REQUEST FOR GROUP QUOTATION

Ryder Financial
204, 400 Crowfoot Cres. NW
Calgary, AB T3G 5H6
Telephone: 403-472-1780
Email: csylven@ryderins.ca

Employer:	**Date Submitted:**	☐ Email Proposal to me
Address:		**Province:**

Is there a present Insurer? ☐ No ☐ Yes (if Yes, complete information below) Next Renewal Date:

Insurer: ____________________

Note: The following information is required. Please check those items included with this RFQ.
☐ Current Booklet(s) ☐ Current Billing(s) ☐ Claims Experience (2 years) ☐ Rate History (2 years) ☐ Insurer Renewal Reports (2 years) (if available)

1. Nature of business:____________________ How long in business? __________
2. Any affiliates or subsidiaries to be included? ☐ No ☐ Yes (if Yes, provide list)__________
3. Are all eligible employees participating in this plan? ☐ No ☐ Yes (if No, explain)__________
4. At the present time, are any employees absent from work due to disability, maternity/parental leave or other leave of absence? ☐ No ☐ Yes
   (If yes, provide separate listing of employees with date last worked, nature of absence, nature of disability if applicable, and expected date of return to work)
5. Do all employees work at least 20 hours per week? ☐ No ☐ Yes (if No, explain)__________
6. Are all employees covered by Workers' Compensation? ☐ No ☐ Yes (if No, explain)__________
7. Are any of the employees seasonal? ☐ No ☐ Yes (if Yes, provide details)__________
8. What percentage of the employees are related? ______%
9. Are any independent contractors seeking coverage? ☐ No ☐ Yes (if Yes, provide details)

Classifications	**CURRENT PLAN**	**WHAT WE WOULD LIKE**
Life Insurance and ADD	Flat Benefit $__________ ***or*** X annual to max $_____ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80	Flat Benefit $__________ ***or*** X annual to max $_____ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80
Dependent Life	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ Other__________ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ Other__________ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80
Short Term Disability	Benefit Amount________% to a maximum of $__________/week Plan Design ☐ 1-8-17 ☐ 1-8-26 ☐ 15-15-15 ☐ 15-15-26 First day hospital? ☐ No ☐ Yes Taxable? ☐ No ☐ Yes Termination age: ☐ 65 or ☐ 70	Benefit Amount________% to a maximum of $__________/week Plan Design ☐ 1-8-17 ☐ 1-8-26 ☐ 15-15-15 ☐ 15-15-26 First day hospital? ☐ No ☐ Yes Taxable? ☐ No ☐ Yes Termination age: ☐ 65 or ☐ 70
Long Term Disability	Benefit Amount________% to a maximum of $__________/month ***or***________% of the 1st $__________plus____% of the next $________plus__________% of the balance, to a maximum of $__________/month Elimination Period ☐ 120 days ☐ 180 days Benefit Period ☐ to age 65 ☐ 5 years ☐ 2 years Taxable? ☐ No ☐ Yes COLA? ☐ No ☐ Yes________% Termination age: ☐ 65 or ☐ 70	Benefit Amount________% to a maximum of $__________/month ***or***________% of the 1st $__________plus____% of the next $________plus__________% of the balance, to a maximum of $__________/month Elimination Period ☐ 120 days ☐ 180 days Benefit Period ☐ to age 65 ☐ 5 years ☐ 2 years Taxable? ☐ No ☐ Yes COLA? ☐ No ☐ Yes________% Termination age: ☐ 65 or ☐ 70
Critical Illness	Benefit Amount $__________ Termination age: ☐ 65 or ☐ 70	Benefit Amount $__________ Termination age: ☐ 65 or ☐ 70
Extended Health Care	Deductible ☐ No Deductible ☐ $______Single $______Family Co-insurance ☐ Drugs____% ☐ Other Expenses________% Drug Plan ☐ Pay Direct Card ☐ Reimbursement Dispensing Fee Deductible? ☐ No ☐ Yes Per Script Deductible? ☐ No ☐ Yes $________per prescription Paramedical Maximum $________per practitioner Vision Care ☐ No ☐ Yes $________every 24 months Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80	Effective Date: ____________________ (dd/mm/yyyy) Benefit Year:____________________ (dd/mm/yyyy) Unused benefit to be: (only select ONE) ☐ Forfeited ☐ Carry Forward Maximum ☐ Carry Forward Receipts Plan Design:
Employee Assistance Plan	☐ Telephonic Plan ☐ Full Service Plan	
Dental Care	☐ Basic/Preventive Treatments __________% -- maximum per calendar year __________ -- recall exam frequency __________months ☐ Major Restorative Treatments (5+ lives) __________% -- maximum per calendar year ☐ Combined with Basic ***or*** ☐ $__________ ☐ Orthodontic Treatments (10+ lives) __________% -- lifetime maximum $__________ Termination age: ☐ 65 or ☐ 70 or ☐ 71 or ☐ 75 ☐ 80	
Second Medical Opinion	☐ Yes ☐ No	☐ Yes ☐ No

Plan Design:

Employee Classification		Max Fixed Annual Benefit Amount		
Class Code	Class Level (ex: owner..)	Health/Dental	Wellness	%Co-Pay
A				
B				
C				
D				

	# REQUEST FOR GROUP QUOTATION	Ryder Financial 204, 400 Crowfoot Cres. NW Calgary, AB T3G 5H6 Telephone: 403-472-1780 Email: csylven@ryderins.ca

*Please attach a copy of your employee records with the following information to the application

Number	Employee Last Name / ID#	Class / Division	Date Of Birth (mm-dd-yyyy)	Gender	Occupation	Hire Date (yyyy)	Salary	Hourly	Hours Per Week	Employment Province	Coverage Status (see below)		
											Dependent Life (Y - Yes, N - No, W-Waive)	Health	Dental
1													
2													
3													
4													
5													

FINANCIAL SUMMARY

CLAIMS EXPERIENCE

Policy Year	Last Year		2 Years Ago		3 Years Ago	
Benefit	**Premiums**	**Paid Claims**	**Premiums**	**Paid Claims**	**Premiums**	**Paid Claims**
Life						
AD&D						
Short Term Disability						
Long Term Disability						
Critical Illness						

Claim(s) Details:

RATE HISTORY

Carrier:			
Policy Year:			
Benefit:	**Rate (s)**	**Rate (s)**	**Rate (s)**
Life			
AD&D			
Dependent Life			
Long Term Disability			
Short Term Disability			
Critical Illness			

Comments:

Alternate Plan Design Options: