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	68.75	=	0
		X	68.75	=	0
		X	68.75	=	0
		X	68.75	=	0
		X	68.75	=	0

Total **0**

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

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

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: _____