CORE DENTAL PLAN

MONTHLY CONTRIBUTION REPORT

For remittance after April 1, 2024

TO:	Employee Benefit Program 3sHealth 600-1919 Saskatchewan Drive Regina, SK S4P 4H2 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	77.75	=	
		X	77.75	=	
		X	77.75	=	
		X	77.75	=	
		X	77.75	=	

Total ______________________________

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

$$\text{F.T.E.} = \frac{\text{TOTAL PAID HOURS FOR ALL EMPLOYEES IN THE GROUP FOR THE MONTH}}{\text{1 F.T.E. PER MONTH (HOURS)}}$$

EXAMPLE

OOS Group F.T.E. = 4000/162.40 = 24.63
F.T.E. Premium = 24.63 X 77.75 = $1914.98

Authorized Signature: ______________________________

Date: ______________________________

Contact Name: ______________________________

Phone: ______________________________

Email: ______________________________

PLEASE DO NOT STAPLE CHEQUE TO REMITTANCE FORM

202404