Phone: (902) 742-0276
E-Mail: risl@eastlink.ca

Ryan Insurance Services Ltd.

Fax: (902) 742-4625
www.ryan-ins.com

Group Quotation Request

Client Name

Company Contact

Date

Effective Date

Date Required

1. What is the exact nature of your business?
2. How many years has your company been in business?
3. Are there any subsidiaries or affiliates to be covered? If yes, provide names.
4. Are all eligible employees participating in this plan? If no, please explain.
5. At the present time, are any employees absent from work due to disability, maternity leave or other leaves of absence? If yes, please explain.
6. Do all employees work at least 24 hours per week?
7. Are any of your employees seasonal?
8. Are there any independent contractors seeking coverage? If yes, indicate on Employee Data Sheet
9. a) How many employees have been hired in the past 2 years?

   b) Was this caused by growth/turnover?
10. What is the overall employer contribution in percent.(%)
11. Name of current/previous carrier and length of time with each.

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Employee Information

12. Please indicate any employees that are related to primary decision maker by blood or marriage.

13. Indicate any employees not covered by Workers Compensation.

14. Indicate any employees that are not residents of Canada.

15. Indicate any employees that regularly work or travel outside of Canada.

16. Indicate any employee who, as part of his/her work, is involved in hazardous activities such as flying, off-shore activities, handling dangerous chemicals, etc.

17. a) Has any employee ever been declined for any coverage for any reason?

    b) Has any employee been absent from work within the past 3 years for more than a five day duration due to any illness, injury, maternity leave or leave of absence, etc.?

    c) Are there any employees currently on CPP, Workers Compensation, Waiver of Premium or LTD?

18. What is the most important aspect of a group benefit plan to you?

    Price___ Service___ Financial Stability of insurance company___

19. What areas of protection are most significant to you and your employees?

    Death___ Disability___ Healthcare___ Dentalcare___ Confidential Counselling___

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Plan Design

Life Insurance
Flat Amount ____
1 - 5 X Salary ____

AD & D
Flat Amount ____
1 - 5 X Salary ____

Optional Life
Yes/No ____

Dependent Term Life (child 1/2 amount)
$5,000 ___ $10,000 ___ $15,000 ___
$20,000 ___ $25,000 ___
Child Coverage: ___ From Birth ___ From15th day

Critical Illness
Y / N ___ $ ____

Short-Term Disability
Non-taxable (60 - 66.67%) ____
Taxable (55% or 66.67 - 75%) ____
Benefit Period: 15 weeks ___
17 weeks ___
26 weeks ___
1st day hospital (Y/N) ___

Long-Term Disability
Flat non-taxable (60 - 66.67%) ____
Graded non-taxable Y/N ____
Flat taxable (66.67 - 75%) ____
Waiting Period: 120 days ___
180 days ___
Benefit Period: 2 years ___
5 years ___
to age 65 ___
Inflation Protection: 0,3,4 or 5% ____
Occ. Definition ____

Healthcare
Deductible (single/family)
0/0 ___ 25/25 ___ 25/50 ___
50/50 ___ 50/100 ___ 100/100 ___
100/200 ___ 250/250 ___ 250/500 ___
Reimbursement (overall) (50 - 100% ____
Reimbursement (drugs) (50 - 100%) ____
Drug Plan: Reimbursement ___
Drug Card ___
Drugs: Prescribed ___
Pres. By law ___
Formulatory ___
Paramed Pkg. Basic ___
Basic & Supp. ___
Paramed maximum
$300 ___ $500 ___ $750 ___
Visioncare maximum
$100 ___ $150 ___ $200 ___
$250 ___
Hospital type:
Semi-private ___ Private ___ Ward ___

Dentalcare
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%) ____
Max ___ $1,000 ___ $1,500 ___
$2,000 ___ $2,500 ___ Unlimited ___
Major Reimbursement (50 - 80%) ____
Max ___ $750 ___ $1,000 ___
$1,500 ___ $2,000 ___ $2,500 ___
Unlimited ___
Combined basic & major max? ____
Ortho Reimbursement (50 - 60%) ____
Max ___ $1,000 ___ $1,500 ___
$2,000 ___ $2,500 ___
Recall Exams:
2/12 months ___ 1/9 mo. ___ 1/12 mo. ___

EMPLOYEE CENSUS

Employer's Name: ____________________
Address: ____________________
Province: ________
Anticipated Enrolment Level: ________

	Employee Name	Sex M/F	Date of Birth Month/YR	Status Single Family	Earnings	Occupation	Occ. Class	Date of Hire	Waiving Y/N?
1									
2									
3									
4									
5									
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25									

Agent **John B. Ryan RHU**
c/o Ryan Insurance Services Limited
368 Main St. Suite 108
Yarmouth NS B5A 1E9
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