

Request for Quotation



1 Company information

Name of business			
City/Town		Province	
Nature of Business			
Length of time in business	Total number of employees	Is the company funded by a government agency?	Yes <input type="checkbox"/> No <input type="checkbox"/> %
Are there any employees or dependents with a significant health problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide details:	
Are there any other employees not actively at work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide details:	
Are there any commissioned employees?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide details:	
Are any employees being excluded from coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are there any independent contractors to be insured?	Yes * <input type="checkbox"/> No <input type="checkbox"/>
Is everyone covered by WSIB/CSST (Workers' Compensation)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Exceptions:	
Are there any seasonal employees to be covered?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide details:	
What is the percentage of employees living in the same household?	%	Employer contribution (minimum of 50% is required)	%
Please indicate any other information relevant to underwriting this group.			

* A separate questionnaire must be completed to determine eligibility.

2 Advisor information

Name		
Business name		
Telephone number ()	Fax number ()	E-mail
Advisor status for this client:	<input type="checkbox"/> Agent of record <input type="checkbox"/> Written authorization to obtain quotes only <input type="checkbox"/> Verbal authorization to obtain quotes only	

3 Existing Group coverage

Please include a premium and claims experience summary and rate history for the most recent 2 policy years. This is essential information and we will not issue a quote without it.

Does the client currently have a group benefits plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		Insurer: _____	
Effective date of insurance with the above mentioned insurer (d/m/y)	How long has the current plan been in-force?	Has there been a different insurer in the past 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>

4 Plan Design

Life, AD&D and Dependent Life are mandatory benefits. In addition to these products, at least one other product must be selected as well to make the plan valid.

In Quebec, the Drug portion of the EHC benefit is mandatory.

The following plan details describe coverage currently in effect for this group: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Please provide details of any difference.
Benefit differences by class of employees (list differences as well as class descriptions):

Life Insurance

Flat Amount * \$ _____ Multiple of salary _____ * Minimum \$25,000
 Overall Maximum: \$300,000 Other _____

Accidental Death and Dismemberment Insurance

Same as Life Insurance Other _____

Dependent Life Insurance

Spousal amount \$ _____ (Child amount is 1/2 of Spousal amount)

Long-Term Disability Insurance (LTD)

Flat formula _____ Graded formula _____
 Highest maximum monthly benefit available Other _____
 Taxable Non-Taxable
 Cost of Living Adjustment (COLA): 3% 4% 5%
 Primary CPP/QPP Offset Other _____
 Elimination period: 120 days 180 days
 Duration: Age 65 Earlier of 5 years and age 65

Extended Health Care (EHC)

Annual Deductible (Single/Family)

None \$25/\$25 \$25/\$50 \$50/\$50 \$50/\$100 \$100/\$100

Overall Reimbursement Percentage (Excluding drugs, hospital and vision)

Coinurance: 100% 80% Other _____

Prescription Drugs: Drug Card Reimbursement

Coinurance: 100% 80% Other _____

Drug Card Dispensing Fee Maximum:

\$5 \$6 \$7 \$8 \$9 \$10 Other _____

Drug Card per Prescription Deductible:

\$0 \$2 \$5 \$10 Equal to dispensing fee Other _____

Paramedical Practitioners (i.e. Physiotherapist, Chiropractor, Masseur, etc.)

Annual Maximum: \$300 \$500 \$750 Other _____

Hospital Room & Board: Private Semi-private

Coinurance: 100% 80% Other _____

Vision Care (always reimbursed at 100%)

\$100/2 years \$150/2 years \$200/2 years Other _____

Dental Insurance

Annual Deductible (Single/Family)

None \$25/\$25 \$25/\$50 \$50/\$50 \$50/\$100 \$100/\$100

Basic Reimbursement

100% 80% Other _____
 Annual Maximum: \$1,000 \$1,500 \$2,000 \$2,500 Other _____
 Recall Frequency: 5 months 6 months 9 months 12 months

Major Reimbursement*

50% 80% Other _____
 Annual Maximum: \$1,000 \$1,500 \$2,000 \$2,500 Other _____
 Combined with Basic Maximum? Yes No

Orthodontics Reimbursement**

Reimbursement: 50% 60%
 Lifetime Maximum: \$1,000 \$1,500 \$2,000 Other _____

*Minimum of 5 participants

**Minimum of 10 participants

Short-Term Disability Insurance (STD)

Flat formula _____ Graded formula _____
 Highest maximum weekly benefit available Other _____
 Taxable Non-Taxable
 Plan: 1-8-17; 1-8-26; 1-4-17; 1-4-26; 15-15-15 Other _____
 First day of coverage for illness if employee is hospitalized.

Employee Assistance Plan (EAP)

Critical Illness Insurance (CII)

Amount of coverage \$ _____

Plan Design Alternatives (Options)
