

REQUEST FOR SOLO QUOTE:

Please print & fax the following to Sam Esaw at (604) 526-6803

INSURED PERSON'S NAME: _____ Province: _____

Date of Birth: _____ Gender? _____ Are you a Smoker? Yes or No?

Mailing Address: _____

Insured's Occupation: _____ Phone: _____

Insured's Email: _____ Fax: _____

Insurable GROSS Annual Income: _____ (needed to calculate disability benefits)

NAME OF SPOUSE: _____ TO BE COVERED: Yes or No?

Date of Birth: _____ Gender? _____ is your spouse a Smoker? - Yes or No?

Insured's Occupation & Duties: _____

Insurable GROSS Annual Income: _____ (needed to calculate disability benefits)

LIFE INSURANCE COVERAGE Desired Amount: \$20,000 or \$ _____

Accident Insurance Amount: \$ None or \$ _____

Spouse's Life Insurance Amount: \$ None or \$ _____

Spouse's Accident Insurance Amount: \$ None or \$ _____

Children's Insurance Amount: \$ None or \$5,000 or \$10,000

DISABILITY INCOME REPLACEMENT Desired Amount: \$ None or \$ _____ monthly

Better Definition of Disability to last: 24 months, 60 months, or to age 65

Disability Benefits to begin after: 14-days, 30-days, 60-days, or 120-days

Disability Benefit Period to last: 5 years, or to Age 65

Are you covered by Workers Compensation: Yes or No?

EXTENDED HEALTH BENEFITS & DRUG CARD: Desired: Yes or No?

Annual Deductible:

\$50 single, \$100 family 80% Reimbursement

\$500 one time only 100% Reimbursement

\$5 user pay drug card 80% Reimbursement

\$50 single, \$100 family 100% Reimbursement

DENTAL COVERAGE DESIRED: Yes or No?

Reimbursement Amount Desired: 70% or 100%

Dental for Single (one Individual only)

Dental for Couple (two adult persons only)

Dental for Single Parent (one adult with children under age 19)

Dental for Family (two parents with children under age 19)