REQUEST TO QUOTE

"Choice$"

Employer:	**Date Submited:**	☐ Email Proposal to me
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) (if available)

1. Nature of business: _____ How long in business? _____
2. Any affiliates or subsidiaries to be included? ☐ No ☐ Yes (if Yes, provide list) _____
3. Are all eligible employees participating in this plan? ☐ No ☐ Yes (if No, explain) _____
4. 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)
5. Do all employees work at least 20 hours per week? ☐ No ☐ Yes (if No, explain) _____
6. Are all employees covered by Workers' Compensation? ☐ No ☐ Yes (if No, explain) _____
7. Are any of the employees seasonal? ☐ No ☐ Yes (if Yes, provide details) _____
8. What percentage of the employees are related? _____%
9. 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 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80	Flat Benefit $_____ ***or*** ____X annual to max $_____ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80
Dependent Life	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ Other_____ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ Other_____ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 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 or ☐ 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 or ☐ 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 or ☐ 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 or ☐ 70
Critical Illness	Benefit Amount $_____ Termination age: ☐ 65 or ☐ 70	Benefit Amount $_____ Termination age: ☐ 65 or ☐ 70
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 or ☐ 70 or ☐ 71 or ☐ 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 or ☐ 70 or ☐ 71 or ☐ 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 or ☐ 70 or ☐ 71 or ☐ 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 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80
Second Medical Opinion	☐ Yes ☐ No	☐ Yes ☐ No

*Please attach a copy of your employee records with the following information to the application

Number	Employee Last Name / ID#	Class / Division	Date Of Birth (mm-dd-yyyy)	Gender	Occupation	Hire Date (yyyy)	Salary	Hourly	Hours Per Week	Employment Province	Coverage Status (see below)		
											Dependent Life (Y - Yes, N - No, W-Waive)	Health	Dental
1													
2													
3													
4													
5													

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: