112- 5805 Whittle Road, Mississauga, Ontario L4Z 2J1
Tel: 905-272-3060 Mario ext 245 Lisa ext 225 Fax: 905-272-5472

REQUEST FOR GROUP INSURANCE QUOTATION

Please complete all applicable sections of the form. Return the specifications to GroupQuest Benefits Resources Inc. by fax (905) 272-5472

Client Information

Company Name: ____________________
Street: ____________________
City, Province: ____________________
Number of Employees: ____________________
Website: ____________________
Date of Request: ____________________

Advisor Information

Advisor Name: ____________________
Company Name: ____________________
Street: ____________________
City, Province: ____________________
Telephone Number: ____________________
Cell Number: ____________________
Fax Number: ____________________
E-mail Address: ____________________

Advisor Requirements

A. Plan Design **B.** Census Data **C.** Claims Experience* **D.** Rate History*

*A minimum of 2 (preferably 3) years of rates and experience is required if the client has current insurance coverage.

REQUEST FOR QUOTATION

Please provide any information about your client. Any important details will assist in the underwriting process.

Client Questions

Please complete the following questions:

1. Nature of business; please provide specific details: ____
   ____

2. Number of years in business: ____

3. Are there any seasonal or contract employees? Yes ☐ No ☐
   If yes, please specify: ____

4. Are 50% or more of the employees from the same family? Yes ☐ No ☐
   If yes, please indicate relationship and if they reside in the same household. __________________
   ____

5. Are all employees and owners covered by Workers Compensation (WSIB)? Yes ☐ No ☐

6. Premium contribution basis: Employer Pays ________ % Employee Pays ________ %
   (The employer is required to pay a minimum of 50%)

7. Are there any disabled employees? Yes ☐ No ☐
   If yes, please complete the following chart in full (the notes area at the end may also be used):

Employee Name	Occupation	Date of Disability	Nature of Disability	Prognosis	Life Waiver Approved ?

8. Are they currently insured? Yes ☐ No ☐ If yes please indicate the following:
   Current Carrier: ______________________ **# of years with carrier** _________ (max 2 insurers in the past 5 years) **Renewal Date:** ______________________

9. Are benefits being quoted the same as their current plan? Yes ☐ No ☐ If not, explain why:
   ____

10. Experience and rates provided? Yes ☐ No ☐ Please include the most current month and a minimum of two years (preferably three).

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Plan Design

Plan Design:

Class A: ________________

Life

Flat Amount: ☐ $25,000 ☐ $50,000
☐ $100,000 ☐ other $ _________

Multiple of Salary: ☐ 1X ☐ 2X ☐ other $________

Maximum: ☐ highest ☐ other $________

Optional Life ☐ Yes ☐ No

Dependent Life ☐ Yes ☐ No

Spousal Amount: ☐ $5,000 ☐ $10,000
☐ $20,000 ☐ other $ __________

Child amount: 50% of spouse

AD&D ☐ Yes ☐ No

Amount: ☐ Same as Life ☐ other $_______

Short Term Disability: ☐ Yes ☐ No

Benefit Amount:

Non taxable: (100% employee paid)
☐ 50 ☐ 60 ☐ 66.66%

Taxable: (100% employer paid)
☐ 50 ☐ 60 ☐ 66.66%
☐ 70 ☐ 75%

Flat amount: $____________________________

Maximum: ☐ highest ☐ other $________

Accident waiting period: ☐ 1 ☐ 4 ☐ 8 ☐ 15 Days

Sickness waiting period: ☐ 4 ☐ 8 ☐ 15 Days

First day hospital: ☐ Yes ☐ No

Benefit period: ☐ 15 ☐ 17 ☐ 26 weeks

Long Term Disability ☐ Yes ☐ No

Benefit Amount:

Non taxable: (100% employee paid)
☐ 50 ☐ 60 ☐ 66.66%

Taxable: (100% employer paid)
☐ 50 ☐ 60 ☐ 66.66%
☐ 70 ☐ 75%

Graded formula: ☐ 60% of 1st $2,500, 50% of next $2,500, 40% of balance

Flat amount: $____________________________

Maximum: $____________________________

Disability definition ☐ 2 yr own occ. ☐ any occupation

Waiting period ☐ 90 ☐ 120 ☐ 180 days

Benefit period: ☐ 2 yrs ☐ to age 65

Benefit offset ☐ primary ☐ full

Cola: ☐ 0% ☐ 2% ☐ 3% ☐ 4%

Alternate or Class B: _________________

Life

Flat Amount: ☐ $25,000 ☐ $50,000
☐ $100,000 ☐ other $ _________

Multiple of Salary: ☐ 1X ☐ 2X ☐ other $________

Maximum: ☐ highest ☐ other $________

Optional Life ☐ Yes ☐ No

Dependent Life ☐ Yes ☐ No

Spousal Amount: ☐ $5,000 ☐ $10,000
☐ $20,000 ☐ other $ __________

Child amount: 50% of spouse

AD&D ☐ Yes ☐ No

Amount: ☐ Same as Life ☐ other $_______

Short Term Disability ☐ Yes ☐ No

Benefit Amount:

Non taxable: (100% employee paid)
☐ 50 ☐ 60 ☐ 66.66%

Taxable: (100% employer paid)
☐ 50 ☐ 60 ☐ 66.66%
☐ 70 ☐ 75%

Flat amount: $____________________________

Maximum: ☐ highest ☐ other $________

Accident waiting period: ☐ 1 ☐ 4 ☐ 8 ☐ 15 Days

Sickness waiting period: ☐ 4 ☐ 8 ☐ 15 Days

First day hospital: ☐ Yes ☐ No

Benefit period: ☐ 15 ☐ 17 ☐ 26 weeks

Long Term Disability ☐ Yes ☐ No

Benefit Amount:

Non taxable: (100% employee paid)
☐ 50 ☐ 60 ☐ 66.66%

Taxable: (100% employer paid)
☐ 50 ☐ 60 ☐ 66.66%
☐ 70 ☐ 75%

Graded formula: ☐ 60% of 1st $2,500, 50% of next $2,500, 40% of balance

Flat amount: $____________________________

Maximum: $____________________________

Disability definition ☐ 2 yr own occ. ☐ any occupation

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Benefit period: ☐ 2 yrs ☐ to age 65

Benefit offset ☐ primary ☐ full

Cola: ☐ 0% ☐ 2% ☐ 3% ☐ 4%

Plan Design

Plan Design:

Class A: ________________

Extended Health Care ☐ Yes ☐ No

Major Medical:

Annual deductible $: ☐ none ☐ 25/25 ☐ 25/50 ☐ 50/50 ☐ 50/100 ☐ 100/200

Reimbursement: ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ other _______%

Paramedical maximum: ☐ $300 ☐ $500 ☐ $750 ☐ other $ _____ ☐ combined max.

Paramedical coinsurance: ☐ 70% ☐ 80% ☐ 100%

Hospital room: ☐ semi-private ☐ private

Hospital reimbursement: ☐ 70% ☐ 80% ☐ 100%

Drugs:

Drug card: ☐ Yes ☐ No

Prescription deductible: ☐ $0 ☐ $2.00 ☐ $5.00 ☐ $10.00 ☐ dispensing fee ☐ other $ ______

Dispensing fee cap: ☐ $0 ☐ $5.00 ☐ $7.00 ☐ $10.00 ☐ other $ ___________

Reimbursement: ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ other _______%

Per person maximum: ☐ unlimited ☐ other $ _______

Other options:

Smoking cessation ☐ Yes ☐ No

Fertility ☐ Yes ☐ No

Vision care ☐ none ☐ $100 ☐ $200

(per 2 years- 100%) ☐ $300 ☐ other $ ___________

Dental ☐ Yes ☐ No

Annual deductible $: ☐ none ☐ 25/25 ☐ 25/50 ☐ 50/50 ☐ 50/100 ☐ 100/200

Basic & Preventative:

Reimbursement: ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ other _______%

Recall: ☐ 5 ☐ 6 ☐ 9 ☐ 12 months

Annual maximum: ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ other $ ___________

Major: ☐ Yes ☐ No (5 employee min)

Reimbursement: ☐ 50% ☐ 80% ☐ other _____%

Annual maximum: ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ other $ ___________ ☐ combined max with basic & prev.

Orthodontics: ☐ Yes ☐ No (10 employee min)

Benefit ☐ children only ☐ children and adult

Reimbursement: ☐ 50% ☐ 60% ☐ other _____%

Alternate or Class B: __________________

Extended Health Care ☐ Yes ☐ No

Major Medical:

Deductible $: ☐ none ☐ 25/25 ☐ 25/50 ☐ 50/50 ☐ 50/100 ☐ 100/200

Reimbursement: ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ other _______%

Paramedical maximum: ☐ $300 ☐ $500 ☐ $750 ☐ other $ _____ ☐ combined max.

Paramedical coinsurance: ☐ 70% ☐ 80% ☐ 100%

Hospital room: ☐ semi-private ☐ private

Hospital reimbursement: ☐ 70% ☐ 80% ☐ 100%

Drugs:

Drug card: ☐ Yes ☐ No

Prescription deductible: ☐ $0 ☐ $2.00 ☐ $5.00 ☐ $10.00 ☐ dispensing fee ☐ other $ ______

Dispensing fee cap: ☐ $0 ☐ $5.00 ☐ $7.00 ☐ $10.00 ☐ other $ ___________

Reimbursement: ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ other _______%

Per person maximum: ☐ unlimited ☐ other $ _______

Other options:

Smoking cessation ☐ Yes ☐ No

Fertility ☐ Yes ☐ No

Vision care ☐ none ☐ $100 ☐ $200

(per 2 years- 100%) ☐ $300 ☐ other $ ___________

Dental ☐ Yes ☐ No

Annual deductible $: ☐ none ☐ 25/25 ☐ 25/50 ☐ 50/50 ☐ 50/100 ☐ 100/200

Basic & Preventative:

Reimbursement: ☐ 70% ☐ 80% ☐ 90% ☐ 100% ☐ other _______%

Recall: ☐ 5 ☐ 6 ☐ 9 ☐ 12 months

Annual maximum: ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ other $ ___________

Major: ☐ Yes ☐ No (5 employee min)

Reimbursement: ☐ 50% ☐ 80% ☐ other _____%

Annual maximum: ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ other $ ___________ ☐ combined max with basic & prev.

Orthodontics: ☐ Yes ☐ No (10 employee min)

Benefit ☐ children only ☐ children and adult

Reimbursement: ☐ 50% ☐ 60% ☐ other _____%

Plan Design

Plan Design:

Class A: ________________

Critical Illness	☐ Yes ☐ No
Flat amount	☐ $10,000 ☐ $25,000 ☐ $50,000
	☐ $100,000 ☐ other $ _________
Number of illnesses	☐ basic ☐ enhanced
Health Spending Account	☐ Yes ☐ No
Annual maximum:	☐ $500 ☐ $1,000 ☐ $1,500
	☐ $2,000 ☐ other $ ___________
Cost Plus	☐ Yes ☐ No

Alternate or Class B: _________________

Critical Illness	☐ Yes ☐ No
Benefit	☐ $10,000 ☐ $25,000 ☐ $50,000
	☐ $100,000 ☐ other $ _________
Number of illnesses	☐ basic ☐ enhanced
Health Spending Account	☐ Yes ☐ No
Annual maximum:	☐ $500 ☐ $1,000 ☐ $1,500
	☐ $2,000 ☐ other $ ___________
Cost Plus	☐ Yes ☐ No

Other Alternatives, Notes or Comments

EMPLOYEE DATA

Employee Name	Sex	Class	Date of Birth	Occupation	Salary	Dep. Status S-Single F–Family W–Waiver	Date of Hire	Prov
1.								
2.								
3.								
4.								
5.								
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