INTEGRITY
INSURANCE & FINANCIAL
SERVICES INC.

Request for Quotation

Date: _____

Company Profile

Full Legal Business Name:	Address:
Business Description:	Length of time in business (minimum 6 months):
Current number of full time employees:	Number of employees related to owner:
Any employees involved in hazardous occupations?	Any employees not actively at work? If yes, provide details.
Are all employees covered by Workers' Compensation?	If no, who is not covered:

Existing Group Coverage

Do you currently have coverage?	If yes, name of carrier:
Number of years with current carrier:	

Proposed Plan

Proposed effective date for new plan:	Percentage of premium paid by employer: (minimum of 50%)
Class A Description:	Class B Description (if applicable)

Plan Design

☐ **Life Insurance/Accidental Death & Dismemberment**

    ☐ Flat insurance amount $_____ (minimum $10,000)

    ☐ _____ x Salary to a maximum of $_____

☐ **Dependent Life**

Spouse $ _____   Child Eligibility: ☐ Birth ☐ 14 days
Child – ½ of spousal amount

☐ **Short Term Disability**

Benefit is 66 2/3% of salary to a maximum amount of $_____

Waiting period (accident/sickness): ☐ 0/3 days ☐ **0/7 days** ☐ 14/14 days

Benefit period : ☐ 5 weeks ☐ 17 weeks ☐ 26 weeks

Taxability: ☐ Taxable ☐ Non-taxable

☐ **Long Term Disability**

Benefit is 66 2/3% of salary to a maximum amount of $_____

Waiting period: ☐ 105 days ☐ **119 days** ☐ 179 days

Benefit period : ☐ 5 years ☐ to age 65

Taxability: ☐ Taxable ☐ Non-taxable

☐ **Extended Health Care**

    ☐ $0 deductible or ☐ $_____ deductible

Drug Coverage: ☐ 80% coverage   ☐ 100% coverage

    ☐ Maximum $_____ or ☐ Unlimited amount

Paramedical Coverage (chiropractor, massage therapist, etc.):

Calendar year maximums:
☐ $300 ☐ $500 ☐ $1000

Other Services:

    ☐ **Hospital; Semi-private**

Vision:

    ☐ $ _____ **Maximum (every 2 calendar years) or** ☐ **eye exam only**

☐ **Dental Coverage**

    ☐ $0 deductible   or   ☐ $_____ deductible

    ☐ Basic

Coinsurance: ☐ 80% ☐ 100%   ☐ $_____Max. or ☐ Unlimited

    ☐ Combine Basic with Major

Recall exam:

    ☐ 2/year ☐ 6 months ☐ 9 months ☐ 12 months

    ☐ **Major Restorative:** ☐ 50%;   ☐ $_____Max or ☐ Unlimited

    ☐ **Orthodontia** (minimum 5 lives) ☐ 50%

Deviations for Class B

Additional Plan Design Options/Notes: