Request For Group Insurance Quotation

Please return this completed pdf to quote@yourfwb.ca

FWB
Your Friend With Benefits®

Request for Group Insurance Quotation

Advisor Information

Company: Your Friend With Benefits Inc.

Contact: (833) 968-7392 / 833 Your-FWB

Address: 16 Miniot Circle. Toronto, ON M1K 2K2

Website: www.yourfriendwithbenefits.ca

Client Information

Company Name: _____

Address: _____

Effective Date: _____

Special Instructions

Client Questions

Nature of Business: _____

Number of years in business: _____ Number of Employees: _____

Are there any seasonal or contract employees? Yes ☐ No ☐

If yes, please specify: _____

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: _____

Are all employees and owners covered by Workers Compensation (WSIB) Yes ☐ No ☐

Premium Contribution basis: Employer pays: _____% Employee pays: _____%

Are there any employees currently off work (excluding normal vacation)? Yes ☐ No ☐

If yes, please specify Employee Name, Occupation, Date of Disability, Nature of Disability, Prognosis, and Life Waiver Approved.

_____

Does the group currently have coverage? Yes ☐ No ☐

If yes, Current Carrier: _____ Number of years with carrier: _____ Renewal Date: _____

Is the experience available? Yes ☐ No ☐ N/A ☐ If yes, please include a copy of your recent renewal.

PLAN DESIGN:	CLASS A:		ALTERNATE ☐ OR CLASS B ☐	
LIFE Flat amount:	☐$25,000 ☐$100,000	☐$50,000 ☐Other $_____	☐$25,000 ☐$100,000	☐$50,000 ☐Other $_____
Multiple of salary:	☐1x ☐2x	☐Other _____	☐1x ☐2x	☐Other _____
Maximum:	☐Highest	☐Other $_____	☐Highest	☐Other $_____
OPTIONAL LIFE	☐Yes	☐No	☐Yes	☐No
DEPENDENT LIFE	☐Yes	☐No	☐Yes	☐No
Spousal amount	☐$5,000 ☐$20,000	☐$10,000 ☐Other $_____	☐$5,000 ☐$20,000	☐$10,000 ☐Other $_____
Child amount	50% of spouse		50% of spouse	
SHORT TERM DISABILITY	☐Yes	☐No	☐Yes	☐No
Benefit amount Non-taxable:	(100% employee paid) ☐50% ☐60%	☐66.66%	(100% employee paid) ☐50% ☐60%	☐66.66%
Benefit amount Taxable:	(Employer paid) ☐50% ☐60% ☐70% ☐75%	☐66.66%	(Employer paid) ☐50% ☐60% ☐70% ☐75%	☐66.66%
Maximum:	☐Highest	☐Other $_____	☐Highest	☐Other $_____
Accident waiting period:	☐1 Day ☐4 Days	☐8 Days ☐15 Days	☐1 Day ☐4 Days	☐8 Days ☐15 Days
Sickness waiting period:	☐4 Days ☐8 Days	☐15 Days	☐4 Days ☐8 Days	☐15 Days
First day hospital:	☐Yes	☐No	☐Yes	☐No
Benefit period (weeks):	☐15 ☐17	☐26	☐15 ☐17	☐26
LONG TERM DISABILITY	☐Yes	☐No	☐Yes	☐No
Benefit amount Non-taxable:	(100% employee paid) ☐50% ☐60%	☐66.66%	(100% employee paid) ☐50% ☐60%	☐66.66%
Benefit amount Taxable:	(Employer paid) ☐50% ☐60% ☐70% ☐75%	☐66.66%	(Employer paid) ☐50% ☐60% ☐70% ☐75%	☐66.66%
Maximum:	$_____		$_____	
Disability definition:	☐2 yr own occ.	☐Any Occupation	☐2 yr own occ.	☐Any Occupation
Waiting period (Days):	☐90 ☐120	☐180	☐90 ☐120	☐180
Benefit period:	☐2 yrs ☐5 yrs	☐To age 65	☐2 yrs ☐5 yrs	☐To age 65
COLA:	☐0% ☐2%	☐3% ☐4%	☐0% ☐2%	☐3% ☐4%
Critical Illness Insurance	☐Yes	☐No	☐Yes	☐No
Flat amount	☐$10,000 ☐$25,000 ☐ $100,000	☐$50,000 ☐ Other $_____	☐$10,000 ☐$25,000 ☐ $100,000	☐$50,000 ☐ Other $_____
Health Spending Account	☐Yes	☐No	☐Yes	☐No
Annual Maximum	☐$500 ☐$2000	☐$1000 ☐Other $_____	☐$5,000 ☐$20,000	☐$10,000 ☐Other $_____
Cost Plus	☐Yes	☐No	☐Yes	☐No

PLAN DESIGN:	CLASS A:			ALTERNATE OR CLASS B:		
EXTENDED HEALTH CARE						
Prescription drug card:	☐Yes		☐No	☐Yes		☐No
Prescription deductible:	☐Yes		☐No	☐Yes		☐No
Dispensing deductible:	☐$0	☐$2	☐$7	☐$0	☐$2	☐$7
	☐Dispensing fee		☐ Other $_____	☐Dispensing fee		☐ Other $_____
Prescription	☐70%	☐80%	☐90%	☐70%	☐80%	☐90%
reimbursement:	☐100%		☐Other %_____	☐100%		☐Other %_____
Per person maximum:	☐Unlimited		☐Other $_____	☐Unlimited		☐Other $_____
Drug formulary:	☐Generic Equivalent		☐Generic Mandatory	☐Generic Equivalent		☐Generic Mandatory
Vaccines	☐Yes		☐No	☐Yes		☐No
Smoking cessation	☐Yes		☐No	☐Yes		☐No
Fertility	☐Yes		☐No	☐Yes		☐No
Erectile Dysfunction:	☐Yes		☐No	☐Yes		☐No
Major medical						
Annual deductible:	☐None	☐25/25	☐25/50	☐None	☐25/25	☐25/50
	☐50/100	☐100/200		☐50/100	☐100/200	
Reimbursement:	☐70%	☐80%	☐90%	☐70%	☐80%	☐90%
	☐100%		☐Other %_____	☐100%		☐Other %_____
Hospital Room	☐Semi-Private		☐Private	☐Semi-Private		☐Private
Orthopedic Shoes	☐Included		☐NOT included	☐Included		☐NOT Included
Paramedicals included:	☐Basic		☐Enhanced	☐Basic		☐Enhanced
Paramedical	☐70%	☐80%	☐90%	☐70%	☐80%	☐90%
reimbursement:	☐100%		☐Other %_____	☐100%		☐Other %_____
Paramedical maximum	☐$300	☐$400	☐$500	☐$300	☐$400	☐$500
	☐$750		☐Other $_____	☐$750		☐Other $_____
Paramedical coverage	☐Per practitioner		☐Combined max	☐Per practitioner		☐Combined max
Vision	☐Yes		☐No	☐Yes		☐No
Vision Coverage	☐$100	☐$200	☐$300	☐$100	☐$200	☐$300
	☐$400		☐Other $_____	☐$400		☐Other $_____
DENTAL	☐Yes		☐No	☐Yes		☐No
Annual deductible:	☐None	☐25/25	☐25/50	☐None	☐25/25	☐25/50
	☐50/100	☐100/200		☐50/100	☐100/200	
Basic and Preventative	☐70%	☐80%	☐90%	☐70%	☐80%	☐90%
Reimbursement:	☐100%		☐Other %_____	☐100%		☐Other %_____
Recall (months):	☐6	☐9	☐12	☐6	☐9	☐12
Annual Maximum	☐$500	☐$1000	☐ Other $_____	☐$500	☐$1000	☐ Other $_____
Major:	☐Yes		☐No	☐Yes		☐No
Reimbursement:	☐50%	☐80%	☐ Other %_____	☐50%	☐80%	☐ Other %_____
Annual maximum:	☐$1,000	☐$1,500	☐$2,000	☐$,1000	☐$1,500	☐$2,000
	☐ Other $_____		☐Combined Max	☐ Other $_____		☐Combined Max

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