MDM Insurance Services Inc.

REQUEST FOR GROUP QUOTATION - PLAN G.1111

COMPANY INFORMATION

Company Name:
(full legal name of the business)

Location address:

_____
Street City Province Postal Code

Legal Status: ❒ Corporation ❒ Partnership ❒ Sole proprietorship ❒ Trustee
❒ Union ❒ Association ❒ Other _____

Nature of the business (goods or services provided):

How long has the company been in business? _____

Print the full names and addresses of any subsidiary or affiliated companies which are to be covered.

Subsidiary	Affiliated	Full names and addresses of the companies
❒	❒	_____
❒	❒	_____
❒	❒	_____

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

Life/AD&D _____ % Dependent Life _____% Short Term Disability _____% Long Term Disability _____ %

Extended Health Care _____% Dental _____%

Proposed effective date requested: _____

EXISTING PLAN PROFILE

Name of carrier(s): _____

How long with present carrier(s): _____ ❒ year(s) ❒ months Number of carriers in last five years: _____

Why is this group being marketed? _____

What is the anniversary of the current policy? _____

Renewal rates: Effective date of renewal rates (if different than policy anniversary): _____

❒ Life _____ / $1000 ❒ AD&D _____ / $1000 ❒ Dep. Life _____ ❒ LTD _____ / $100 ❒ STD _____ / $10

❒ EHC _____ / single _____ / family ❒ Dental _____ / single _____ / family

High Level Pooling/Stop Loss Limit $_____ per ❒ insured individual ❒ employee (and all covered dependents combined)

❒ other _____

Please include rate, premium, and claims history by coverage for the last three years, and a benefit booklet summary by class with this form.

ELIGIBILITY

Eligible Employees To Be Covered	# of Eligible Employees
❒ Permanent full-time	_____
❒ Permanent part-time	_____
❒ Seasonal	_____
❒ Contract (employee)	_____
❒ Contract (independent)	_____

Full-time employees must work at least _____ hours per week.

Part-time employees must work at least _____ hours per week.

Percentage of full-time employees participating in the plan _____ %

Percentage of part-time employees participating in the plan _____ %

EMPLOYEE INFORMATION

If YES is responded to any of the following questions, please provide details below or attach a separate page. For questions 1 and 2, list each employee, date of disability, expected return to work date and, if available, diagnosis, and prognosis.	Yes	No
1) a. Are any employees currently receiving disability benefits under a group plan, WSIB, or any other source?	❒	❒
b. Has the current insurer waived the life insurance premium for these employees?	❒	❒
2) Are any employees currently absent from work due to sickness or injury?	❒	❒
3) Are any dependents currently in the hospital? If YES, list employee(s) of the dependent(s).	❒	❒
4) Are any employees NOT covered by WSIB? If YES, list.	❒	❒
5) Are any employees NOT covered by Employment Insurance? If YES, list.	❒	❒
6) Has there been any significant change in the number of employees over the past year? If YES, provide details.	❒	❒
7) If employer has current coverage, are any employees not members of that plan? If YES, list, and provide details.	❒	❒
8) Have any employees ever been declined group coverage? If YES, provide details.	❒	❒
9) Will plan participation for current employees be mandatory under this plan?	❒	❒
10) Will plan participation for new employees be mandatory under this plan?	❒	❒

ADMINISTRATION

1) If the group has more than one class and/or location, are separate invoices required for each class and/or location?	❒	❒
2) Will invoices be paid by electronic funds transfer (EFT)?	❒	❒
3) Will invoices be sent by e-mail?	❒	❒
4) Will claim cheques be sent to the employer's address?	❒	❒

AGENT/BROKER PROFILE

Name: _____ Signature: _____

Address: _____

Phone: _____ Current agent of record: ❒ Yes ❒ No

Agent/Broker Comments: _____

_____

MDM Insurance Services Inc.

GROUP BENEFITS REQUESTED - BY CLASS

Class: _____

New employees are eligible: ❒ On the first day of employment
❒ After having been employed for _____ ❒ days ❒ month(s) ❒ year(s)
❒ Other _____

Definition of dependent child: Under age _____ or under age _____ if a full-time student.

❒ GROUP LIFE	
❒ Salary related: _____ x annual salary to a maximum benefit of $ _____ ❒ Flat benefit: $ _____	
❒ Minimum amount under age 65 is $ _____	
❒ Reducing by 50% at age 65 **OR** ❒ No reduction at age 65 **OR** ❒ Other _____	
Terminating at age: ❒ 65, or earlier retirement ❒ 70, or earlier retirement ❒ Other _____	
✗ OPTIONAL LIFE	Multiples of $10,000. Maximum of $300,000 for employee and/or spouse. Terminates at age: ❒ 65 ❒ 70
❒ ACCIDENTAL DEATH AND DISMEMBERMENT	❒ 1x Life benefit Terminating at age: ❒ 65, or earlier retirement ❒ 70, or earlier retirement ❒ 2x Life benefit ❒ Other _____
❒ DEPENDENT LIFE	Spouse: $ _____ Child: $ _____ Terminating at age: ❒ 65, or earlier retirement ❒ 70, or earlier retirement ❒ Other _____ Termination based on: ❒ Employee's age ❒ Dependent's age
❒ SHORT TERM DISABILITY	❒ STD first payor ❒ EI first payor ❒ EI carve out Top up? ❒ Yes ❒ No
Benefit amount	_____ % of weekly salary **OR** Flat $ _____
Maximum benefit	❒ EI maximum **OR** ❒ NEM **OR** ❒ HEM **OR** ❒ $ _____
Type of plan	❒ Taxable ❒ Non-taxable (employee must pay 100% of the STD premium)
Elimination period	Accident: _____ days Hospital: _____ days Sickness: _____ days
Duration	_____ weeks ❒ from date of disability ❒ from end of elimination period
CPP/QPP offsets	❒ Primary ❒ Full ❒ Nil
Coverage while at work	❒ Yes ❒ No
Pre-existing condition clause	❒ Yes ❒ No
Exclude motor vehicle accidents	❒ Yes ❒ No
Terminating at age	❒ 65, or earlier retirement ❒ 70, or earlier retirement ❒ Other _____
❒ LONG TERM DISABILITY	
Benefit amount	_____ % of monthly salary **OR** _____ % of first _____ **OR** Flat $ _____ _____ % of next _____ _____ % COLA _____ % of balance
Maximum benefit	❒ NEM **OR** ❒ HEM **OR** ❒ $ _____
Type of plan	❒ Taxable ❒ Non-taxable (employee must pay 100% of the LTD premium)
Elimination period	_____ days
Duration	❒ 5 years ❒ to age 65 ❒ Other _____
CPP/QPP offsets	❒ Primary ❒ Full ❒ Nil
Definition of disability	❒ Own occupation - _____ years from end of elimination period ❒ Any occupation
Exclude motor vehicle accidents	❒ Yes ❒ No
Terminating at age	65, or earlier retirement

❒ EXTENDED HEALTH CARE

Reimbursement Percentages:

Emergency Out-of-Canada _____ %
Hospital Expenses _____ %
Vision Care _____ %
Paramedical Practitioners _____ %
Other _____ %

Dollar maximums are **insured year** maximums.

Maximum $ _____
❒ per accident/illness ❒ lifetime
❒ Semi-private room ❒ Private room
Maximum $ _____ per _____ months.

Deductible (calendar year):

❒ Nil
❒ $ _____ / single
$ _____ / family

If the group has a pay-direct drug card, are drugs subject to the calendar year deductible? ❒ Yes ❒ No

❒ **Trip Cancellation Insurance**

❒ **Travel Benefits Plus**

Drug Coverage: Standard G.1111 Formulary #10. Include coverage for Viagra and other ED drugs? ❒ Yes ❒ No

Drug Plan Type:

❒ Reimbursement
❒ Pay-direct
❒ Mandatory generic substitution

Drug Plan Pays:

_____ % to a maximum of $ _____, or
_____ % of first $ _____
_____ % of next $ _____
_____ % of balance

Drug Plan Options:

❒ filling fee maximum $ _____
❒ deductible per prescription $ _____

Paramedical Practitioners:

Yearly maximum: ❒ Standard $400 ❒ Other $ _____
Per visit maximum: ❒ $7.00 ❒ $15.00 ❒ $20.00 ❒ Other $ _____
Include first visit coverage where allowed by law? ❒ Yes ❒ No

Exclude motor vehicle accidents: ❒ Yes ❒ No Survivor Benefit: ❒ 2 years ❒ 5 years ❒ Other _____

Terminating at age: ❒ 65, or earlier retirement ❒ 70, or earlier retirement ❒ Other _____
Termination based on: ❒ Employee's age ❒ Dependent's age

❒ DENTAL

Coverages	Reimbursement	Maximums
Level 1a: Diagnostic Services	_____ %	$ _____ per insured year (Levels 1a-3b combined maximum)
Level 1b: Preventative Services	_____ %	
Level 2a: Minor Surgical/Restorative Services	_____ %	
Level 2b: Major Surgical Services	_____ %	
Level 2c: Denture Repair Services	_____ %	
Level 3a: Endodontic Services	_____ %	
Level 3b: Periodontic Services	_____ %	
Level 4a: Crowns & Bridges	_____ %	$ _____ per insured year (Levels 4a-4b)
Level 4b: Complete & Partial Dentures	_____ %	
Level 5: Orthodontic Services	_____ %	$ _____ per lifetime
Level 6: Temporomandibular Services	_____ %	$ _____ per lifetime
Level 7: Implantology Services	_____ %	$ _____ per lifetime

Orthodontic coverage for dependent children only? ❒ Yes ❒ No Combine Levels 1a-3b maximum with Level 4a-4b maximum? ❒ Yes ❒ No
If yes, cover dependents under age _____ Orthodontic treatment started prior to age _____

Deductible (calendar year):

❒ Nil
❒ $ _____ / single
$ _____ / family

Fee Guide Schedule:

❒ Fee guide year: _____
❒ Current fee guide
❒ Current less _____ year(s)

Dental Plan and Recall Examination Frequency:

Plan #5: ❒ once every 5 months (no more than twice every 12 months)
Plan #6: ❒ once every 9 months
Plan #7: ❒ once every 12 months

Fluoride treatment for patients under age _____

Allow for electronic payment of claims? ❒ Yes ❒ No Allow assignment of claims payment to dentist? ❒ Yes ❒ No

Exclude motor vehicle accidents: ❒ Yes ❒ No Survivor Benefit: ❒ 2 years ❒ 5 years ❒ Other _____

Terminating at age: ❒ 65, or earlier retirement ❒ 70, or earlier retirement ❒ Other _____
Termination based on: ❒ Employee's age ❒ Dependent's age

NOTES

Are the benefits requested the same as the current plan design with respect to coverages, deductibles, co-insurance, and per visit maximums?
If no, please list the differences on a separate page. ❒ Yes ❒ No