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? Yes _____ No _____
How many? _____

Do all employees work at least 24 hrs/wk Yes _____ No _____
How many? _____

Are any related? How many, explain _____
_____
_____

Other information:

_____
_____
_____
_____
_____
_____

Letter of Authorization

Dated: _____

To: _____

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

PLAN DESIGN FOR: _____ CLASS _____

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
[] 50/50 [] 50/100 [] 100/100
[] 100/200 [] 250/250 [] 250/500
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

Dental care: BASIC PLAN
Deductible (single/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 12 months
[] 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 Illness:
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)