CORE DENTAL PLAN
MONTHLY CONTRIBUTION REPORT

TO:	Employee Benefit Program 3sHealth 700-2002 Victoria Avenue Regina, SK S4P0R7 ebp@3sHealth.ca	ORGANIZATION NAME: ORGANIZATION NUMBER:	

Details of premium remittance for the month of ________________________________, 20______

AFFILIATION	NUMBER OF F.T.E.		COST PER F.T.E.		PREMIUMS
		X		=	
		X		=	
		X		=	
		X		=	
		X		=	

Total ________________________

Calculation of number of full-time equivalents (F.T.E.):

F.T.E. = TOTAL PAID HOURS FOR ALL EMPLOYEES IN THE GROUP FOR THE MONTH / 1 FTE PER MONTH (HOURS)

EXAMPLE
OOS Group F.T.E. = 4000/162.40 = 24.63
FTE Premium = 24.63 X 68.75 = $1693.31

PLEASE DO NOT STAPLE CHEQUE TO REMITTANCE FORM

Authorized Signature: ________________________

Date: ________________________

Contact Name: ________________________

Phone: ________________________

Email: ________________________

04/01/2021

CORE DENTAL PLAN
MONTHLY CONTRIBUTION REPORT

To be used for March 31, 2021 and previous.

TO:	Employee Benefit Program 3sHealth 700-2002 Victoria Avenue Regina, SK S4P0R7 ebp@3sHealth.ca	ORGANIZATION NAME:	
		ORGANIZATION NUMBER:	

Details of premium remittance for the month of ________________________________, 20______

AFFILIATION	NUMBER OF F.T.E.		COST PER F.T.E.		PREMIUMS
		X		=	
		X		=	
		X		=	
		X		=	
		X		=	

Total ______________________________

Calculation of number of full-time equivalents (F.T.E.):

F.T.E. = TOTAL PAID HOURS FOR ALL EMPLOYEES IN THE GROUP FOR THE MONTH / 1 FTE PER MONTH (HOURS)

EXAMPLE
OOS Group F.T.E. = 4000/162.40 = 24.63
FTE Premium = 24.63 X 72.25 = $1779.52

PLEASE DO NOT STAPLE CHEQUE TO REMITTANCE FORM

Authorized Signature: ______________________________

Date: ______________________________

Contact Name: ______________________________

Phone: ______________________________

Email: ______________________________