

Association of Early Childhood Educators of Alberta
EMPLOYEE BENEFIT PROGRAM REQUEST FOR QUOTATION



Your Organization

Company Name:	Contact Person:
City, Province:	Phone Number:
Do you presently have a company benefit program in place? (Yes / No)	
(If yes, please include a recent billing statement)	

Your Employees

	Employee Name	Gender	Date of Birth	Plan Coverage*	Salary	No. Hours Worked Per Week	Job Title
	Last Name, First Name	M or F	MM/DD/YYYY	Single / Family / Waive	\$	XX	Position Description
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

*An employee can waive Health and Dental coverage (only) if they have coverage in place through a spousal plan. All other benefits are mandatory.



Please scan and return completed form to: kyle.stinson@hubinternational.com

Questions? Contact HUB International at 780-784-2610 (toll-free 1.866.525.5055), or email kyle.stinson@hubinternational.com