Please complete pages 4 to 7 and return via fax 250-391-9380 or email to quotes@martellinsurance.com

CONFIDENTIAL

GROUP BENEFITS

FACT FINDER

EMPLOYEE BENEFITS INFORMATION

Personal Estate and Business Succession Planning • Employee Benefits
3161 Antrobus Crescent, Victoria, BC, V9B 5M6
Phone (250) 391-9933 Fax (250) 391-9380

The way we work ……………. For You!

1. We believe that we work for you, the client and acting upon your direction, tempered with our advice and experience, we shop the market for a plan that helps you accomplish your goals at the most reasonable cost.

2. We place the business with the selected carrier(s) and assist you in efficiently completing all the paperwork.

3. We provide you and your plan administration with:

a. Booklets for each employee
b. An easy way to use administration/claims kit for your plan administrator
c. An Employee information meeting to review the coverage, explain any procedures for claims and answer any questions
d. A personal service contact(s) at the insurance company chosen

4. As long as rates and claims experience are reasonable, but at the most every 3 years, we do a complete market review to "Test the Water" on your behalf to make sure your rates are in line with market pricing.

The purpose of an employee benefit plan:

1. **To provide employees with the security of knowing certain financial uncertainties are protected.**

2. **To define and limit a company's legal and financial obligations to its employees in the event of a death or disability.**

3. **To provide some "Special" benefits to the "Special" people who are instrumental in the company's success.**

4. **To attract and retain key employees who are instrumental in your company's success.**

COMPANY INFORMATION

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______________________________

____

____

____

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	/ /	/ /	/ /

CONFIDENTIAL EMPLOYEE DATA

(Please photocopy if firm has more than 20 employees)

BUSINESS NAME ____________________________________

EMPLOYEES NAME	C L A S S	S E X	DATE OF BIRTH D/M/Y	HIRE DATE M/Y	EARNINGS __MONTH __ANNUAL	OCCUPATION (JOB DESCRIPTION)	COVERAGE S=SINGLE F=FAMILY W=WAIVE*	P R O V
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.*

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: ____ E.I. 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

	Options	Deductible	Co-Insurance
__	1	$0/$0	100%
__	2	$25/$50	100%
__	3	$0/$0	80% Drugs 100% Other
__	4	$0/$0	70% Drugs 100% Other
__	5	$0/$0	60% Drugs 100% Other

Optional __ Vision Care up to $_______ every 2 years for glasses
__ Pay Direct Drugs % or $______ deductible per prescription
__ Employee Assistance Program ___ Yes ___ No

DENTAL CARE

	Options		Deductible	Co-Insurance
__	1	Basic Care (preventive and diagnostic)	$_________	_________ %
__	2	Basic with Major (dentures, crowns)	$_________	_________ %
__	3	Basic, Major	$_________	_________ %
__	4	Basic, Major and Orthodontia	$_________	_________ %

Critical Illness Insurance

__ Level Amount $25,000.00
__ Level Amount $50,000.00
__ Level Amount (Other) $______________