

REQUEST TO QUOTE

Employer				Date Submitted					
Address				Province					
Is there a present Insurer?		<input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, complete information)		Current Insurer		Next Renewal Date			
Note: The following information is required at time of quote: <input type="checkbox"/> Current Booklet(s) or Benefit Summary – All Classes <input type="checkbox"/> Insurer Renewal Reports (2 years) <input type="checkbox"/> Current Billing(s) <input type="checkbox"/> Claims Experience (2 years) <input type="checkbox"/> Rate History (2 years)									
Nature of business:				How long in business?					
Any affiliates or subsidiaries to be included?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Are all eligible employees participating in this plan?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Do all employees work at least 24 hours per week?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Are all employees covered by Workers' Compensation?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Are any of the employees seasonal?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Are any independent contractors seeking coverage?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
What percentage of the employees are related?						%			
At the present time, are any employees absent from work due to disability, maternity / parental leave or other leave of absence?				<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Classification(s)		Class 1:			Class 2:				
Life Insurance and AD&D		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Benefit:	Flat \$ or X Annual to max \$			Flat \$ or X Annual to max \$					
Termination Age:	<input type="checkbox"/> 65 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 75 <input type="checkbox"/> 80			<input type="checkbox"/> 65 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 75 <input type="checkbox"/> 80					
Dependent Life		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Benefit:	<input type="checkbox"/> \$5,000/\$2,500 <input type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> \$20,000/\$10,000 <input type="checkbox"/> Other _____			<input type="checkbox"/> \$5,000/\$2,500 <input type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> \$20,000/\$10,000 <input type="checkbox"/> Other _____					
Critical Illness		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Spouse Covered:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Child Covered	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse covered		<input type="checkbox"/> Yes <input type="checkbox"/> No	Child covered	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Amount:		\$			\$				
Termination Age:		<input type="checkbox"/> 65 <input type="checkbox"/> 70			<input type="checkbox"/> 65 <input type="checkbox"/> 70				
Short-Term Disability		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Benefit:	% To a maximum of \$ /week			% To a maximum of \$ /week					
Plan Design		<input type="checkbox"/> 1-8-16 <input type="checkbox"/> 1-8-17 <input type="checkbox"/> 1-8-26 <input type="checkbox"/> 8-8-15 <input type="checkbox"/> 8-8-16 <input type="checkbox"/> 8-8-25			<input type="checkbox"/> 1-8-16 <input type="checkbox"/> 1-8-17 <input type="checkbox"/> 1-8-26 <input type="checkbox"/> 8-8-15 <input type="checkbox"/> 8-8-16 <input type="checkbox"/> 8-8-25				
Taxable:		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Termination Age:		<input type="checkbox"/> 65 <input type="checkbox"/> 70			<input type="checkbox"/> 65 <input type="checkbox"/> 70				

Long-Term Disability		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Benefit:	% To a maximum of \$ /mo.			% To a maximum of \$ /mo.			
Graded	% Of the first \$ /mo.			% Of the first \$ /mo.			
plus	% Of the next \$ /mo.			% Of the next \$ /mo.			
plus	% Of the balance to max of \$ /mo.			% Of the balance to max of \$ /mo.			
Waiting Period	<input type="checkbox"/> 90	<input type="checkbox"/> 112	<input type="checkbox"/> 120	<input type="checkbox"/> 180	<input type="checkbox"/> 365	<input type="checkbox"/> 90 <input type="checkbox"/> 112 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> 365	
Duration of Benefit	<input type="checkbox"/> 2 years		<input type="checkbox"/> 5 years	<input type="checkbox"/> to age 65/70			
Survivor Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months		
COLA	<input type="checkbox"/> Yes <input type="checkbox"/> No	% %			<input type="checkbox"/> Yes <input type="checkbox"/> No	% %	
Taxable:	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Termination Age:	<input type="checkbox"/> 65 <input type="checkbox"/> 70			<input type="checkbox"/> 65 <input type="checkbox"/> 70			
Extended Health Care		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Deductible	<input type="checkbox"/> No Deductible		<input type="checkbox"/> \$ Single	\$ Family		<input type="checkbox"/> No Deductible <input type="checkbox"/> \$ Single \$ Family	
Co-Ins.	Drugs	% Other Expenses		% Other Expenses		Drugs % Other Expenses %	
Equal to Dispensing Fee Deductible			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Per Script Deductible	\$ Dispensing Fee per prescription		\$ Dispensing Fee per prescription				
Per Script Deductible	Reimburse 100% dispensing fee up to \$		Reimburse 100% dispensing fee up to \$				
Paramedical Services	% Co-Ins. \$		Per practitioner		% Co-Ins. \$ Per practitioner		
Vision Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	% Co-Ins.			<input type="checkbox"/> Yes <input type="checkbox"/> No	% Co-Ins.	
Maximum per 24 months		\$			Maximum per 24 months \$		
Termination Age:	<input type="checkbox"/> 65	<input type="checkbox"/> 70	<input type="checkbox"/> 71	<input type="checkbox"/> 75	<input type="checkbox"/> 80	<input type="checkbox"/> 65 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 75 <input type="checkbox"/> 80	
Dental Care		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Deductible	<input type="checkbox"/> No Deductible		<input type="checkbox"/> \$ Single	\$ Family		<input type="checkbox"/> No Deductible <input type="checkbox"/> \$ Single \$ Family	
Basic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		% Co-Ins.		<input type="checkbox"/> Yes <input type="checkbox"/> No % Co-Ins.		
Maximum per calendar year		\$			Maximum per calendar year \$		
Recall Frequency	<input type="checkbox"/> 6 mos.		<input type="checkbox"/> 9 mos.	<input type="checkbox"/> 12 mos.			
Major Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		% Co-Ins.		<input type="checkbox"/> Yes <input type="checkbox"/> No % Co-Ins.		
Maximum per calendar year		<input type="checkbox"/> Combined with Basic			Maximum per calendar year <input type="checkbox"/> Combined with Basic		
Or <input type="checkbox"/> \$			Or <input type="checkbox"/> \$				
Orthodontic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		% Co-Ins.		<input type="checkbox"/> Yes <input type="checkbox"/> No % Co-Ins.		
Maximum per lifetime		\$			Maximum per lifetime \$		
Termination Age:	<input type="checkbox"/> 65	<input type="checkbox"/> 70	<input type="checkbox"/> 71	<input type="checkbox"/> 75	<input type="checkbox"/> 80	<input type="checkbox"/> 65 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 75 <input type="checkbox"/> 80	

Employee Assistance Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit	<input type="checkbox"/> Full Program <input type="checkbox"/> Telephonic	<input type="checkbox"/> Full Program <input type="checkbox"/> Telephonic
2nd Medical Opinion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elder Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIMS EXPERIENCE

Carrier				
Policy Year				
Benefit:	Paid Premium	Paid Claims	Paid Premium	Paid Claims
Life				
AD&D				
Critical Illness				
Short-Term Disability				
Long-Term Disability				
Extended Health Care				
Dental Care				

Claim(s) Details:

RATE HISTORY

Carrier												
Policy Year												
Benefit:	Rate(s)		Rate(s)									
Life												
AD&D												
Critical Illness												
Short-Term Disability												
Long-Term Disability												
Extended Health Care	\$		Single	\$		Family	\$		Single	\$		Family
Dental Care	\$		Single	\$		Family	\$		Single	\$		Family

Alternate Plan Design Options: