimited

Paramedical Coverage
☐ Basic
☐ Standard
☐ Enhanced

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

Other Services
☐ Hospital
☐ semi-private

☐ Vision
☐ $ _____ Maximum (every 2 calendar years) or ☐ eye exam only

PREVIOUS NEXT

Plan Design - Class A

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

☐ **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

Deviations for Class B

Additional Plan Design Options/Notes

PREVIOUS NEXT

Employee Data

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