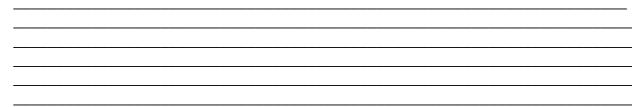
Group Quotation Request Form

Company Information:				
Company Name:		 		
President/Owner:		 		
Contact Person:		 		
Business Address:		 		
Phone:		 		
Type of Business:				
Explain the Nature of Business:		 		
How many years in operation:				
Are there any Seasonal Employees How many?			No	
Do all employees work at least 24 How many?			No	
Are any related? How many, expl	ain	 		

Other information:



Letter of Authorization

Dated:

То:_____

This letter will authorize *Risk Management Strategic* Planners to complete a full review and analysis of our employee benefits program.

The review and analysis includes the following:

- 1) To review our requirements for an employee benefits program.
- 2) To prepare specifications for submission to insurers.
- 3) To obtain quotations from selected insurers.
- 4) To analyze these quotations and make specific recommendations.
- 5) To transact business with the appropriate insurer(s) upon our acceptance of his/her recommendations.

The Employee Benefits Program is for:

(Company Name)

This letter is in effect for a period of 90 days and rescinds all previous authorization unless cancelled in writing.

Your co-operation is requested in supplying information and quotations with respect to this appointment.

Regards,

(Owner)

CONFIDENTIAL LISTING EMPLOYEE DATA SHEET for:

Employees Name	Occupation	Birth Y	date M	D	Sex M/F	Annual Salary	Start Y	Date M	D	Single / Family	Class
											_
											<u> </u>
							1				
	-										<u> </u>
										1	
							1				
							<u> </u>				<u> </u>

PLAN DESIGN FOR: _____

Term Life Insurance Amount: Flat Amount: ______ 1 – 5 x salary _____ AD & D [] Yes [] No Dependant Term Life Amount: [] \$5,000 [] \$10,000 [] \$15,000 [] \$20,000 [] \$25,000 child coverage from: [] birth [] 15th day Short Term Disability [] Non-taxable(55 or 60-66.67%): _____% [] Taxable (66.67 -75%): % Benefit period: [] 15 weeks [] 17 weeks [] 26 weeks First Day hospital: [] Yes [] No Overall maximum: Long Term Disability [] Taxable: Flat 66.67 – 75% ____% [] Non-taxable: [] Flat 60 – 66.67%: _____% [] Graded: [] Yes [] No Waiting Period: [] 120 days [] 180 days Benefit Period: [] 2 years [] 5 years [] to age 65 Inflation Protection: []0% [] 3% [] 4% [] 5% Overall Maximum: _____ Healthcare Deductible (single/family): []0/0 [] 25/25 [] 25/50 [] 50/100 [] 100/100 [] 50/50 [] 250/500 [] 100/200 [] 250/250 Max Amount: [] unlimited or \$ Reimbursement (drugs) (50 – 100%): _____ % Reimbursement (overall) (50 – 100%): ___ % Hospital type: [] semi-private [] private Drug Plan Type: [] Traditional reimbursement [] Drug card point–of-sale reimbursement Max Amount: [] unlimited or \$ [] Prescribed Prescription by law [] Formulary Paramedicals package: (ie Chiropractor, massage therapist) [] Basic [] Basic + supplementary

Paramedical maximum: [] \$300 [] \$500 [] \$750

Vision care max: [] \$100 [] \$150 [] \$200 [] \$250 [] \$300 Per [] 12 months or [] 24 months

CLASS

Dental care:	BASIC PLAN					
Deductible (sir	ngle/family):					
[] 0 / 0	[] 25/25	[] 25/50				
[] 50/50	[] 50/100	[] 100/100				
[] 100/200	[] 250/250	[] 250/500				
Basic reimbursement (50-100%)%						
Maximum:	[] \$1,000	[] \$1,500				
[] \$2,000	[] \$2,500	[] unlimited				
Recall exams:						
	[] 1 every 9 months					

Dental Major:				
Reimbursement (50 – 80%):%				
Maximum: [] \$1	,000 []	\$1,500		
[] \$2,000	[] 2,500	[] unlimited		

Orthodontic: Reimbursement (50 – 60%) _____% Max: [] 1,000 [] 1,500 [] 2,000 [] 2,500

Group Net Carriers Internet plan administration tool: [] Yes [] No

Medical Reimbursement Plan Cost-plus arrangement: [] Yes [] No

Basic Critical IIIness: Type of Plan: [] Standard [] Enhanced [] Multiple of Salary (1,2,3,4 or 5 times) salary to a max of \$250,000 _____

Dependent? [] Yes [] No (spouse \$10,000)