MDM Insurance Services Inc.

REQUEST FOR GROUP QUOTATION - PLAN G1000

APPLICANT INFORMATION

Applicant:
(Print 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
❒	❒	____________________
❒	❒	____________________
❒	❒	____________________

Proposed effective date requested: ______________________________

Existing Plan Profile

If group is presently insured, please provide:

Name of carrier: ____________________

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

Why is this group being marketed? ____________________

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

What is the anniversary of the current policy? ______________________________

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

Premium Contributions

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

Life/AD&D	__________ %	Long Term Disability	__________ %
Dependent Life	__________ %	Extended Health Care	__________ %
Short Term Disability	__________ %	Dental Care	__________ %

ELIGIBILITY

Eligible Classes To Be Covered	# of Eligible Employees
❒ Permanent full-time	__________________
❒ Permanent part-time	__________________
❒ Union	__________________
❒ Non-union	__________________
❒ Seasonal	__________________
❒ Contract	__________________
❒ Other, please specify:	__________________

____

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, indicate date of disability, age, cause of disability, and expected date of return to work. Names do not need to be provided for questions 1, 2, and 3.

		Yes	No
1)	a. Are any employees currently receiving disability benefits under a group plan, WSIB, or any other source? If YES, provide diagnosis and prognosis.	❐	❐
	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? If YES, provide diagnosis and prognosis.	❐	❐
3)	Are any dependents currently in the hospital? If YES, provide diagnosis and prognosis.	❐	❐
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** ❒ Reducing to $ _______________ at age _____ **OR** ❒ No reduction at age 65.	
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 - 2 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:

Dollar maximums are **insured year** maximums.

Emergency Out-of-Canada ______ %

Vision Care ______ % Maximum $ _____ per _____ months.

Other ______ %

Hospital Expenses ______ % ❒ Semi-private room ❒ Private room

Hospital maximum $ ______ per day

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 A.S.G. Formulary #10 - See Schedules & Guidelines For Agents for formulary details.
Include coverage for Viagra and other ED drugs? ❒ Yes ❒ No

Drug Plan Type:	**Drug Plan Pays:**	**Drug Plan Options:**
❒ Reimbursement	______ % of first $ _______________	❒ filling fee maximum $ ________
❒ Pay-direct	______ % of next $ _______________	❒ deductible per prescription $ ________
	______ % of balance	❒ co-pay ______ % to a maximum of $ ________

Other Health Practitioners:

Yearly maximum: ❒ Standard $400 ❒ Other $ ________

Per visit maximum: ❒ $7.00 ❒ $15.00 ❒ $20.00 ❒ Other $ ________

Include first visit coverage for chiropractors and podiatrists? ❒ Yes ❒ No

Exclude motor vehicle accidents: ❒ Yes ❒ No Survivorship 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):	**Fee Guide Schedule:**	**Dental Plan:** Standard A.S.G. Plan #5 - See Schedules & Guidelines For Agents for formulary details.
❒ Nil	❒ Fee guide year: ________	Recall package covered once every: ❒ 5 months (twice every 12 months)
❒ $ _____ / single	❒ Current fee guide	❒ 9 months
$ _____ / family	❒ Current less _____ year(s)	❒ 12 months

Fluoride treatment for patients under age ________ Lab Fees reimbursed at __________ %

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

Exclude motor vehicle accidents: ❒ Yes ❒ No Survivorship 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