GROUP FORCE
BENEFITS INC.

6400 Northwest Drive
Mississauga, ON L4V 1K1
Tel: 905 238- 6723
Fax: 905 238-0215

REQUEST FOR GROUP INSURANCE QUOTATION

Please complete all application sections of the form. Return the specifications to Group Force Benefits Inc. by fax (905) 238-0215 or email to quotes@groupforce.ca

Client Information

Company Name: _____
Street: _____
City, Province _____
Postal Code: _____
Number of Employees: _____
Phone Number _____
Fax Number _____
Website: _____
Date of Request: _____

Advisor Information

Advisor Name: _____
Company Name: _____
Street: _____
City, Province _____
Postal Code _____
Telephone Number: _____
Cell Number: _____
Fax Number: _____
E-Mail Address: _____
Commission Schedule: _____

Advisor Requirements

A. Plan Design B. Census 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.

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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 _____ %
7. Are there any employees not actively at work? ☐ Yes ☐ No
   If yes, please provide details _____
8. 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?

9. Are they currently insured? ☐ Yes ☐ No If yes please indicate the following:
   Current Carrier: _____ number of years with carrier _____ (max 2 insurers in the past 5 years)
10. Renewal Date _____
11. Are benefits being quoted the same as their current plan? ☐ Yes ☐ No If not, Explain why:

12. Experience and rates provided? ☐ Yes ☐ No Please include the most current month and a Minimum of two years (preferably three). If not, please explain why:

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REQUEST TO QUOTE – PLAN SPECIFICATIONS

Class A	
Class B	
Class C	
Class D	

Basic Life and Accidental Death and Dismemberment (Mandatory)

	Class A	Class B	Class C	Class D
Flat Amount *(Minimum = $25,000)*	☐ $	☐ $	☐ $	☐ $
Formula Amount *(Minimum = $25,000)*	☐ *1 X Annual Salary* ☐ *2 X Annual Salary* ☐ *3 X Annual Salary*	☐ *1 X Annual Salary* ☐ *2 X Annual Salary* ☐ *3 X Annual Salary*	☐ *1 X Annual Salary* ☐ *2 X Annual Salary* ☐ *3 X Annual Salary*	☐ *1 X Annual Salary* ☐ *2 X Annual Salary* ☐ *3 X Annual Salary*
Life Termination Age :				
Optional Life	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Dependent Life (Optional)

	Class A	Class B	Class C	Class D
Dependent Life Coverage	☐ $20,000 spouse/ $10,000 child ☐ $10,000 spouse/ $5,000 child ☐ $5,000 spouse/ $2,500 child	☐ $20,000 spouse/ $10,000 child ☐ $10,000 spouse/ $5,000 child ☐ $5,000 spouse/ $2,500 child	☐ $20,000 spouse/ $10,000 child ☐ $10,000 spouse/ $5,000 child ☐ $5,000 spouse/ $2,500 child	☐ $20,000 spouse/ $10,000 child ☐ $10,000 spouse/ $5,000 child ☐ $5,000 spouse/ $2,500 child

Weekly Indemnity (Optional)

	Class A	Class B	Class C	Class D
Schedule	☐ 0/7/17 ☐ 0/7/26 ☐ 14/14/26	☐ 0/7/17 ☐ 0/7/26 ☐ 14/14/26	☐ 0/7/17 ☐ 0/7/26 ☐ 14/14/26	☐ 0/7/17 ☐ 0/7/26 ☐ 14/14/26
Flat Benefit	☐ 60% ☐ 66 2/3% ☐ 70% ☐ 75%	☐ 60% ☐ 66 2/3% ☐ 70% ☐ 75%	☐ 60% ☐ 66 2/3% ☐ 70% ☐ 75%	☐ 60% ☐ 66 2/3% ☐ 70% ☐ 75%
Maximum (Highest max. available is $1,200)	☐ EI Maximum ☐ $700 ☐ $1,000 ☐ $900 ☐ Other $	☐ EI Maximum ☐ $700 ☐ $1,000 ☐ $900 ☐ Other $	☐ EI Maximum ☐ $700 ☐ $1,000 ☐ $900 ☐ Other $	☐ EI Maximum ☐ $700 ☐ $1,000 ☐ $900 ☐ Other $
Flat Amount	☐ $	☐ $	☐ $	☐ $
1st Day Hospital	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included

Long Term Disability (Optional)

	Class A	Class B	Class C	Class D
Elimination Period	☐ 17 weeks ☐ 26 weeks	☐ 17 weeks ☐ 26 weeks	☐ 17 weeks ☐ 26 weeks	☐ 17 weeks ☐ 26 weeks
Flat Benefit	☐ 60% ☐ 66 2/3% ☐ 70%* ☐ 75%*	☐ 60% ☐ 66 2/3% ☐ 70%* ☐ 75%*	☐ 60% ☐ 66 2/3% ☐ 70%* ☐ 75%*	☐ 60% ☐ 66 2/3% ☐ 70%* ☐ 75%*
Graded Benefit	**%** of the first **$** of monthly income, **%** of the next **$** and **%** of the balance.	**%** of the first **$** of monthly income, **%** of the next **$** and **%** of the balance.	**%** of the first **$** of monthly income, **%** of the next **$** and **%** of the balance.	**%** of the first **$** of monthly income, **%** of the next **$** and **%** of the balance.
Maximum	☐ $	☐ $	☐ $	☐ $
Tax Status	☐ Taxable ☐ Non-Taxable	☐ Taxable ☐ Non-Taxable	☐ Taxable ☐ Non-Taxable	☐ Taxable ☐ Non-Taxable

*Plans with 70% and 75% benefit must be taxable. If the employee pays 100% of this premium, the benefit received during disability will be tax-free.

- Integration: Primary C.P.P./Q.P.P., 85% All Source Maximum
- Own Occupation period: The first 24 months of any benefit period for the purpose of the 'Total Disability" definition. Partial Disability is included.
- Cost of Living Adjustment: Not Included

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REQUEST TO QUOTE – PLAN SPECIFICATIONS (CONT'D)

Extended Health Benefit

	Class A	Class B	Class C	Class D
Drug Type	☐ Paper Reimbursement ☐ Pay Direct Card	☐ Paper Reimbursement ☐ Pay Direct Card	☐ Paper Reimbursement ☐ Pay Direct Card	☐ Paper Reimbursement ☐ Pay Direct Card
Drug Maximums	☐ Unlimited ☐ $2,000 ☐ $3,000 ☐ $5,000 ☐ Other $	☐ Unlimited ☐ $2,000 ☐ $3,000 ☐ $5,000 ☐ Other $	☐ Unlimited ☐ $2,000 ☐ $3,000 ☐ $5,000 ☐ Other $	☐ Unlimited ☐ $2,000 ☐ $3,000 ☐ $5,000 ☐ Other $
Drug Classifications	☐ Brand Name ☐ Generic ☐ Mandatory Generic	☐ Brand Name ☐ Generic ☐ Mandatory Generic	☐ Brand Name ☐ Generic ☐ Mandatory Generic	☐ Brand Name ☐ Generic ☐ Mandatory Generic
Deductibles				
Per Script Deductibles	☐ Nil ☐ $2 ☐ $5 ☐ $10	☐ Nil ☐ $2 ☐ $5 ☐ $10	☐ Nil ☐ $2 ☐ $5 ☐ $10	☐ Nil ☐ $2 ☐ $5 ☐ $10
OR Deductible=Dispensing Fee	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
OR Dispensing Fee Cap	☐ Nil ☐ $7 ☐ $8 ☐ $9	☐ Nil ☐ $7 ☐ $8 ☐ $9	☐ Nil ☐ $7 ☐ $8 ☐ $9	☐ Nil ☐ $7 ☐ $8 ☐ $9
OR Annual Deductible	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $
Coinsurance	☐ 60% ☐ 75% ☐ 80% ☐ 90% ☐ 100%	☐ 60% ☐ 75% ☐ 80% ☐ 90% ☐ 100%	☐ 60% ☐ 75% ☐ 80% ☐ 90% ☐ 100%	☐ 60% ☐ 75% ☐ 80% ☐ 90% ☐ 100%
Smoking Cessation $300 Lifetime Maximum	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included
Erectile Dysfunction	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included
Fertility Drugs	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included
Vaccines	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included
Major Medical Services & Supplies				
Deductible	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $	☐ Nil ☐ $25/$50 ☐ $50/$100 ☐ Other $
Coinsurance	☐ 70% ☐ 80% ☐ 90% ☐ 100%	☐ 70% ☐ 80% ☐ 90% ☐ 100%	☐ 70% ☐ 80% ☐ 90% ☐ 100%	☐ 70% ☐ 80% ☐ 90% ☐ 100%
Paramedical Services*	☐ Yes ☐ No If YES, select ONE maximum only	☐ Yes ☐ No If YES, select ONE maximum only	☐ Yes ☐ No If YES, select ONE maximum only	☐ Yes ☐ No If YES, select ONE maximum only
	Per Insured, per Practitioner ☐ $300 ☐ $500 ☐ $750 **OR**	Per Insured, per Practitioner ☐ $300 ☐ $500 ☐ $750 **OR**	Per Insured, per Practitioner ☐ $300 ☐ $500 ☐ $750 **OR**	Per Insured, per Practitioner ☐ $300 ☐ $500 ☐ $750 **OR**
	All Practitioners combined ☐ $300 ☐ $500 ☐ $750 ☐ $1,000 ☐ Other $	All Practitioners combined ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $1,000 ☐ Other $	All Practitioners combined ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $1,000 ☐ Other $	All Practitioners combined ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $1,000 ☐ Other $
Referral Required (Massage Therapy only)	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included

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REQUEST TO QUOTE – PLAN SPECIFICATIONS (CONT'D)

Extended Health Benefit (cont'd)

	Class A	Class B	Class C	Class D
Private Duty Nursing (per year)	☐ $5,000 ☐ $10,000	☐ $5,000 ☐ $10,000	☐ $5,000 ☐ $10,000	☐ $5,000 ☐ $10,000
Semi-Private - $0 deductible, 100% coinsurance	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included
Orthotic Inserts and Shoes (per year)	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included	☐ Included ☐ Not Included
Vision Care $0/$0 deductible, 100% coinsurance, every 24 months	☐ Nil ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ Other $	☐ Nil ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ Other $	☐ Nil ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ Other $	☐ Nil ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ Other $
Eye Exams, every 24 months	☐ Not Included ☐ $ ______ ☐ R&C	☐ Not Included ☐ $ ______ ☐ R&C	☐ Not Included ☐ $ ______ ☐ R&C	☐ Not Included ☐ $ ______ ☐ R&C
EHC Termination Age :				

Dental

	Class A	Class B	Class C	Class D
Level 1 , 2 and 3 Deductible	☐ Nil ☐ $25/$50 ☐ $50/$100	☐ Nil ☐ $25/$50 ☐ $50/$100	☐ Nil ☐ $25/$50 ☐ $50/$100	☐ Nil ☐ $25/$50 ☐ $50/$100
Level 1 &2 Basic Restorative Including Preventative Services Periodontics - Endodontic	☐ 70% coinsurance ☐ 80% coinsurance ☐ 90% coinsurance ☐ 100% coinsurance ☐ $1,000 max ☐ $1,500 max ☐ Other $ ______ ☐ Unlimited	☐ 70% coinsurance ☐ 80% coinsurance ☐ 90% coinsurance ☐ 100% coinsurance ☐ $1,000 max ☐ $1,500 max ☐ Other $ ______ ☐ Unlimited	☐ 70% coinsurance ☐ 80% coinsurance ☐ 90% coinsurance ☐ 100% coinsurance ☐ $1,000 max ☐ $1,500 max ☐ Other $ ______ ☐ Unlimited	☐ 70% coinsurance ☐ 80% coinsurance ☐ 90% coinsurance ☐ 100% coinsurance ☐ $1,000 max ☐ $1,500 max ☐ Other $ ______ ☐ Unlimited
Recall Basis	☐ 6 months ☐ 9 months ☐ 12 months	☐ 6 months ☐ 9 months ☐ 12 months	☐ 6 months ☐ 9 months ☐ 12 months	☐ 6 months ☐ 9 months ☐ 12 months
Level 3 Major Restorative	☐ Included ☐ Not included ☐ 50% coinsurance ☐ 80% coinsurance ☐ $1,500 max ☐ $2,000 max ☐ Other $ ______ ☐ Combined ☐ With Level 1 & 2	☐ Included ☐ Not included ☐ 50% coinsurance ☐ 80% coinsurance ☐ $1,500 max ☐ $2,000 max ☐ Other $ ______ ☐ Combined ☐ With Level 1 & 2	☐ Included ☐ Not included ☐ 50% coinsurance ☐ 80% coinsurance ☐ $1,500 max ☐ $2,000 max ☐ Other $ ______ ☐ Combined ☐ With Level 1 & 2	☐ Included ☐ Not included ☐ 50% coinsurance ☐ 80% coinsurance ☐ $1,500 max ☐ $2,000 max ☐ Other $ ______ ☐ Combined ☐ With Level 1 & 2
Level 4 Orthodontics for dependent Children - lifetime maximum (Only available if Level 3 Is elected)	☐ Included ☐ Not Included ☐ 50% coinsurance ☐ 60% coinsurance$ Maximum $ ______	☐ Included ☐ Not Included ☐ 50% coinsurance ☐ 60% coinsurance$ Maximum $ ______	☐ Included ☐ Not Included ☐ 50% coinsurance ☐ 60% coinsurance$ Maximum $ ______	☐ Included ☐ Not Included ☐ 50% coinsurance ☐ 60% coinsurance$ Maximum $ ______
Fee Guide	☐ Current ☐ Prior	☐ Current ☐ Prior	☐ Current ☐ Prior	☐ Current ☐ Prior
Dental Scaling Units	☐ 6 Units ☐ 8 Units ☐ 10 Units ☐ 12 Units ☐ 15 Units	☐ 6 Units ☐ 8 Units ☐ 10 Units ☐ 12 Units ☐ 15 Units	☐ 6 Units ☐ 8 Units ☐ 10 Units ☐ 12 Units ☐ 15 Units	☐ 6 Units ☐ 8 Units ☐ 10 Units ☐ 12 Units ☐ 15 Units
Dental Termination Age :				

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REQUEST TO QUOTE – PLAN SPECIFICATIONS (CONT'D)

Critical Illness				
Critical Illness	**Class A**	**Class B**	**Class C**	**Class D**
Benefit Amount	☐ Not Included ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other $	☐ Not Included ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other $	☐ Not Included ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other $	☐ Not Included ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other $
Health Care Spending Account (HCSA)	**Class A**	**Class B**	**Class C**	**Class D**
Benefit Amount	☐ Not Included ☐ $500 ☐ $1,000 ☐ Other $	☐ Not Included ☐ $500 ☐ $1,000 ☐ Other $	☐ Not Included ☐ $500 ☐ $1,000 ☐ Other $	☐ Not Included ☐ $500 ☐ $1,000 ☐ Other $

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CLAIMS EXPERIENCE AND RATE HISTORY

If there is current coverage in place, please provide the most current rates and experience for a minimum of the last 2 years. (Preferably three)

RATE HISTORY

	Life	AD&D	Dep Life	STD	LTD
Renewal Pooled Rates					
Current Pooled Rates					

Period	Effective Date	Health Single	Health Family	Dental Single	Dental Family
Renewal					
Current					
Prior					
Prior-1					

CLAIMS EXPERIENCE

Period	Dates From/To	Health Premiums	Health Claims	Dental Premiums	Dental Claims
Current					
Prior					
Prior-1					

LARGE AMOUNT POOLING (STOP LOSS)

Are there any large amount pooling claims?	☐ YES	☐ NO	
If yes…Amount pooled in Current Period	$		
Amount pooled in Prior Period	$		
Amount pooled in Prior-1 Period	$		
Are these claims recurring	☐ YES	☐ NO	
Current Carrier's Stop Loss Amount	$	☐ Per person	☐ Per certificate

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OTHER ALTERNATIVES, NOTES OR COMMENTS