

Employer Sponsored Group Health and Dental Benefit Plan Request for Quote



Attention Business Owners!

Interested in an Employee Benefit Plan? We can customize a plan just for you and your full time employees!

For a FREE, no-obligation quote, please complete and return the attached form.

COMPANY PROFILE

Full Legal Business Name

City/Town/Province

Postal Code

Contact Name/Phone Number

Business Description

Length of Time in Business (minimum 6 months)

Current Carrier

Length of Time with Current Carrier

Current Number of Full Time Employees

Number of Full Time Employees a year ago

Number of employees are related to the Owner

Are there any seasonal or contract employees to be covered?

Is the company funded by a government agency?

Are there any employees involved in a hazardous occupation?

Are all employees actively at work?

If not, provide details:

Yes No

Are all employees covered by Worker's Compensation?

If no, who is not covered?

Yes No

PROPOSED PLAN

When would you like the plan to start?

What percentage of the premium would you like to pay?

50% 75% Other _____ (minimum 50%)

PLAN ADVISOR PROFILE

Plan Advisor Name

Email Address

Company or MGA Name, and Business Address

Phone

Fax

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PLAN OPTIONS

Basic Life and AD&D

Flat \$25,000 Multiple of Earnings: _____ times salary (1x, 2x, 3x) to max \$ _____

No medical requirements under \$100,000!

Dependent Life (Optional)

Yes No

Spouse \$10,000 / Child \$5,000; Child coverage from birth to age 21 (age 25 if full time student)

Long Term Disability (Optional)

Yes No

66.7% of monthly earnings to a maximum of \$5,000
Non Taxable, 2 year own occupation definition of disability
119 day elimination period. Benefit to age 65.

No medical requirements under \$1,200!

Extended Health Care

Option 1

80% Drugs with Pay Direct Drug Card
80% Professional Services, up to **\$350** per practitioner per year
80% Medical Supplies and Services
100% Private Duty Nursing and Out of Country Emergency Travel Assistance
Includes Vision at **\$100/2 years**, and Semi Private Hospital

Option 2

100% Drugs with Pay Direct Drug Card
100% Professional Services, up to **\$500** per practitioner per year
100% Medical Supplies and Services
100% Private Duty Nursing and Out of Country Emergency Travel Assistance
Includes Vision at **\$100/2 years**, and Semi Private Hospital

Dental Care

Option 1

Yes No

80% Basic and Supplementary Services
\$1,500 maximum per year
1 recall period per 9 months

Option 2

100% Basic and Supplementary Services
50% Major Restorative
\$2,000 maximum per year for Basic and Major Services **combined**.
2 recall periods per year

Other plan options are available. Please check here if we should contact you regarding other plan options.

EMPLOYEE DATA

Please provide the following information for each employee. For your convenience, we have also attached an employee spreadsheet.

- **Date of Birth**
- **Date of Hire**
- **Occupation**
- **Gender**
- **Salary**
- **Province of Residence**
- **Coverage Information** (Single, Family, Waive – Health or dental may only be waived if employee is already covered under a spousal plan)
- **Class**