Agency Name

Agency Address

Contact Info

Response to Request for Additional Information as Required by Regulation 194

Description of Alternative Quotes Presented - Health & Disability

Purchaser Name _____

Effective Date of Coverage _____

DISABILITY INCOME

INSURER	MONTHLY INDEMNITY (Subject to social insurance limit?)	PREMIUM (Level, increasing, decreasing)	RIDERS (Lifetime benefits at what age, cost of living, residual benefits, etc)	DEFINITION OF DISABILITY	COMPENSATION TO PRODUCER, OR ANY PARENT, SUBSIDIARY, OR AFFILIATE ($ or %)

GROUP MEDICAL

INSURER	IN OR OUT OF NETWORK COVERAGE?	MONTHLY PREMIUM	CO-PAYS/DEDUCTIBLES (Physician, prescription)	ANNUAL MAXIMUM / LIFETIME MAXIMUM	COMPENSATION TO PRODUCER, OR ANY PARENT, SUBSIDIARY, OR AFFILIATE ($ or %)

Signature of Purchaser _____ Date _____