R.W. Insurance Group Inc.

CONFIDENTIAL REQUEST FOR H.S.A. QUOTE

Company Information

Company Name: _____ Phone: _____

Street Address: _____ Unit#: _____

City: _____ ,Ontario P.C. _____

Owner: _____ Email: _____

Admin Contact: _____ Email: _____

Client Questions

Please complete the following questions:

1) What is the nature of your business, please be specific: _____

_____

2. Number of years in business: _____

3: Are there any seasonal or contract workers: ☐ Yes ☐ No
If yes, please specify: _____

4: Are 50% or more of the employees' family? ☐ Yes ☐ No
If yes, please indicate relationship and if any reside in the same household. _____

_____

5: Are all employees and owners covered by Workers Compensation (WSIB)? ☐ Yes ☐ No

6. Premium contribution basis: Employer Pays _____ % Employee Pays _____%
(The employer is required to pay a minimum of 50%)

7: Are there any disabled employees? ☐ Yes ☐ No
If yes, please complete the following chart in full (the notes area at the end may also be used):

Employee Name	Occupation	Date of Disability	Nature of Disability	Prognosis	Life Waiver Approved

Health Spending Account – Base Life Plan with Monthly HSA Contributions

Life Insurance

Life Insurance: ☐ $100,000.00 ☐ $200,000.00 **Other** ☐ $: _____

Health Spending Account

Monthly Single: ☐ $50.00 ☐ $75.00 **Other** ☐ $: _____

Monthly Family: ☐ $100.00 ☐ $150.00 ☐ $: _____

Initial Lump Contribution: ☐ Yes ☐ No $: _____

Optional Benefits

Long Term Disability

Non Taxable

100% Employee paid ☐ Yes ☐ No

☐ 50% ☐ 60% ☐ 66$

Taxable

100% Employer paid ☐ Yes ☐ No

☐ 50% ☐ 60% ☐ 66% ☐ 70% ☐ 75%

Travel Insurance

Monthly cost is $5.00 for Family and $3.00 for Single ☐ Yes ☐ No

Disability (D.I.)

Check optional Benefits you would like to provide

Disability: (Accident)	Waiting Period	☐ 14 Days	☐ 30 Days	☐ 90 days
Benefit Period:	Years	☐ 2 Years	☐ 5 Years	☐ To age 65
Disability:(Sickness)	Waiting Period	☐ 14 Days	☐ 30 Days	☐ 90 days
Benefit Period:	Year	☐ 2 Years	☐ 5 Years	☐ To age 65

Critical Illness (C.I.)

Benefit Amount	☐ $25,000.00	☐ $50,000.00	☐ $75,000.00	**Other** ☐ $ _____
Type:	☐ T-10	☐ T-20	☐ T-75	☐ T-100

Catastrophic Prescription

Catastrophic Prescription ☐ Yes ☐ No

Annual Deductible ☐ $4,500.00 ☐ $10,200.00

Long Term Care (LTC)

All LTC Plans are Monthly and has the Indexation option pre-selected

Benefit Amount	☐ $1000.00	☐ $1500.00	☐ $2,500.00	**Other** $: _____
Length of Benefit	☐ 2 Years	☐ 5 Years	☐ Life	

Registered Retirement Savings Plan (RRSP)

This plan is a 50/50 split. Employer sets max amount they will contribute on a match bases. For example the employer will match an employee's contribution to a maximum predetermined amount.

Do you want and RRSP Plan:	☐ Yes	☐ No		
Monthly Maximum:	☐ $25.00	☐ $50.00	☐ $100.00	☐ $150.00

Once you have completed this form please send save and email it to the Advisor or Assistant who sent it to you.

If you have any questions please contact:

Advisor: Rodney S. WIllis Phone:1(519) 362-1792

Email: rodney.willis@rogers.com

Rev: 30/04/2014

Employee Listing

Company Name: ____

First Name	Last Name	Smoke Y/N	Division	Gender	Status F = Family S =Single W = Waive	Date of Birth (MM/DD/YYYY)	Annual Salary	Province	Date of Hire	Occupation