

# 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							
<b>Note:</b> The following information is required at time of quote: <input type="checkbox"/> Current Booklet(s) or Benefit Summary – All Classes <input type="checkbox"/> Current Billing(s)												<input type="checkbox"/> Insurer Renewal Reports (2 years) <input type="checkbox"/> Rate History (2 years)	
Nature of business:						How long in business?							
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					
<b>Life Insurance and AD&amp;D</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				<b>Dependent Life</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Benefit:</b>	Flat \$		or		X Annual to max		\$		<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 _____				
<b>Termination Age:</b>	<input type="checkbox"/> 65 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 75 <input type="checkbox"/> 80												
<b>Critical Illness</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<b>Spouse Covered:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Child Covered</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Short-Term Disability</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Benefit Amount:</b>		\$				<b>Benefit:</b>		% To a maximum of \$ /week					
<b>Termination Age:</b>	<input type="checkbox"/> 65		<input type="checkbox"/> 70		\$		<b>Plan Design</b>		<input type="checkbox"/> 1-8-16 <input type="checkbox"/> 1-8-17 <input type="checkbox"/> 1-8-26 <input type="checkbox"/> 8-8-15				
<b>Long-Term Disability</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				<b>Taxable:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Benefit:</b>	% To a maximum of		\$		/mo.		<b>Termination Age:</b>		<input type="checkbox"/> 65 <input type="checkbox"/> 70				
<b>Graded</b>	% Of the first		\$		/mo.		<b>Employee Assistance Plan</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				
plus	% Of the balance to max of		\$		/mo.		<b>2nd Medical Opinion</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				
plus	% Of the balance to max of		\$		/mo.		<b>Elder Care</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Waiting Period</b>		<input type="checkbox"/> 90		<input type="checkbox"/> 112		<input type="checkbox"/> 120		<input type="checkbox"/> 180		<input type="checkbox"/> 365			
<b>Duration of Benefit</b>		<input type="checkbox"/> 2 years		<input type="checkbox"/> 5 years		<input type="checkbox"/> to age 65/70		<b>Deductible</b>		<input type="checkbox"/> No <input type="checkbox"/> yes			
<b>Survivor Benefit</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 3 months		<input type="checkbox"/> 6 months		<b>Basic Services</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			
						% Co-Ins.							

COLA		<input type="checkbox"/> Yes <input type="checkbox"/> No		%		Maximum per calendar year		\$							
Taxable:		<input type="checkbox"/> Yes <input type="checkbox"/> No				Recall Freq.		<input type="checkbox"/> 6 mos.		<input type="checkbox"/> 9 mos.		<input type="checkbox"/> 12 mos.			
Termination Age:		<input type="checkbox"/> 65 <input type="checkbox"/> 70				Major Services		<input type="checkbox"/> Yes <input type="checkbox"/> No		% Co-Ins.					
Extended Health Care			<input type="checkbox"/> Yes <input type="checkbox"/> No				Maximum per calendar year			<input type="checkbox"/> Combined with Basic					
Deductible	<input type="checkbox"/> No Deductible		<input type="checkbox"/>	\$	Single	\$	Family	Orthodontic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		% Co-Ins.				
Co-Ins.	Drugs			%	Other Expenses			%	Maximum per lifetime		\$				
Equal to Dispensing Fee Deductible				<input type="checkbox"/> Yes <input type="checkbox"/> No				Termination Age:		<input type="checkbox"/> 65 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 75 <input type="checkbox"/> 80					
Per Script Deductible		\$		Dispensing Fee per prescription											
Per Script Deductible		Reimburse 100% dispensing fee up to												\$	
Paramedical Services		% Co-Ins.		\$										Per practitioner	
Vision Care		<input type="checkbox"/> Yes <input type="checkbox"/> No		% Co-Ins.											
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													

CLAIMS EXPERIENCE													
Benefit:	Paid Premium (Current Year)				Paid Claims (Current Year)			Paid Premium (Previous year)			Paid Claims (Previous Year)		
Life													
AD&D													
Critical Illness													
Short-Term Disability													
Long-Term Disability													
Extended Health Care													
Dental Care													
RATE HISTORY													
Benefit:	Rate(s) (Current Year)							Rate(s) (Previous Year)					
Life													
AD&D													
Critical Illness													
Short-Term Disability													
Long-Term Disability													
Extended Health Care	\$		Single	\$		Family	\$		Single	\$		Family	
Dental Care	\$		Single	\$		Family	\$		Single	\$		Family	