GROUP FORCE BENEFITS INC.

6205A Airport Rd., Suite 300
Mississauga, Ontario L4V 1E1

Tel: 905 238 6723
Fax: 905 238 0215

CLEAR

REQUEST FOR GROUP INSURANCE QUOTATION

Please complete all application sections of the form. Return the specifications to Group Force Benefits Inc. by email to quotes@groupforce.ca

Client Information

Company name _____
Address _____
City and Province _____
Postal code _____
Phone number _____
Website _____
Number of employees _____
Date of request _____

Advisor Information

Advisor name _____
Company name _____
Address _____
City, Province _____
Postal code _____
Telephone number _____
Email address _____
Commission Schedule _____

Advisor Requirements

Plan Design • **Claims Experience** • **Rate History** • **Employee Data**

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

REQUEST FOR GROUP INSURANCE QUOTATION

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

Client Questions

Nature of business

Number of years In business

Any contract or seasonal employees

Are 50% or more employees from the same family, if so, do they reside in the same household

Are all employees and owners covered by Workers Compensation (WSIB)

Premium contribution basis (ie; Employer pays 50% / Employee pays 50%)

Are any employees not actively at work

Are there any disabled employees (Yes/No, If yes, please complete the following chart in full)

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

CLAIMS EXPERIENCE

Experience Period*	Health		Dental	
	Billed Premiums	Paid Claims	Billed Premiums	Paid Claims

Pooled Premiums and Pooled Claims included above

Experience Period	STD	
	Billed Premiums	Paid Claims
0		
0		
0		

Experience Period**	LAP PREMIUMS / CLAIMS	
	Pooled Premiums	Pooled Claims
0		
0		
0		

Pooled Premiums and Pooled Claims included here are separate from above experience

Are there any large amount pooling claims?
If yes, please advise total claims amount pooled:
Are these claims recurring?
Current carrier's stop loss amount:

Please refer to the attached email for any additional notes or alternate quote requests

Requested Plan

Benefits	Basic Plan	Alternative Plan
LIFE AND AD&D		
Schedule	Flat Amount	Flat Amount
Maximum Benefit	$25,000	$25,000
Reduction Schedule	50% at age 65	50% at age 65
Non Evidence Maximum	$25,000	$25,000
Termination Age	71 or earlier retirement	71 or earlier retirement
DEPENDENT LIFE		
Spouse Coverage	$5,000	$5,000
Child Coverage	$2,500 per child	$2,500 per child
EXTENDED HEALTH CARE		
Drugs		
Deductible	Equal to the Dispensing Fee	**Nil**
Coinsurance	80%	**100%**
Plan Type	Pay Direct Drug Card	Pay Direct Drug Card
Drug Type	Mandatory Generic	Mandatory Generic
Maximum	Unlimited	Unlimited
Lifestyle Drugs		
Fertility Drugs/Smoking Cessation	Not requested	Not requested
Vaccines	Requested	Requested
Major Medical		
Deductible	Nil	Nil
Coinsurance	80%	**100%**
Hospital	Not requested	**100%, Semi-private room**
Orthopaedic Shoes/Orthotic Inserts	Requested	Requested
Private Duty Nursing	$10,000 per year	$10,000 per year
Paramedical Services		
Coinsurance	80%	**100%**
Maximum Benefit	$300 per practitioner per year	$300 per practitioner per year
Vision Care		
Coinsurance	100% (Eye Exam only)	100%
Glasses, Contacts, Etc.	Not requested	**$100 every 24 months**
Eye Exams	1 exam every 24 months (R&C)	1 exam every 24 months (R&C)
DENTAL CARE		
Deductible	Nil	Nil
Basic and Preventative Coinsurance	80%	**100%**
Endodontics and Periodontics Coinsurance	80%	**100%**
Maximum Benefit	$1,000 per year	**$1,500 per year**
Major Restorative Coinsurance	Not requested	Not requested
Orthodontics Coinsurance	Not requested	Not requested
Recall Exams	Every 9 months	**Every 6 months**
Units of Scaling	8 units per year	8 units per year
Fee Guide	Current year	Current year
Health & Dental Termination Age	75 or earlier retirement	75 or earlier retirement