

GROUP QUOTATION REQUEST

from : Trudi St. Marie
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Date: _____

Name of Employer: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

UNDERWRITING INFORMATION SECTION

1. Nature of Business:

Legal Status:

Corporation Partnership Sole Proprietor Other {specify}

Number of years in operation: _____

Reason for Quotation: _____

2. Number of *eligible full-time* employees under age 70 (*full time* = _____ *hours per week*)

Number of full time employees: _____

3. Participation: Mandatory Voluntary

4. Are there any disabled employees at the present time? No Yes

5. Number of employees not covered by Workers' Compensation: _____

6. Are any employees being excluded from this plan? No Yes

Number of Employees excluded: _____

Reason for exclusion: _____

7. Does the client have a group plan now? No Yes
 Life AD&D Dep. Life STD LTD Health Dental

Are current and/or renewal rates available? No Yes

Present Insurer: _____ Number of years _____
 Previous Insurer: _____ Number of years _____
 Previous Insurer: _____ Number of years _____

8. Is the employer paying a share of the total premium? No Yes - what %: _____
 Is the employer paying a share of the LTD premium? No Yes - what %: _____
 Is the employer paying a share of the STD premium? No Yes - what %: _____

BENEFITS SECTION

LIFE

1. **(A) EMPLOYEE TERM LIFE**
(B) EMPLOYEE AD&D

CLASS	CLASS DESCRIPTION	AMOUNT OF INSURANCE	ALTERNATE PLAN DETAILS

2. **(A) OPTIONAL EMPLOYEE TERM LIFE**
(B) OPTIONAL EMPLOYEE AND SPOUSAL TERM LIFE (available on a self-admin basis only)

3. **DEPENDENT LIFE INSURANCE BENEFIT:**
 Spouse: \$ _____
 Child(ren): \$ _____

ALTERNATE PLAN DETAILS:
 Spouse: \$ _____
 Child(ren): \$ _____

[] 4. **SHORT TERM DISABILITY BENEFIT:**

Class Description:			
Weekly earnings %:			
Maximum Benefit:	[] \$ _____ [] UIC Max.	[] \$ _____ [] UIC Max.	[] \$ _____ [] UIC Max.
\$ - Flat Amount:			
Benefits Payable From:			
for Accident	_____ day Acc.	_____ day Acc.	_____ day Acc.
For Sickness	_____ day Sick.	_____ day Sick.	_____ day Sick.
For Hospital	_____ day Hosp.	_____ day Hosp.	_____ day Hosp.
Benefit Period # of weeks	_____ weeks	_____ weeks	_____ weeks

Alternate Plan Description: _____

[] 5. **LONG TERM DISABILITY BENEFIT:**

Class Description			
1. Monthly earnings %			
2. Of the 1st \$			
3. %			
4. of the Next \$			
5. % of the Remainder			
6. Maximum Benefit			
Elimination Period			
CPP/QPP Offsets			
All Source Maximum			
Benefit Period			
Own Occupation Period			
Pre-Existing Conditions			
Residual Benefit, OR Partial Benefit OR Total Disability Benefit			

ADDITIONAL LTD PLAN OPTIONS:

- COLA: _____ % # of increases _____ linked to cpi
- Conversion Privilege: 1 month 6 months
- Survivor Benefit: 3 months 6 months
- Pension Supplement: _____ % \$_____ Max./month (if applicable)
- Other: _____

Alternate Plan Description: _____

6. HEALTH CARE BENEFIT

Calendar Year Deductible: \$ _____ Single \$ _____ Family
Coinsurance%: _____ %

Hospital Coverage: Semi-Private Private
Drugs: Prescription Pay Direct Plan _____
Deductible _____

Private Duty Nursing: \$ _____ per calendar year
Paramedical Practitioners: \$ _____ per practitioner type per calendar year
Hearing Aids: \$ _____ per _____ years
Orthopaedic Shoes: \$ _____ per calendar year
Other: \$ _____
Vision Care: \$ _____ per 24 months - frames and lenses
\$ _____ per lifetime; medically necessary contacts

2 year survivor benefit with premium payment: Yes _____ No _____
2 year survivor benefit without premium payment: Yes _____ No _____

ALTERNATE PLAN DETAILS:

7. DENTAL CARE BENEFIT

Calendar Year Deductible: \$ _____ Single \$ _____ Family

Fee Schedule: _____

Recall Exam: _____

Basic Dental: Coinsurance: _____ % \$ _____ per calendar year

Major Dental: Coinsurance: _____ % \$ _____ per calendar year

Orthodontics: Coinsurance: _____ % \$ _____ per calendar year

Adult Ortho. Dependent Ortho. Only.

2 year survivor benefit with premium payment: Yes _____ No _____

2 year survivor benefit without premium payment: Yes _____ No _____

ALTERNATE PLAN DETAILS

ADDITIONAL INFORMATION SECTION:

Pooled Claims Disclosure: Are any claims above the pooling level of \$ _____? Yes / No

CONFIDENTIAL EMPLOYEE DATA

NAME	AGE [] YEAR OF BIRTH []	Sex	COVERAGE S - Single F - Family W - Waiver	Earnings	Occupation	Date Employed DD MM YY
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
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18.						
19.						
20.						
21.						
22.						
23.						