Request for Proposal

AGENT/BROKER INFORMATION

Name & Company Name: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

COMPANY INFORMATION

Legal Company Name

Company Address

Street _____

City _____ Province _____ Postal Code _____

Phone ( ) _____ Fax ( ) _____

Contact Name

Contact Email Address

Nature of Business _____

Non-Profit ☐ YES ☐ NO

Years in Business _____

☐ Corporation ☐ Partnership

☐ Proprietorship ☐ Other

☐ Union

Class(es) _____

☐ Non-Union

Present Carrier

Effective Date

Renewal Date

FOR GROUPS WITH CURRENT COVERAGE PLEASE ATTACH THE FOLLOWING

- Rate History (renewal rates, current rates and prior years rates)
- Billing statement (if available)
- Employee booklet (if available)
- 3 consecutive years of claims experience for Health, Dental and STD (must be less than 6 months old)

Number of Employees Eligible

Number of Related Employees

Employee Classes Not Covered

Do all participants work a minimum of 24 hours per week? If "No", please provide details ☐ YES ☐ NO

Are all participants covered by Workers Compensation Benefits? If "No", please provide details ☐ YES ☐ NO

Are any employees disabled or not actively at work? (personal leave, maternity leave, lay-off etc.) ☐ YES ☐ NO

Have there been any LTD claims in the past 36 months? ☐ YES ☐ NO

Do you have any reason to believe that any of the employees and/or their dependents are not healthy? ☐ YES ☐ NO

If "Yes" to any of the above, please provide the following details (attach separately if additional space is required):

NAME	REASON NOT ACTIVELY AT WORK or NATURE OF DISABILITY	DATE LAST WORKED	RETURN TO WORK DATE or EXPECTED DATE	LIFE WAIVER APPROVAL FOR OPEN CLAIMS
				☐ YES ☐ NO
				☐ YES ☐ NO

PLAN DESIGN DETAILS

Class _____

Description: _____

BASIC LIFE and ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT

☐ Flat Amount $_____

or

☐ _____times annual earnings

N.E.M. $ _____

Maximum $ _____

Termination ☐ Age 65 ☐ Age 70

Reduction ___% at Age ___

CRITICAL ILLNESS

☐ Not Required

Flat Amount $_____

DEPENDENT LIFE

☐ Not Required

☐ $5,000 Spouse / $2,500 Child
☐ $10,000 Spouse / $5,000 Child
☐ $20,000 Spouse / $10,000 Child

Class _____ or ☐ Alternative Plan Design

Description: _____

BASIC LIFE and ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT

☐ Flat Amount $_____

or

☐ _____times annual earnings

N.E.M. $ _____

Maximum $ _____

Termination ☐ Age 65 ☐ Age 70

Reduction ___% at Age ___

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☐ Not Required

Flat Amount $_____

DEPENDENT LIFE

☐ Not Required

☐ $5,000 Spouse / $2,500 Child
☐ $10,000 Spouse / $5,000 Child
☐ $20,000 Spouse / $10,000 Child

PLAN DESIGN DETAILS

Class _____

Description: _____

SHORT TERM DISABILITY

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO *Administrative Services Only*

☐ Non-Taxable ☐ Taxable

Schedule	Start*	Duration
☐ 60%	☐ 1-4-1	☐ 17 Weeks
☐ 66 2/3%	☐ 1-8-1	☐ 15 Weeks
☐ 70%	☐ 15-15-15	☐ 26 Weeks
		☐ 52 Weeks

Maximum $ _____

*Benefits Start:
Accident, Illness, Hospitalization (must be hospitalized 24 hours or more)

LONG TERM DISABILITY

☐ Not Required

☐ Non-Taxable ☐ Taxable

Schedule	Elimination	Duration
☐ 60%	☐ 17 Weeks	☐ 2 Years
☐ 66 2/3%	☐ 26 Weeks	☐ 5 Years
☐ 70%	☐ Other _____	☐ Age 65

☐ 2 tier graded ___% of the first $ ____ plus ___% of the remainder

☐ 3 tier graded ___% of the first $ ____ plus ___% of the next $____ plus ___% of the remainder

N.E.M. $ _____

Maximum $ _____

Definition Own Occupation ☐ Any ☐ 1 Year ☐ 2 Year ☐ 3 Year

Benefits terminate at Age 65

Class _____ or ☐ Alternative Plan Design

Description: _____

SHORT TERM DISABILITY

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO *Administrative Services Only*

☐ Non-Taxable ☐ Taxable

Schedule	Start*	Duration
☐ 60%	☐ 1-4-1	☐ 17 Weeks
☐ 66 2/3%	☐ 1-8-1	☐ 15 Weeks
☐ 70%	☐ 15-15-15	☐ 26 Weeks
		☐ 52 Weeks

Maximum $ _____

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Accident, Illness, Hospitalization (must be hospitalized 24 hours or more)

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☐ Not Required

☐ Non-Taxable ☐ Taxable

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N.E.M. $ _____

Maximum $ _____

Definition Own Occupation ☐ Any ☐ 1 Year ☐ 2 Year ☐ 3 Year

Benefits terminate at Age 65

PLAN DESIGN DETAILS

Class _____

Description: _____

EXTENDED HEALTH CARE

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO
Administrative Services Only

Stop Loss Pooling

☐ Nil ☐ $5,000 ☐ $10,000 ☐ _____

Co-insurance

☐ 80% Drugs / 80% Other
☐ 80% Drugs / 100% Other
☐ 100% Drugs / 100% Other

Deductible (Per Calendar Year)
Single / Family

☐ Nil ☐ $25 / $25 ☐ $25 / $50
☐ $50 / $50 ☐ $50 / $100 ☐ $100 / $200

Drugs

☐ Reimbursement ☐ Pay Direct

Pay Direct Drug Plan Deductible

☐ Nil ☐ $ _____ / Rx ☐ Dispensing Fee
☐ Dispensing Fee Cap $ _____

Limitations (Pay Direct only)

☐ None ☐ Managed Formulary
☐ Standard Generic Substitution
Plan pays generic drug unless specified on prescription "no substitutions"
☐ Mandatory Generic Substitution
Plan pays generic drug regardless if prescription states "no substitutions"

Vision Care ☐ Nil ☐ 80% ☐ 100% ☐ _____

Maximum:
☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ _____

Survivor Benefits

☐ None ☐ 12 Months ☐ 24 Months

Class _____ or ☐ Alternative Plan Design

Description: _____

EXTENDED HEALTH CARE

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO
Administrative Services Only

Stop Loss Pooling

☐ Nil ☐ $5,000 ☐ $10,000 ☐ _____

Co-insurance

☐ 80% Drugs / 80% Other
☐ 80% Drugs / 100% Other
☐ 100% Drugs / 100% Other

Deductible (Per Calendar Year)
Single / Family

☐ Nil ☐ $25 / $25 ☐ $25 / $50
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Maximum:
☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ _____

Survivor Benefits

☐ None ☐ 12 Months ☐ 24 Months

PLAN DESIGN DETAILS

Class _____

Description: _____

DENTAL CARE

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO
Administrative Services Only

Co-insurance

Basic	Major	Orthodontic
☐ 100%	☐ Nil	☐ Nil
☐ 80%	☐ 50%	☐ 50%
	☐ 80%	☐ 60%

Calendar Year Maximums*

Basic
☐ Unlimited ☐ $1,000 ☐ $1,500 ☐ $2,000

Major
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

OR

Combined Basic and Major
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

Orthodontic ***Orthodontic Maximums are Per Lifetime**
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

Deductible (Per Calendar Year)
Single / Family
☐ Nil ☐ $25 / $25 ☐ $25 / $50
☐ $50 / $50 ☐ $50 / $100 ☐ $100 / $200

Survivor Benefits
☐ None ☐ 12 Months ☐ 24 Months

Class _____ or ☐ Alternative Plan Design

Description: _____

DENTAL CARE

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO
Administrative Services Only

Co-insurance

Basic	Major	Orthodontic
☐ 100%	☐ Nil	☐ Nil
☐ 80%	☐ 50%	☐ 50%
	☐ 80%	☐ 60%

Calendar Year Maximums*

Basic
☐ Unlimited ☐ $1,000 ☐ $1,500 ☐ $2,000

Major
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

OR

Combined Basic and Major
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

Orthodontic ***Orthodontic Maximums are Per Lifetime**
☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

Deductible (Per Calendar Year)
Single / Family
☐ Nil ☐ $25 / $25 ☐ $25 / $50
☐ $50 / $50 ☐ $50 / $100 ☐ $100 / $200

Survivor Benefits
☐ None ☐ 12 Months ☐ 24 Months

EMPLOYEE CENSUS DATA

	OCCUPATION	CLASS	PROVINCE	WCB Y/N*	DATE OF HIRE YY/MM/DD	SEX M/F	S/F/ W**	DATE OF BIRTH/AGE YY/MM/DD	ANNUAL EARNINGS
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									

***Does the employee have WCB coverage?**
**** F - Family Coverage; S - Single Coverage; W - Waiver of Coverage (Covered under spouse for Health & Dental)**

Should you have any questions regarding the preparation of your Request for Proposal please contact us, we would be pleased to assist you.

CONTACT US:

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