ClearBenefits.ca

Experience-Rated Program

338 - 1641 Lonsdale Ave., North Vancouver, BC V7M 2J5
Tel: 778.338.4083 TF: 888.803.3800
www.clearbenefits.ca Email: connect@clearbenefits.ca

Group Benefits Quotation Request

Producer Name	
Desired Effective Date	Please provide quote by:
Company Name	
Business Address	
City / Province / Postal Code	
Mailing Address (if different than above)	
City / Province / Postal Code	
Phone	
Fax	
Email / Website Address	
Nature of business:	
Home Based?	____ Yes ____ No
Years in business:	
Associated / subsidiaries covered:	____ Yes ____ No
All eligible employees participating	____ Yes ____ No
Employee(s) absent due to disability	____ Yes ____ No
Employees currently traveling outside Canada?	____ Yes ____ No
Employees work min. 20 hours weekly	____ Yes ____ No
Seasonal Employees (9 month min)	____ Yes ____ No
Employees covered by WCB	____ Yes ____ No
# of employees related to owner	____
Independent contractors	____ Yes ____ No
Employer contribution	____ %
Priority (1 – 5)	____ Life Insurance ____ Drugs ____ EHC ____ Vision ____ Dental ____ WI ____ LTD
Current Employee Benefit plan?	____ Yes ____ No
Current Insurance Carrier	
Current Benefits	___ Life ___ AD&D ___ Dep Life ___ Drugs ___ EHC ___ Vision ___ Dental ___ WI ___ LTD
# of carriers in the past 5 years	____ (Reason):
Reason for requesting quote	____ Broker approached ____ Renewal ____ Changing plan design ____ Price
Last billing statement attached	____ Yes ____ No ____ To Follow
Copy of current benefit booklet	____ Yes ____ No ____ To Follow

- If quoting other than manual / book rates, please confirm what % off manual was quoted
- Please advise target / loss ratios
- Please advise EHC stop loss / pooling limits
- Please quote at standard commission scale

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Producer Name	
Company Name	

Quote 1 / Class ____		**Quote 2 / Class ____**	
Employee Life	$	**Employee Life**	$
AD & D	____ Yes ____ No	**AD & D**	____ Yes ____ No
Dependant Life	$ /	**Dependant Life**	$ /
Critical illness	____ Yes ____ No	**Critical illness**	____ Yes ____ No
Employee CI	$	**Employee CI**	$
Dependant CI	$ /	**Dependant CI**	$ /
Short Term Disability	____ % Non-taxable (60 – 66.7%)	**Short Term Disability**	____ % Non-taxable (60 – 66.7%)
	____ % Taxable (55% / 66.7–75%)		____ % Taxable (55% / 66.7–75%)
Benefit Period	____ 15 ____ 17 ____ 26 Weeks	**Benefit Period**	____ 15 ____ 17 ____ 26 Weeks
Maximum Benefit	**$**	**Maximum Benefit**	**$**
First Day Hospital	____ Yes ____ No	**First Day Hospital**	____ Yes ____ No
Long Term Disability	____% Flat non-taxable (60 — 66.67%)	**Long Term Disability**	____% Flat non-taxable (60 — 66.67%)
	____ Yes ____ No Graded non-taxable		____ Yes ____ No Graded non-taxable
	____% Flat taxable (66.67 – 75%)		____% Flat taxable (66.67 – 75%)
Waiting period:	___ 112 days ___ 120 days ___ 180 days	**Waiting period:**	___ 112 days ___ 120 days ___ 180 days
Benefit period:	___ 2 years ___ 5 years ___ to age 65	**Benefit period:**	___ 2 years ___ 5 years ___ to age 65
COLA	____ 3% ____4% ____5%	**COLA**	____ 3% ____4% ____5%
Maximum Benefit	**$**	**Maximum Benefit**	**$**
Extended Health Care	$____ / $ ____ Deductible (single/family)	**Extended Health Care**	$____ / $ ____ Deductible (single/family)
Overall Maximum	$ / Unlimited	**Overall Maximum**	$ / Unlimited
Overall EHC Coverage	____ % (50 – 100%)	**Overall EHC Coverage**	____ % (50 – 100%)
Prescription Coverage	____ % (50 – 100%)	**Prescription Coverage**	____ % (50 – 100%)
Drug Plan	____ Reimbursement ____ Drug card	**Drug Plan:**	____ reimbursement ____ drug card
Drugs	___ Rx ___ Rx by Law ___ Formulary	**Drugs**	___ Rx ___ Rx by Law ___ Formulary
Paramedical Services	___ Basic ___ Basic & Supplementary	**Paramedical Services**	___ Basic ___ Basic & Supplementary
Paramedical Services Max.	___ $300 ____ $500 ____ $750	**Paramedical Services Max.**	___ $300 ____ $500 ____ $750
Visioncare (Eye exams)	____ Yes ____ No	**Visioncare (Eye exams)**	____ Yes ____ No
Visioncare (Frames / lenses)	__$100 ___$150 ___$200 ___$250	**Visioncare (Frames / lenses)**	__$100 ___$150 ___$200 ___$250
Hospital	____ Private ____ Semi ____ Ward	**Hospital**	____ Private ____ Semi ____ Ward
Employee Assistance Program	____ Yes ____ No	**Employee Assistance Program**	____ Yes ____ No
Dental	$___ / $ ___ Deductible (single/family)	**Dental**	$___ / $ ___ Deductible (single/family)
Combine Deductible with EHC	____ Yes ____ No (if available)	**Combine Deductible with EHC**	____ Yes ____ No (if available)
Basic (50 – 100%)	___% (1000, 1500, 2000, 2500, UL)	**Basic (50 – 100%)**	____% (1000, 1500, 2000, 2500, UL)
Major (50 – 80%)	___% (750, 1000, 1500, 2000, 2500, UL)	**Major (50 – 80%)**	____% (750, 1000, 1500, 2000, 2500,UL)
Ortho (50 – 60%)	___% (1000, 1500, 2000, 2500)	**Ortho (50 – 60%)**	____% (1000, 1500, 2000, 2500)
Recall exams	1 / 6 months, 1 / 9 months, 1 / 12 months	**Recall exams**	1 / 6 months, 1 / 9 months, 1 / 12 months

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Quote 3 / Class ____		**Quote 4 / Class ____**	
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Dependant Life	$ /	**Dependant Life**	$ /
Critical illness	____ Yes ____ No	**Critical illness**	____ Yes ____ No
Employee CI	$	**Employee CI**	$
Dependant CI	$ /	**Dependant CI**	$ /
Short Term Disability	____ % Non-taxable (60 – 66.7%)	**Short Term Disability**	____ % Non-taxable (60 – 66.7%)
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Benefit period:	___ 2 years ___ 5 years ___ to age 65	**Benefit period:**	___ 2 years ___ 5 years ___ to age 65
COLA	____ 3% ____4% ____5%	**COLA**	____ 3% ____4% ____5%
Maximum Benefit	**$**	**Maximum Benefit**	**$**
Extended Health Care	$____ / $ ____ Deductible (single/family)	**Extended Health Care**	$____ / $ ____ Deductible (single/family)
Overall Maximum	$ / Unlimited	**Overall Maximum**	$ / Unlimited
Overall EHC Coverage	____ % (50 – 100%)	**Overall EHC Coverage**	____ % (50 – 100%)
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Major (50 – 80%)	___% (750, 1000, 1500, 2000, 2500, UL)	**Major (50 – 80%)**	____% (750, 1000, 1500, 2000, 2500,UL)
Ortho (50 – 60%)	___% (1000, 1500, 2000, 2500)	**Ortho (50 – 60%)**	____% (1000, 1500, 2000, 2500)
Recall exams	1 / 6 months, 1 / 9 months, 1 / 12 months	**Recall exams**	1 / 6 months, 1 / 9 months, 1 / 12 months

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Employee Name	Occupation	Birth Date	Gender	Province of Residence	Weekly Hours	Wage / Salary	Date Employed	S/C/F	Class

Payroll Frequency: ___ Weekly ___ Bi-weekly ___ Semi-monthly ___ Monthly

S = Single C=Couple F = Family W = Waiving EHC & Dental I/C = Independent Contractor

This Notice of Authorization and Appointment supersedes and replaces all others issued prior to this date

This letter appoints _____ to act as our Agent of Record for the purpose soliciting quotations and negotiating on our behalf in regard to our Employee Benefits Program.

This is our authorization to any insurance company or other organization underwriting such plans to supply any information that may be requested regarding existing plans, possible future plans, or quotations on our Employee Benefits plan.

This also constitutes our request to any such organizations to recognize the above mentioned Advisor as Agent of Record with respect to any such plans, and to pay any compensation that may be due on such business.

Information collected by ClearBenefits.ca and it's associates is used or the purpose of allowing Insurance carriers, ClearBenefits.ca and it's associates to prepare proposals and services including Group Benefits, and other related products and services.

Information collected will remain confidential and only be used for these purposes.

Dated at _____ this _____ day of _____ / 20__

_____ _____

Signature Group Benefits Advisor

_____

Name & Title

_____

Company Name

_____

Insurance Carrier & Plan #