gms

GROUP BENEFIT PLAN
Request for Quotation

A. Company Information

Company Name			
Address	City	Province	Postal Code
Phone	Fax	Email	
Name & Title of Group Administrator			

B. Background Information

1. What is the exact nature of business?

2. How many years has the company been established?

3. Are there any subsidiaries or branch affiliates to be included?
   - ☐ Yes
   - ☐ No

4. Number of persons employed:
   Total: _____
   Full-Time (min. 20 hours/week): _____ Part-Time: _____
   Commissioned: _____ Contract: _____ Seasonal: _____
   Please identify contract and seasonal employees on the employee data listing

5. Are all eligible employees participating in this plan?
   - ☐ Yes
   - ☐ No - *please explain* _____

6. What percentage of employees related by blood or marriage living in the same household? _____

7. At the present time, are any employees absent from work due to sickness or injury, maternity leave, or other leaves of absence?
   ☐ No ☐ Yes - *please provide name and details* _____

8. Are all employees covered by Workers Compensation?
   ☐ Yes ☐ No - *please explain why* _____

9. Are any employees regularly working outside of Canada?
   ☐ No ☐ Yes - *please provide name and details* _____

10. Other than STD & LTD, who will contribute towards the cost of this plan?
    Employee _____% Employer _____% *(minimum 25% employer contribution)*
    Who will contribute towards the cost of STD and LTD?
    Employee _____% Employer _____%

C. Current Group Benefits Provider *(Complete this section if a group benefits plan currently exists for this employer)*

1. Who is the current insurance carrier?

   Please attach a benefit booklet, current billing and rate history over the past three years with effective dates and claim experience.

2. When did coverage begin with the current insurance carrier? _____

3. Names of group insurance carriers over the past 3 years and dates of coverage:

4. Is this plan intended to replace the existing group coverage?
   - ☐ Yes
   - ☐ No

5. What is the primary reason for requesting quotation?

D. Agent/Broker

Company Name		Address		
City	Province	Postal Code	Phone	Fax
Internal Rep	Requested Return Date *(DD/MM/YYYY)*		Proposed Effective Date *(DD/MM/YYYY)*	

Unless otherwise specified, a standard commission will apply. Flat ☑ _____

E. Employee Data Listing

Employee Full Name	Occupation	Class	Birthdate (YYYY/MM/DD)	Hire Date (YYYY/MM/DD)	Sex (M/F)	Hours Per Week	Income	Pay Basis A: Annual M: Monthly H: Hourly	Province	Coverage S: Single C: Couple F: Family W: Waived	
										Health	Dental

Comments