Request for Group Benefits Quotation

One Concorde Gate, Suite 802 | Toronto | Ontario | M3C 3N6

Employer Profile

Name of Organization: (legal name)	
Address:	
Phone:	Fax:
Email:	Web:
Contact Name:	Legal Status: ❑ Corporation
Nature of Organization:	

Year established	Unionized: ❑ No	Number of **Covered** Employees Full time:____ Part time:_____	How many hours do part-time employees work (consistently)? ______ (Only include those who are eligible for the benefits plan)

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.

#	Question	Answer	
1.	Are any employees currently receiving disability benefits under a group plan, WSIB or any other source?	❑ Yes ❑ No	
2.	Are any employees currently absent from work due to sickness or injury?	❑ Yes ❑ No	
3.	Has any employee been absent from work due to any one injury or illness for 14 consecutive days in the past 12 months?	❑ Yes ❑ No	
4.	Has any employee been absent from work on 6 or more occasions over the past 12 months?	❑ Yes ❑ No	
5.	Are any employees not covered by Worker's Compensation?	❑ Yes ❑ No	
6.	Are any employees not covered by Employment Insurance?	❑ Yes ❑ No	
7.	Are any employees related to one another (i.e., spouse, parent, child, etc)	❑ Yes ❑ No	
8.	Are any employees paid in full or in part by commission?	❑ Yes ❑ No	
9.	Has there been any significant change in the number of employees in the past 3 years? If yes, why?	❑ Yes ❑ No	
10.	Does the organization receive outside funding? If yes, from where and what percentage?	❑ Yes ❑ No	
11.	Please list any LTD claims made over the past five years including date and nature, outcome or prognosis of the claims		

Premiums: The employer will be paying the following percentage of premium for each benefit

Life/AD&D _______%	Dependent Life _______%	Long-term Disability _______%
Weekly Indemnity _______%	Extended Health Care _____%	Dental Care _______%

Proposed Effective Date of Coverage: ______________________________

Existing Plan Profile

Name of current Carrier:	How long with present carrier?	How many carriers in the last 5 years?

Benefits to Quote

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

☐ 1st 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

☐ 1st 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

☐ 66 2/3% 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 to Quote

Extended Health Care:

Co-insurance Options:

Drugs	Major Medical	Deductible Options:	Maximums:
☐ 100%	☐ 100%	☐ Nil	Paramedical ____________
☐ 90%	☐ 90%	____ / Family	Audio ________________
☐ 80%	☐ 80%	____ / Single	PDN ________________
☐ 70%	☐ 70%		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

Survivor Benefit: ❑ 2 years ❑ 5 years | Benefits terminate at age: ❑ 65 ❑ 70

Dental Care:

Coverages:	***Co-insurance***	***Annual Maximum***
❑ Basic Service:		
❑ Endodontic & Periodontal:		
❑ Major Restorative:		
❑ Orthodontia:		

Deductible: ❑ Nil ________/single ________/family

❑ Current Fee Guide ❑ Fixed Fee guide year ______

Survivor benefit: ❑ 2 years ❑ 5 years | Benefits terminating at age: ❑ 65 ❑ 70

Applicants Signature: ___________________________ Date: ____________________

OFFICE USE ONLY

Funding: ❑ Rated ❑ ASO ❑ Retention

Comm. Flat __________ Scaled __________

Demographic Count

	S	F
Div	___	___
Div	___	___
Div	___	___

Notes: