



"Choice\$"

# REQUEST TO QUOTE

<b>Employer:</b> _____		<b>Date Submitted:</b> _____	<input type="checkbox"/> Email Proposal to me
<b>Address:</b> _____		<b>Province:</b> _____	
Is there a present Insurer? <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, complete information below)		Next Renewal Date: _____	
Insurer: _____			
<b>Note:</b> The following information is required. Please check those items included with this RFQ.			
<input type="checkbox"/> Current Booklet(s) <input type="checkbox"/> Current Billing(s) <input type="checkbox"/> Claims Experience (2 years) <input type="checkbox"/> Rate History (2 years) <input type="checkbox"/> Insurer Renewal Reports (2 years)    (if available)			
1. Nature of business: _____		How long in business? _____	
2. Any affiliates or subsidiaries to be included? <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, provide list) _____			
3. Are all eligible employees participating in this plan? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (if No, explain) _____			
6. Are all employees covered by Workers' Compensation? <input type="checkbox"/> No <input type="checkbox"/> Yes (if No, explain) _____			
7. Are any of the employees seasonal? <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, provide details) _____			
8. What percentage of the employees are related? _____%			
9. Are any independent contractors seeking coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, provide details) _____			
<b>Classifications</b>	<b>CURRENT PLAN</b>	<b>WHAT WE WOULD LIKE</b>	
<b>Life Insurance and ADD</b>	Flat Benefit \$ _____ or _____ X annual to max \$ _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	Flat Benefit \$ _____ or _____ X annual to max \$ _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	
<b>Dependent Life</b>	<input type="checkbox"/> \$5,000/\$2,500 <input type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> Other _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	<input type="checkbox"/> \$5,000/\$2,500 <input type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> Other _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	
<b>Short Term Disability</b>	Benefit Amount _____% to a maximum of \$ _____/week Plan Design <input type="checkbox"/> 1-8-17 <input type="checkbox"/> 1-8-26 <input type="checkbox"/> 15-15-15 <input type="checkbox"/> 15-15-26 First day hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes    Taxable? <input type="checkbox"/> No <input type="checkbox"/> Yes Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70	Benefit Amount _____% to a maximum of \$ _____/week Plan Design <input type="checkbox"/> 1-8-17 <input type="checkbox"/> 1-8-26 <input type="checkbox"/> 15-15-15 <input type="checkbox"/> 15-15-26 First day hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes    Taxable? <input type="checkbox"/> No <input type="checkbox"/> Yes Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70	
<b>Long Term Disability</b>	Benefit Amount _____% to a maximum of \$ _____/month or _____% of the 1 <sup>st</sup> \$ _____ plus _____% of the next \$ _____ plus _____% of the balance, to a maximum of \$ _____/month Elimination Period <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days Benefit Period <input type="checkbox"/> to age 65 <input type="checkbox"/> 5 years <input type="checkbox"/> 2 years Taxable? <input type="checkbox"/> No <input type="checkbox"/> Yes COLA? <input type="checkbox"/> No <input type="checkbox"/> Yes _____% Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70	Benefit Amount _____% to a maximum of \$ _____/month or _____% of the 1 <sup>st</sup> \$ _____ plus _____% of the next \$ _____ plus _____% of the balance, to a maximum of \$ _____/month Elimination Period <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days Benefit Period <input type="checkbox"/> to age 65 <input type="checkbox"/> 5 years <input type="checkbox"/> 2 years Taxable? <input type="checkbox"/> No <input type="checkbox"/> Yes COLA? <input type="checkbox"/> No <input type="checkbox"/> Yes _____% Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70	
<b>Critical Illness</b>	Benefit Amount \$ _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70	Benefit Amount \$ _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70	
<b>Extended Health Care</b>	Deductible <input type="checkbox"/> No Deductible <input type="checkbox"/> \$ _____ Single \$ _____ Family Co-insurance <input type="checkbox"/> Drugs _____% <input type="checkbox"/> Other Expenses _____% Drug Plan <input type="checkbox"/> Pay Direct Card <input type="checkbox"/> Reimbursement Dispensing Fee Deductible? <input type="checkbox"/> No <input type="checkbox"/> Yes Per Script Deductible? <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ per prescription Paramedical Maximum \$ _____ per practitioner Vision Care <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ every 24 months Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	Deductible <input type="checkbox"/> No Deductible <input type="checkbox"/> \$ _____ Single \$ _____ Family Co-insurance <input type="checkbox"/> Drugs _____% <input type="checkbox"/> Other Expenses _____% Drug Plan <input type="checkbox"/> Pay Direct Card <input type="checkbox"/> Reimbursement Dispensing Fee Deductible? <input type="checkbox"/> No <input type="checkbox"/> Yes Per Script Deductible? <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ per prescription Paramedical Maximum \$ _____ per practitioner Vision Care <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ every 24 months Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	
<b>Employee Assistance Plan</b>	<input type="checkbox"/> Telephonic Plan <input type="checkbox"/> Full Service Plan	<input type="checkbox"/> Telephonic Plan <input type="checkbox"/> Full Service Plan	
<b>Dental Care</b>	<input type="checkbox"/> Basic/Preventive Treatments _____% -- maximum per calendar year _____ -- recall exam frequency _____ months <input type="checkbox"/> Major Restorative Treatments (5+ lives) _____% -- maximum per calendar year <input type="checkbox"/> Combined with Basic or <input type="checkbox"/> \$ _____ <input type="checkbox"/> Orthodontic Treatments (10+ lives) _____% -- lifetime maximum \$ _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	<input type="checkbox"/> Basic/Preventive Treatments _____% -- maximum per calendar year \$ _____ -- recall exam frequency _____ months <input type="checkbox"/> Major Restorative Treatments (5+ lives) _____% -- maximum per calendar year <input type="checkbox"/> % Combined with Basic or <input type="checkbox"/> \$ _____ <input type="checkbox"/> Orthodontic Treatments (10+ lives) _____% -- lifetime maximum \$ _____ Termination age: <input type="checkbox"/> 65 or <input type="checkbox"/> 70 or <input type="checkbox"/> 71 or <input type="checkbox"/> 75 <input type="checkbox"/> 80	
<b>Second Medical Opinion</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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						

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			

Comments:

Alternate Plan Design Options: