# Request for Proposal

Reset Form

## 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: _____**


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☐ Flat Amount $_____

or

☐ _____times annual earnings

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Maximum $ _____

Termination ☐ Age 65 ☐ Age 70

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## CRITICAL ILLNESS

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Flat Amount $_____

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☐ $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 |
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| ☐ 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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| ☐ 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

# 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
☐ $50 / $50 ☐ $50 / $100 ☐ $100 / $200

**Drugs**

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**Vision Care** ☐ Nil ☐ 80% ☐ 100% ☐

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 | | | | | | | | | |
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| 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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