# Request for Quotation

Date (dd/mmm/yyyy)

## Company Profile

| Full Legal Business Name | City /Town |
|---|---|
| Province<br>Ontario | Postal Code |
| SIC/Business Description | Length of time in business (minimum 6 months) |
| Current number of full time employees | Number of employees a year ago |
| Number of employees related to owner | Any employees involved in hazardous occupations?<br>☐ Yes<br>☐ No |
| Any employees not actively at work?<br>☐ Yes<br>☐ No | If yes, provide details: |
| Are all employees covered by Workers' Compensation?<br>☐ Yes<br>☐ No | If no, who is not covered: |

## Advisor Profile

| Plan Advisor Name<br>Tchavdar (Charles) Elenkov, CFP, CHS | Email Address<br>tchavdar@elenkov.com |
|---|---|
| Business Address<br>38 Silkwood Crescent<br>North York, ON M2J 1H2 | Phone<br>(416) 496-1482<br>Fax<br>(416) 496-2152 |
| Commission Schedule<br>☐ Flat ____________%<br>☒ Graded (standard)<br>☐ 15-10 graded<br>☐ Other (please attach) | Mode of Delivery<br>☒ Email<br>☐ Hard copy |

## Existing Group Coverage

| Does the group currently have coverage?<br>☐ Yes<br>☐ No | If yes, name of carrier: |
|---|---|
| Number of years with current carrier | |

## Proposed Plan

| Proposed Effective Date | First Renewal<br>☐ 12 month ☐ 16 month ☐ Other _______ |
|---|---|
| Percentage of premium paid by employer (minimum of 50%) | Termination Age<br>☐ 65 ☐ 70 ☐ 65/85 ☐ 70/85 |
| Class A Description: | Class B Description (if applicable) |

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## Plan Design – Class A

**Life/AD&D** (minimum $10,000)

☐ Flat $ ______________ or ☐ Multiple of Salary: ______________________

Maximum: ______________________________

☐ **Dependent Life**

Spouse $ __________________________ Child Eligibility: ☐ Birth ☐ 14 days

Child – ½ of spousal amount

☐ **Long Term Disability**

Benefit %:

☐ Flat ___________% or ☐ Graded ___________________________________

Maximum: $ ____________________________ Elimination Period: ☐ 105 days ☐ 119 days ☐ 179 days

Benefit Period: ☐ 2 yrs ☐ 5 yrs ☐ to age 65 Definition of Disability: ☐ Any occ ☐ 2 year own occ

Taxability: ☐ Taxable ☐ Non-taxable COLA %: ☐ None ☐ 3% ☐ 4% ☐ 5%

☐ **Short Term Disability**

Benefit %: _________________ Maximum: $ _________________

Elimination Period (accident/sickness):
☐ 0/3 days ☐ 0/7 days ☐ 14/14 days

Benefit Period:
☐ 15 weeks ☐ 17 weeks ☐ 26 weeks

Occupational Coverage:
☐ Yes ☐ No

Taxability:
☐ Taxable ☐ Non-taxable

1st day hospital
☐ Yes ☐ No

**Extended Health Care**

EHC Deductible (excl. Drug Card):
☐ 0/0 ☐ 25/25 ☐ 25/50 ☐ 50/50 ☐ 50/100

Other: ______________

EHC Coinsurance (excluding drugs, hospital and vision):
☐ 80% ☐ 90% ☐ 100% ☐ Other _____%

**Drug Coverage**

☐ Reimbursement
☐ Drug Card - Pay Direct Drugs
☐ Deferred Drugs (Quebec only)

Drug Coinsurance:
☐ 80% ☐ 90% ☐ 100% ☐ Other _____%

Drug Card/Deferred Drugs:
☐ Per Prescription Deductible: $ ______
☐ Deductible equals dispensing fee
☐ Dispensing fee cap $ __________

Drug Options:
☐ Prescription
☐ Prescription with exclusions

Drug Plan Basis:
☐ Brand
☐ Generic
☐ Formulary

Drug Maximum:
☐ $1,000 ☐ $5,000 ☐ $10,000 ☐ Unlimited

**Paramedical Coverage**

☐ Basic
☐ Standard
☐ Enhanced

Calendar year maximum:
☐ $200 ☐ $300 ☐ $350 ☐ $400
☐ $450 ☐ $500 ☐ $750 ☐ $1000

Per Visit maximum $ _________________

**Other Services**

☐ Hospital
☐ semi-private

☐ Vision
☐ $ __________Maximum (every 2 calendar years) or ☐ eye exam only

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## Plan Design – Class A

☐ **Dental Care**

Deductible:
☐ 0/0 ☐ 25/25 ☐ 25/50 ☐ 50/100 ☐ 100/100 ☐ Other ________________

**Basic**

Coinsurance:
☐ 80% ☐ 90% ☐ 100% ☐ Other ______%

Maximum:
☐ 500 ☐ 1000 ☐ 1500 ☐ 2000 ☐ 3000
☐ Unlimited ☐ Combined with Major

Recall Exam:
☐ 2/year ☐ 6 months ☐ 9 months ☐ 12 months

☐ **Major Restorative** *(minimum 3 lives)*

Coinsurance:
☐ 50% ☐ 60% ☐ 70% ☐ 80%

Maximum:
☐ 500 ☐ 1000 ☐ 1500 ☐ 2000 ☐ 3000
☐ Combined with Basic

☐ **Orthodontia** (*minimum 5 lives*)

Coinsurance: 50%

Maximum (lifetime):
☐ 1000 ☐ 1500 ☐ 3000

Fee Guide:
☐ Current ☐ Current – 1 yr ☐ Current – 2 yrs

Specialist fees: ☐ Yes ☐ No

☐ **Deviations for Class B**

☐ **Additional Plan Design Options/Notes**

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### Employee Data

| | Name | Sex | Age or Date of Birth (mmm/yyyy) | Hire Date (mmm/yyyy) | Occupation | Prov | Coverage (S,F,W) | | Annual Salary | Hours per week |
|---|---|---|---|---|---|---|---|---|---|---|
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