REQUEST TO QUOTE

Employer:	Date Submitted:
Address:	Province:
Is there a present Insurer? ☐ No ☐ Yes (if Yes, complete information below)	Next Renewal Date:
Insurer:	

Note: **The following information is required. Please check those items included with this RFQ.**

Current Booklet(s) **Current Billing(s) Claims Experience (2 years)**

Rate History (2 years) **Insurer Renewal Reports (2 years)**

Nature of business:	How long in business?

Any affiliates or subsidiaries to be included? ☐ No ☐ Yes (if Yes, provide list)

Are all eligible employees participating in this plan? ☐ No ☐ Yes (if No, explain) _____

At the present time, are any employees absent from work due to disability, maternity/parental leave or other leave of absence? ☐ No ☐ Yes

(If yes, provide separate listing of employees with date last worked, nature of absence, nature of disability if applicable, and expected date of return to work)

Do all employees work at least 20 hours per week? ☐ No ☐ Yes (if No, explain) _____

Are all employees covered by Workers' Compensation? ☐ No ☐ Yes (if No, explain) _____

Are any of the employees seasonal? ☐ No ☐ Yes (if Yes, provide details) _____

What percentage of the employees are related? _____%

Are any independent contractors seeking coverage? ☐ No ☐ Yes (if Yes, provide details) _____

Classifications	CURRENT PLAN	WHAT WE WOULD LIKE
Life insurance and ADD	Flat Benefit $_____ ***or*** ___X annual to max $_____ Termination age: ☐65 ☐70 ☐71 ☐75 ☐80	Flat Benefit $_____ ***or*** ___X annual to max $_____ Termination age: ☐65 ☐70 ☐71 ☐75 ☐80
Dependent Life	☐$5,000/$2,500 ☐$10,000/$5,000 Other_____ Termination age: ☐65 ☐70 ☐71 ☐75 ☐80	☐$5,000/$2,500 ☐$10,000/$5,000 Other_____ Termination age: ☐65 ☐70 ☐71 ☐75 ☐80
Short Term Disability	Benefit Amount_____% to a maximum of $ _____/week Plan Design ☐1-8-17 ☐1-8-26 ☐15-15-15 ☐15-15-26 First day hospital? ☐No ☐Yes Taxable? ☐No ☐Yes Termination age: ☐65 ☐70	Benefit Amount_____% to a maximum of $_____/week Plan Design ☐1-8-17 ☐1-8-26 ☐15-15-15 ☐15-15-26 First day hospital? ☐No ☐Yes Taxable? ☐No ☐Yes Termination age: ☐65 ☐70
Long Term Disability	Benefit Amount_____% to a maximum of $ _____/month ***or***_____% of the 1st $_____plus___% of the next $_____plus_____% of the balance, to a maximum of $_____/month Elimination Period ☐120 days ☐180 days Benefit Period ☐to age 65 ☐5 years ☐2 years Taxable? ☐No ☐Yes COLA? ☐No ☐Yes_____% Termination age: ☐65 ☐70	Benefit Amount_____% to a maximum of $ _____/month ***or***_____% of the 1st $_____plus___% of the next $_____plus_____% of the balance, to a maximum of $_____/month Elimination Period ☐120 days ☐180 days Benefit Period ☐to age 65 ☐5 years ☐2 years Taxable? ☐No ☐Yes COLA? ☐No ☐Yes_____% Termination age: ☐65 ☐70
Critical Illness	Benefit Amount $_____ Termination age: ☐65 ☐70	Benefit Amount $_____ Termination age: ☐65 ☐70

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Extended Health Care	Deductible: No Deductible $____Single $_____Family Co-insurance Drugs___% Other Expenses_____% Drug Plan ☐ Pay Direct Card ☐ Reimbursement Dispensing Fee Deductible? ☐ No ☐ Yes Per Script Deductible? ☐ No ☐ Yes $_____per prescription Paramedical Maximum $_____per practitioner Vision Care ☐ No ☐ Yes $_____every 24 months Termination age: ☐65 ☐70 ☐71 ☐75 ☐80	Deductible: No Deductible $____Single $_____Family Co-insurance Drugs___% Other Expenses_____% Drug Plan ☐ Pay Direct Card ☐ Reimbursement Dispensing Fee Deductible? ☐ No ☐ Yes Per Script Deductible? ☐ No ☐ Yes $_____per prescription Paramedical Maximum $_____per practitioner Vision Care ☐ No ☐ Yes $_____every 24 months Termination age: ☐65 ☐70 ☐71 ☐75 ☐80
Employee Assistance Plan	☐ Telephonic Plan ☐ Full Service Plan	☐ Telephonic Plan ☐ Full Service Plan
Dental Care	Basic/Preventive Treatments _____% -- maximum per calendar year _____ -- recall exam frequency _____months Major Restorative Treatments (5+ lives) ___% -- maximum per calendar year Combined with Basic ***or*** $_____ Orthodontic Treatments (10+ lives) _____% -- lifetime maximum $_____ Termination age: ☐65 ☐70 ☐71 ☐75 ☐80	Basic/Preventive Treatments _____% -- maximum per calendar year _____ -- recall exam frequency _____months Major Restorative Treatments (5+ lives)_____% -- maximum per calendar year Combined with Basic ***or*** $_____ Orthodontic Treatments (10+ lives) _____% -- lifetime maximum $_____ Termination age: ☐65 ☐70 ☐71 ☐75 ☐80
Second Medical Opinion	☐ Yes ☐ No	☐ Yes ☐ No

FINANCIAL SUMMARY						
CLAIMS EXPERIENCE						
Policy Year						
Benefit	**Premiums**	**Paid Claims**	**Premiums**	**Paid Claims**	**Premiums**	**Paid Claims**
Life						
AD&D						
Short Term Disability						
Long Term Disability						
Critical Illness						
EHC						
Health/Dental						

Claim(s) Details:

RATE HISTORY			
Carrier:			
Policy Year:			
Benefit:	**Rate (s)**	**Rate (s)**	**Rate (s)**
Life			
AD&D			
Dependent Life			
Long Term Disability			
Short Term Disability			
Critical Illness			
EHC			
Health/Dental			

Comments:

Alternate Plan Design Options: