



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.):

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

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



CORE DENTAL PLAN MONTHLY CONTRIBUTION REPORT

For remittance prior to 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	70.75	=	
		X	70.75	=	
		X	70.75	=	
		X	70.75	=	
		X	70.75	=	

Total _____

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

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

EXAMPLE OOS Group F.T.E. = 4000/162.40 = 24.63
 F.T.E. Premium = 24.63 X 70.75 = \$1742.57

Authorized Signature: _____
 Date: _____
 Contact Name: _____
 Phone: _____
 Email: _____

PLEASE DO NOT STAPLE CHEQUE TO REMITTANCE FORM