Please email this information to quotes@martellinsurance.com or fax this form to 250-656-3980

GROUP BENEFITS

FACT FINDER

EMPLOYEE BENEFITS INFORMATION

CONFIDENTIAL

Martell Insurance Services
Benefit Consultants
Phone: 250-656-3999 Facs: 250-656-3980

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COMPANY DATA

NAME OF EMPLOYER ______________________________

ADDRESS ______________________________

PERSON TO CONTACT ______________________________

NATURE OF BUSINESS ______________________________

NUMBER OF FULL TIME EMPLOYEES ____________ PART TIME ______

CURRENT INSURANCE CARRIER ______________ SINCE ______

ARE RATE AND CLAIMS EXPERIENCE HISTORY AVAILABLE __________

- IF AVAILABLE PLEASE COMPLETE APPROPRIATE WORKSHEET

ARE ALL EMPLOYEES COVERED BY WORKERS COMPENSATION __________

IF NOT PLEASE PROVIDE DETAILS ______________________________

____

____

IS THERE ANYONE CURRENTLY ON LONG TERM DISABILITY __________

IF SO PLEASE PROVIDE DETAILS ______________________________

____

____

SPECIAL NOTES______________________________

____

____

____

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Please complete this form only if you have an existing plan and are interested in a cost comparison or replacement.

COMPANY NAME ________________________________

RATE HISTORY

	PREVIOUS YR	LAST YEAR	CURRENT YEAR
LIFE			
A.D.&D.			
W.I.			
L.T.D.			
E.H.C. SINGLE FAMILY			
DENTAL SINGLE FAMILY			
DEPENDENT LIFE			

CLAIMS EXPERIENCE

	PREVIOUS YEAR premiums/claims/%	LAST YEAR premiums/claims/%	CURRENT YEAR Premiums/claims/%
WEEKLY INCOME	/ /	/ /	/ /
E.H.C.	/ /	/ /	/ /
DENTAL	/ /	/ /	/ /

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CONFIDENTIAL EMPLOYEE DATA

(Please photocopy if firm has more than 20 employees)

BUSINESS NAME ____

EMPLOYEES NAME	CLASS	SEX	DATE OF BIRTH D/M/Y	HIRE DATE M/Y	EARNINGS __MONTH __ANNUAL	OCCUPATION (JOB DESCRIPTION)	COVERAGE S=SINGLE F=FAMILY W=WAIVE*	PROV
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

** You may "W" Waive EHC and Dental benefits only if covered under a spousal plan.*

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GROUP COVERAGE REQUEST FORM

COMPANY ______________________________________

GROUP LIFE INSURANCE AND
ACCIDENTAL DEATH & DISMEMBERMENT

A) Multiple of Salary

__ 1 X
__ 2 X
__ 3 X

B) Level Amount

Class	Class Description	Amount
1	______________________	$____________
2	______________________	$____________

DEPENDENT LIFE INSURANCE

	Plan	Spouse	Child
__	1	$10,000	$5,000
__	2	$ 5,000	$2,500

WEEKLY INCOME

Percentage of Salary: ___ 60% ___ 67% Maximum: ___ U.I.C. or ___ $

Elimination and __ 1st/8th Day __ 15th Day __ 30th Day __ 60th Day

Benefit Period __ 17 Weeks __ 26 Weeks __ 15 Weeks __ 13 Weeks

LONG TERM DISABILITY

Amount of Benefit ______ % of Monthly Income Maximum $_________

Elimination period __ 17 Weeks __ 26 Weeks

Benefit Period __ 2 Years __ 5 Years __ To Age 65

Definition - 2 Year Own Occ ___ or Any Occ ____

EXTENDED HEALTH CARE

	Plan	Deductible	Co-Insurance
__	1	$0/$0	100%
__	2	$25/$50	100%
__	3	$0/$0	80% Drugs 100% Other
__	4	$0/$0	80%
__	5	$25/$50	80%

Optional __ Vision Care up to $_______ every 2 years for glasses

__ Pay Direct Drugs % or $______ deductible per prescription

__ Employee Assistance Program ___ Yes ___ No

DENTAL CARE

	Plan		Deductible	Co-Insurance
__	1	Basic Care (preventive and diagnostic)	$__________	__________ %
__	2	Basic with Major (dentures, crowns)	$__________	__________ %
__	3	Basic, Major and Orthodontia	$__________	__________ %

PENSION PLANS

__ Money Purchase __ Unit Benefit __ Group R.R.S.P.

Contributions: Employee ______ % of earnings

Employer ______ % of earnings

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