REQUEST TO QUOTE

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

Note: The following information is required at time of quote:

☐ Current Booklet(s) or Benefit Summary – All Classes ☐ Insurer Renewal Reports (2 years)
☐ Current Billing(s) ☐ Claims Experience (2 years) ☐ Rate History (2 years)

Nature of business:	How long in business?	
Any affiliates or subsidiaries to be included?	☐ No	☐ Yes
Are all eligible employees participating in this plan?	☐ No	☐ Yes
Do all employees work at least 24 hours per week?	☐ No	☐ Yes
Are all employees covered by Workers' Compensation?	☐ No	☐ Yes
Are any of the employees seasonal?	☐ No	☐ Yes
Are any independent contractors seeking coverage?	☐ No	☐ 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?	☐ No	☐ Yes

Classification(s)	**Class 1:**	**Class 2:**
Life Insurance and AD&D	☐ Yes ☐ No	☐ Yes ☐ No
Benefit:	Flat $ or X Annual to max $	Flat $ or X Annual to max $
Termination Age:	☐ 65 ☐ 70 ☐ 71 ☐ 75 ☐ 80	☐ 65 ☐ 70 ☐ 71 ☐ 75 ☐ 80
Dependent Life	☐ Yes ☐ No	☐ Yes ☐ No
Benefit:	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ $20,000/$10,000 ☐ Other_____	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ $20,000/$10,000 ☐ Other_____
Critical Illness	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Covered:	☐ Yes ☐ No Child Covered ☐ Yes ☐ No	Spouse covered ☐ Yes ☐ No Child covered ☐ Yes ☐ No
Benefit Amount:	$	$
Termination Age:	☐ 65 ☐ 70	☐ 65 ☐ 70
Short-Term Disability	☐ Yes ☐ No	☐ Yes ☐ No
Benefit:	% To a maximum of $ /week	% To a maximum of $ /week
Plan Design	☐ 1-8-16 ☐ 1-8-17 ☐ 1-8-26 ☐ 8-8-15 ☐ 8-8-16 ☐ 8-8-25	☐ 1-8-16 ☐ 1-8-17 ☐ 1-8-26 ☐ 8-8-15 ☐ 8-8-16 ☐ 8-8-25
Taxable:	☐ Yes ☐ No	☐ Yes ☐ No
Termination Age:	☐ 65 ☐ 70	☐ 65 ☐ 70

Long-Term Disability	☐ Yes ☐ No	☐ Yes ☐ 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	☐ 90 ☐ 112 ☐ 120 ☐ 180 ☐ 365	☐ 90 ☐ 112 ☐ 120 ☐ 180 ☐ 365
Duration of Benefit	☐ 2 years ☐ 5 years ☐ to age 65/70	☐ 2 years ☐ 5 years ☐ to age 65/70
Survivor Benefit	☐ Yes ☐ No ☐ 3 months ☐ 6 months	☐ Yes ☐ No ☐ 3 months ☐ 6 months
COLA	☐ Yes ☐ No %	☐ Yes ☐ No %
Taxable:	☐ Yes ☐ No	☐ Yes ☐ No
Termination Age:	☐ 65 ☐ 70	☐ 65 ☐ 70
Extended Health Care	☐ Yes ☐ No	☐ Yes ☐ No
Deductible	☐ No Deductible ☐ $ Single $ Family	☐ No Deductible ☐ $ Single $ Family
Co-Ins.	Drugs % Other Expenses %	Drugs % Other Expenses %
Equal to Dispensing Fee Deductible	☐ Yes ☐ No	☐ Yes ☐ 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	☐ Yes ☐ No % Co-Ins.	☐ Yes ☐ No % Co-Ins.
Maximum per 24 months	$	Maximum per 24 months $
Termination Age:	☐ 65 ☐ 70 ☐ 71 ☐ 75 ☐ 80	☐ 65 ☐ 70 ☐ 71 ☐ 75 ☐ 80
Dental Care	☐ Yes ☐ No	☐ Yes ☐ No
Deductible	☐ No Deductible ☐ $ Single $ Family	☐ No Deductible ☐ $ Single $ Family
Basic Services	☐ Yes ☐ No % Co-Ins.	☐ Yes ☐ No % Co-Ins.
Maximum per calendar year	$	Maximum per calendar year $
Recall Frequency	☐ 6 mos. ☐ 9 mos. ☐ 12 mos.	Recall Frequency ☐ 6 mos. ☐ 9 mos. ☐ 12 mos.
Major Services	☐ Yes ☐ No % Co-Ins.	☐ Yes ☐ No % Co-Ins.
Maximum per calendar year	☐ Combined with Basic	Maximum per calendar year ☐ Combined with Basic
	Or ☐ $	Or ☐ $
Orthodontic Services	☐ Yes ☐ No % Co-Ins.	☐ Yes ☐ No % Co-Ins.
Maximum per lifetime	$	Maximum per lifetime $
Termination Age:	☐ 65 ☐ 70 ☐ 71 ☐ 75 ☐ 80	☐ 65 ☐ 70 ☐ 71 ☐ 75 ☐ 80

Employee Assistance Plan	☐ Yes ☐ No	☐ Yes ☐ No
Benefit	☐ Full Program ☐ Telephonic	☐ Full Program ☐ Telephonic
2nd Medical Opinion	☐ Yes ☐ No	☐ Yes ☐ No
Elder Care	☐ Yes ☐ No	☐ Yes ☐ 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: