



Group Benefits Quote Request Form



General Information

Agent Information

Agent Name: \_\_\_\_\_ Office: \_\_\_\_\_

Please send quote via:  Courier or  Email or  Mail

Client Information

Company Name: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

In Business Since: \_\_\_\_\_ Province: \_\_\_\_\_

Association?  Yes  No If YES, Association Name: \_\_\_\_\_

Current Number of Employees: \_\_\_\_\_

Are any employees off work due to disability?  Yes  No If YES, please explain

\_\_\_\_\_

Complete the following information only if the company currently has group benefits:

Present Carrier: \_\_\_\_\_ With Present Carrier Since: \_\_\_\_\_

Please include benefit booklet, current billing and claims experience.

## Employee Contributions

Is the plan to be?  Non-Contributory or  Contributory Participation level \_\_\_\_ %

## Employee Waiting Period

2 months for new employees  3 months for new employees  6 months for new employees  other \_\_\_\_\_

## Class Descriptions

Describe the class of employees who will be eligible for benefits

Class A \_\_\_\_\_  Class B \_\_\_\_\_  Class C \_\_\_\_\_

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## Insured Benefits

Match benefit options to existing in-force plan (Proceed to Employee Information)

### Life and Accidental Death & Dismemberment (mandatory)

Flat Benefit Amount	Or Salary-Based Amounts	Maximum (up to \$500,000)
<input type="checkbox"/> Class A \$ _____	<input type="checkbox"/> Class A ____x annual salary	<input type="checkbox"/> Class A _____
<input type="checkbox"/> Class B \$ _____	<input type="checkbox"/> Class B ____x annual salary	<input type="checkbox"/> Class B _____
<input type="checkbox"/> Class C \$ _____	<input type="checkbox"/> Class C ____x annual salary	<input type="checkbox"/> Class C _____
<input type="checkbox"/> Alternate Quote Request _____		

### Dependent Life (mandatory)

\$5,000 spouse; \$2,500 each dependent child  \$20,000 spouse; \$10,000 each dependent child  
 \$10,000 spouse; \$5,000 each dependent child  \$25,000 spouse; \$12,500 each dependent child  
 \$15,000 spouse; \$7,500 each dependent child

Alternate Quote Request \_\_\_\_\_

### Short Term Disability

Coverage	Options	Duration	Maximum
<input type="checkbox"/> 60% of salary	<input type="checkbox"/> 1st day hospital	<input type="checkbox"/> 17 weeks	
<input type="checkbox"/> 66 2/3% of salary	and/or	<input type="checkbox"/> 26 weeks	\$ _____
	<input type="checkbox"/> 4th day illness or		Select maximum up to \$750
	<input type="checkbox"/> 8th day illness		
<input type="checkbox"/> Alternate Quote Request _____			

### Long Term Disability

Options	Duration	Elimination Period	Maximum
<input type="checkbox"/> 60% of monthly salary	<input type="checkbox"/> 5 years	<input type="checkbox"/> 119 days	\$ _____
<input type="checkbox"/> 66 2/3% of monthly salary	<input type="checkbox"/> 10 years	<input type="checkbox"/> 180 days	3 – 14 lives, up to \$5,500
	<input type="checkbox"/> to age 65		15+ lives, up to \$7,000

#### Cost of Living Adjustment (COLA) Option

not included  1%  2%  3%

Alternate Quote Request \_\_\_\_\_

## Reimbursement Benefits

### Healthcare

Choose pre-defined Health Plan (See BeneShield Guide)

A  B  C  D  and/or customize any benefit option below

### Medical Supplies and Services

Semi-Private Hospital, Ambulance and Out of Country expenses included in all Healthcare options, payable at 100%, no deductible

Deductible (also applies to prescription drug expenses)

Nil  25/25  25/50  50/50  50/100

Coinsurance:  50%  60%  70%  80%  90%  100%

Paramedical Maximum:  \$300  \$400  \$500  \$750  Other \$ \_\_\_\_\_

Paramedical Per Visit Maximum:  \$20  \$25  \$30  \$35  \$40

### Drugs

Dispensing Fee Maximum:  \$6.00  \$7.00  \$8.00  \$9.00  Unlimited

Maximum:  \$1,500  \$5,000  \$10,000  Unlimited

Vaccines:  Included  Not Included

Lifestyle Drugs (fertility, anti-smoking, anti-obesity and treatment of sexual dysfunction):  Included  Not Included

### Vision

Included  Not Included

Maximum  \$200  \$250  \$300  Other \$ \_\_\_\_\_

### Dentalcare

Choose pre-defined Dental Plan (See BeneShield Guide)

A  B  C  D  and/or customize any benefit option below

Deductible:  Nil  25/25  25/50  50/50  50/100

Routine Coinsurance:  50%  60%  70%  80%  90%  100%

Routine Maximum:  \$750  \$1,000  \$1,500

Scaling Time Units:  6 units  8 units  10 units  12 units  14 units

Recall Exams:  1 every 6 months  1 every 9 months  1 every 12 months

Major Coinsurance (when 5 or more plan members have this coverage):  50%  60%  70%  80%

Combined Routine and Major Maximum:  \$750  \$1,000  \$1,500  \$2,000  \$2,500

Orthodontic Coinsurance (when 10 or more plan members have this coverage):  50%  60%

Ortho Maximum:  \$1,000  \$1,500  \$2,000  \$2,500

Notes:



**Critical Illness**

Minimum \$10,000 to a Maximum \$100,000

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Employee only                 | Employee                               | Spouse                                 |
| <input type="checkbox"/> Employee and Spouse           | <input type="checkbox"/> Class A _____ | <input type="checkbox"/> Class A _____ |
|  | <input type="checkbox"/> Class B _____ | <input type="checkbox"/> Class B _____ |
|  | <input type="checkbox"/> Class C _____ | <input type="checkbox"/> Class C _____ |
| <input type="checkbox"/> Alternate Quote Request _____ |  |  |

**Employee Assistance Program (EAP)**

**Health Care Spending Account (HCSA)**

Annual Lump Sum     Class A \$ \_\_\_\_\_     Class B \$ \_\_\_\_\_     Class C \$ \_\_\_\_\_

**Current Employee Information** (all employees working a minimum of 24 hours/week)

Name	Date of Birth (yyyy/mm)	Male = M Female = F	Family Status Family = F Single = S *Waived = W	Occupation	Class A,B,C	Basic Monthly Salary	Hire Date (yy/mm)
1.							
2.							
3.							
4.							
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18.							
19.							
20.							

\*Only employees with duplicate coverage may waive health and dental benefits