

# REQUEST FOR GROUP INSURANCE QUOTATION

*Please complete all applicable sections of the form.*

## 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: \_\_\_\_\_

Commission Schedule: \_\_\_\_\_

## 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.

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## 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 employees currently off work (excluding normal vacation)? 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\* \_\_\_\_\_ Renewal Date: \_\_\_\_\_  
\*max 2 insurers in the past 5 years
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).

PLAN DESIGN:	CLASS A:	ALTERNATE OR CLASS B:
LIFE Flat Amount:	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000
Multiple of Salary:	<input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> other \$_____	<input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> other \$_____
Maximum:	<input type="checkbox"/> highest <input type="checkbox"/> other \$_____	<input type="checkbox"/> highest <input type="checkbox"/> other \$_____
OPTIONAL LIFE	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT LIFE	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spousal Amount:	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$20,000
Child Amount:	50% of spouse	50% of spouse
AD&D	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount:	<input type="checkbox"/> Same as Life <input type="checkbox"/> other \$_____	<input type="checkbox"/> Same as Life <input type="checkbox"/> other \$_____
SHORT TERM DISABILITY	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Amount: Non Taxable:	(100% employee paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66%	(100% employee paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66%
Taxable:	(100% employer paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66% <input type="checkbox"/> 70 <input type="checkbox"/> 75%	(100% employer paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66% <input type="checkbox"/> 70 <input type="checkbox"/> 75%
Flat Amount:	\$ _____	\$ _____
Maximum:	<input type="checkbox"/> highest <input type="checkbox"/> other \$_____	<input type="checkbox"/> highest <input type="checkbox"/> other \$_____
Accident Waiting Period:	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 15 Days	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 15 Days
Sickness Waiting Period:	<input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 15 Days	<input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 15 Days
First Day Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Period:	<input type="checkbox"/> 15 <input type="checkbox"/> 17 <input type="checkbox"/> 26 Weeks	<input type="checkbox"/> 15 <input type="checkbox"/> 17 <input type="checkbox"/> 26 Weeks
LONG TERM DISABILITY	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Amount: Non Taxable:	(100% employee paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66%	(100% employee paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66%
Taxable:	(100% employer paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66% <input type="checkbox"/> 70 <input type="checkbox"/> 75%	(100% employer paid) <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 66.66% <input type="checkbox"/> 70 <input type="checkbox"/> 75%
Graded Formula:	<input type="checkbox"/> _____ % of 1st \$ _____ _____% of next \$ _____ _____% of balance	<input type="checkbox"/> _____ % of 1st \$ _____ _____% of next \$ _____ _____% of balance
Maximum:	\$ _____	\$ _____
Disability Definition:	<input type="checkbox"/> 2 yr own occ. <input type="checkbox"/> any occupation	<input type="checkbox"/> 2 yr own occ. <input type="checkbox"/> any occupation
Waiting Period:	<input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 Days	<input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 Days
Benefit Period:	<input type="checkbox"/> 2 yrs <input type="checkbox"/> 5 yrs <input type="checkbox"/> to age 65	<input type="checkbox"/> 2 yrs <input type="checkbox"/> to age 65
Benefit Offset:	<input type="checkbox"/> primary <input type="checkbox"/> full	<input type="checkbox"/> primary <input type="checkbox"/> full
Include:	<input type="checkbox"/> 0% <input type="checkbox"/> 2% <input type="checkbox"/> 3% <input type="checkbox"/> 4%	<input type="checkbox"/> 0% <input type="checkbox"/> 2% <input type="checkbox"/> 3% <input type="checkbox"/> 4%
Residual Definition:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spousal Disability:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Conversion:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLAN DESIGN:	CLASS A:		ALTERNATE OR CLASS B:	
<b>EXTENDED HEALTH CARE</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drugs:</b>				
Drug card:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescription deductible:	<input type="checkbox"/> \$0 <input type="checkbox"/> \$2.00 <input type="checkbox"/> \$5.00 <input type="checkbox"/> \$10.00 <input type="checkbox"/> dispensing fee <input type="checkbox"/> other \$ _____		<input type="checkbox"/> \$0 <input type="checkbox"/> \$2.00 <input type="checkbox"/> \$5.00 <input type="checkbox"/> \$10.00 <input type="checkbox"/> dispensing fee <input type="checkbox"/> other \$ _____	
Dispensing fee cap:	<input type="checkbox"/> \$0 <input type="checkbox"/> \$5.00 <input type="checkbox"/> \$7.00 <input type="checkbox"/> \$10.00 <input type="checkbox"/> other \$ _____		<input type="checkbox"/> \$0 <input type="checkbox"/> \$5.00 <input type="checkbox"/> \$7.00 <input type="checkbox"/> \$10.00 <input type="checkbox"/> other \$ _____	
Reimbursement:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% <input type="checkbox"/> other _____ %		<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% <input type="checkbox"/> other _____ %	
Per person maximum:	<input type="checkbox"/> Unlimited <input type="checkbox"/> other \$ _____		<input type="checkbox"/> Unlimited <input type="checkbox"/> other \$ _____	
Drug formulary:	<input type="checkbox"/> generic mandatory <input type="checkbox"/> generic equivalent <input type="checkbox"/> other		<input type="checkbox"/> generic mandatory <input type="checkbox"/> generic equivalent <input type="checkbox"/> other	
<b>Include:</b>				
Smoking cessation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Erectile Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vaccines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Major Medical:</b>				
Annual deductible:	<input type="checkbox"/> none <input type="checkbox"/> \$25/\$25 <input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$50 <input type="checkbox"/> \$50/\$100 <input type="checkbox"/> \$100/\$200		<input type="checkbox"/> none <input type="checkbox"/> \$25/\$25 <input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$50 <input type="checkbox"/> \$50/\$100 <input type="checkbox"/> \$100/\$200	
Reimbursement:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% <input type="checkbox"/> other _____ %		<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% <input type="checkbox"/> other _____ %	
Paramedical maximum:	<input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> other \$ _____ <input type="checkbox"/> combined max.		<input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> other \$ _____ <input type="checkbox"/> combined max.	
Practitioners included:	<input type="checkbox"/> enhanced <input type="checkbox"/> basic		<input type="checkbox"/> enhanced <input type="checkbox"/> basic	
Paramedical reimbursement:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 100%		<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 100%	
Hospital room:	<input type="checkbox"/> semi-private <input type="checkbox"/> private		<input type="checkbox"/> semi-private <input type="checkbox"/> private	
Hospital reimbursement:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 100%		<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 100%	
<b>Other options:</b>				
Vision care	<input type="checkbox"/> none <input type="checkbox"/> \$100 <input type="checkbox"/> \$200		<input type="checkbox"/> none <input type="checkbox"/> \$100 <input type="checkbox"/> \$200	
(per 2 years- 100%)	<input type="checkbox"/> \$300 <input type="checkbox"/> other \$ _____		<input type="checkbox"/> \$300 <input type="checkbox"/> other \$ _____	
Include Eye Exams	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>DENTAL</b>				
Annual deductible:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> none <input type="checkbox"/> \$25/\$25 <input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$50 <input type="checkbox"/> \$50/\$100 <input type="checkbox"/> \$100/\$200		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> none <input type="checkbox"/> \$25/\$25 <input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$50 <input type="checkbox"/> \$50/\$100 <input type="checkbox"/> \$100/\$200	
<b>Basic &amp; Preventative:</b>				
Reimbursement:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% <input type="checkbox"/> other _____ %		<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100% <input type="checkbox"/> other _____ %	
Recall:	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 9 <input type="checkbox"/> 12 mos.		<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 9 <input type="checkbox"/> 12 mos.	
Annual maximum:	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> other \$ _____		<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> other \$ _____	
<b>Major:</b>				
Reimbursement:	<input type="checkbox"/> Yes <input type="checkbox"/> No (5 employee min) <input type="checkbox"/> 50% <input type="checkbox"/> 80% <input type="checkbox"/> other _____ %		<input type="checkbox"/> Yes <input type="checkbox"/> No (5 employee min) <input type="checkbox"/> 50% <input type="checkbox"/> 80% <input type="checkbox"/> other _____ %	
Annual maximum:	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> other \$ _____ <input type="checkbox"/> combined max with basic & prev.		<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> other \$ _____ <input type="checkbox"/> combined max with basic & prev.	

