

### Request For Group Benefits Quotation

<i>Applicant Information</i>			
Name of Organization: (legal name)			
Address:			
Phone:	Fax:		
Email:	Web:		
Contact Name:			
Legal Status: <input type="checkbox"/> Corporation			
<i>Employer Profile</i>			
Nature of Organization:			
Year established 1995	Unionized: <input type="checkbox"/> No	Number of <b>Covered</b> Employees Full time: ___ Part time: ___	How many hours do part-time employees work (consistently)? _____ (Only include those who are eligible for the benefits plan)
<b>Employee profile: Please complete the following. For "yes", please provide details in the blank space below or attach a separate page. For questions 1 to 4 list the employees, indicate date of disability, age, cause of disability, and expected date of return to work. For questions 6 to 9 list employees.</b>			
1.	Are any employees currently receiving disability benefits under a group plan, WSIB or any other source?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Anyone currently absent from work due to sickness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Has anyone been absent from work due to any one injury or illness for 14 consecutive days in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Has anyone been absent from work on 6 or more occasions over the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Anyone not covered by Worker's Compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Anyone not covered by Employment Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Are any employees related to one another (i.e., spouse, parent, child, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Anyone paid in full or in part by commission?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Has there been any significant change in the number of employees in the past 3 years? If yes, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	Does the organization receive outside funding? If yes, from where and what percentage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Please list any LTD claims made over the past five years including date and nature, outcome or prognosis of the claims			
<b>Premiums: The employer will be paying the following percentage of premium for each benefit</b>			
Life/AD&D _____%	Dependent Life _____%	Long-term Disability _____%	
Weekly Indemnity _____%	Extended Health Care _____%	Dental Care _____%	
Proposed Effective Date of Coverage: _____			
<i>Existing Plan Profile</i>			
Name of Carrier:	How long with present carrier?	How many carriers in the last 5 years?	
<b>Please provide rates for each coverage:</b>			
Life:	_____/\$1000	Extended Health Care:	_____ /single
AD&D:	_____/\$1000		_____ / family
Dependent Life:	_____ / Employee	Dental Care:	_____ /single
Weekly Indemnity:	_____/\$10		_____ /family
Long-term Disability:	_____/\$100	Effective Date for Rates:	

## Benefits Requested

### Basic Group Life and Accidental Death & Dismemberment:

\_\_\_\_\_ Flat Benefit \_\_\_\_\_ (minimum \$25,000/maximum \$500,000)

\_\_\_\_\_ 1 times annual salary to a maximum of \_\_\_\_\_ (Max \$500,000)

\_\_\_\_\_ 2 times annual salary to a maximum of \_\_\_\_\_ (Max \$500,000)

\_\_\_\_\_ 3 times annual salary to a maximum of \_\_\_\_\_ (Max \$500,000)

Terminating at age \_\_\_\_\_ 65 or \_\_\_\_\_ 70, the life benefit reduces by 50% at age 65.

\_\_\_\_\_ Optional Life – Available in multiples of \$10,000 to a maximum of \$300,000. (This coverage is medically underwritten & terminates at age 65)

#### Dependent Life:

\_\_\_\_\_ Child \$1,000  
Spouse \$2,000

\_\_\_\_\_ Child \$2,500  
Spouse \$5,000

\_\_\_\_\_ Child \$5,000  
Spouse \$10,000

\_\_\_\_\_ Child \$10,000  
Spouse \$20,000

#### Weekly Indemnity:

##### Taxable

\_\_\_\_\_ 66 2/3% of weekly salary to a maximum of \$800

\_\_\_\_\_ 70% of weekly salary to a maximum of \$800

\_\_\_\_\_ 75% of weekly salary to a maximum of \$800

Elimination Period: \_\_\_\_\_ 4 days \_\_\_\_\_ 8 days

Duration: \_\_\_\_\_ 15 weeks \_\_\_\_\_ 17 weeks \_\_\_\_\_ 26 weeks \_\_\_\_\_ 52 weeks

\_\_\_\_\_ 1<sup>st</sup> day hospitalization

Termination: \_\_\_\_\_ age 65 \_\_\_\_\_ age 70

CPP/QPP offsets: Primary  
Definition of Disability: Own Occupation  
85% all source maximum  
Pre-Existing Condition: Yes

##### Non-Taxable

\_\_\_\_\_ 60% of weekly salary to a maximum of \$800

\_\_\_\_\_ 65% of weekly salary to a maximum of \$800

Elimination Period: \_\_\_\_\_ 4 days \_\_\_\_\_ 8 days

Duration: \_\_\_\_\_ 15 weeks \_\_\_\_\_ 17 weeks \_\_\_\_\_ 26 weeks \_\_\_\_\_ 52 weeks

\_\_\_\_\_ 1<sup>st</sup> day hospitalization

Termination: \_\_\_\_\_ age 65 \_\_\_\_\_ age 70

CPP/QPP offsets: Primary  
Definition of Disability: Own Occupation  
85% all source maximum  
Pre-Existing Condition: Yes

#### Long-Term Disability:

##### Taxable

\_\_\_\_\_ 66 2/3% of monthly salary to \_\_\_\_\_ (Max \$6,000)

\_\_\_\_\_ 70% of monthly salary to \_\_\_\_\_ (Max \$6,000)

\_\_\_\_\_ 75% of monthly salary to \_\_\_\_\_ (Max \$6,000)

Elimination Period: \_\_\_\_\_ 17 weeks \_\_\_\_\_ 26 weeks \_\_\_\_\_ 52 weeks

**Note: Elimination period should coincide with weekly indemnity duration if weekly indemnity is also quoted.**

Duration: to age 65  
Termination: at age 65

CPP/QPP offsets: Primary only  
Definition of Disability: 2 year own occupation, thereafter any and all  
85% all source maximum  
Pre-Existing Condition: Yes

##### Non-Taxable

\_\_\_\_\_ 60% of monthly salary to \_\_\_\_\_ (Max \$6,000)

\_\_\_\_\_ 65% of monthly salary to \_\_\_\_\_ (Max \$6,000)

\_\_\_\_\_ Tiered

Elimination Period: \_\_\_\_\_ 17 weeks \_\_\_\_\_ 26 weeks \_\_\_\_\_ 52 weeks

**Note: Elimination period should coincide with weekly indemnity duration if weekly indemnity is also quoted.**

Duration: to age 65  
Termination: at age 65

CPP/QPP offsets: Primary only  
Definition of Disability: 2 year own occupation, thereafter any and all  
85% all source maximum  
Pre-Existing Condition: Yes

**Benefits Requested**  
**Extended Health, Drug and Dental Benefits**

**Extended Health Care:**

Co-insurance Options:

Drugs

\_\_\_ 100%  
\_\_\_ 90%  
\_\_\_ 80%  
\_\_\_ 70%

Extended Health

\_\_\_ 100%  
\_\_\_ 90%  
\_\_\_ 80%  
\_\_\_ 70%

Deductible Options:

\_\_\_ / Nil  
\_\_\_ / Family  
\_\_\_ / Single

Maximums:

Paramedical \_\_\_\_\_  
Audio \_\_\_\_\_  
PDN \_\_\_\_\_  
Other: \_\_\_\_\_

Co-payment \$ \_\_\_\_\_

Vision Care:  \$100/ 2years     \$150 / 2 years     \$200 / 2 years     \$250 / 2 years

Hospital Expenses:  Semi-Private Room     Private Room

Prescription Drug Expenses:  Reimbursement Plan     Pay Direct Drug Plan

Survivorship Benefit:  2 years     5 years

Terminating at age:  65     70

**Dental Care:**

<b>Coverages:</b>	<b>Co-insurance</b>	<b>Annual Maximum</b>
Basic Service:		
Endodontal & Periodontal:		
Major Restorative:		
Orthodontal:		

Deductible:  Nil    \_\_\_\_\_/single    \_\_\_\_\_/family

Fee guide year \_\_\_\_\_    \_\_\_\_\_ Current Fee Guide

Survivorship benefit:  2 years     5 years

Terminating at age:  65     70

Applicants Signature: \_\_\_\_\_    Date: \_\_\_\_\_

**OFFICE USE**

Funding:  Rated     ASO     Retention    Comm. Flat \_\_\_\_\_ Scaled \_\_\_\_\_

Demographic Count    Notes:

	S	F
Div	_____	_____
Div	_____	_____
Div	_____	_____