REQUEST TO QUOTE

UNIGROUP INC. The benefits of understanding.

Company Name:	Broker Name:	Date Quote Request Submitted:

Is there a present Insurer? ☐ No ☐ Yes **(if Yes, complete information below)** ☐ Email Proposal to me

Insurer: _____ **How long Insured?**_____ **Next Renewal Date**:_____

Note: The following information is required. Please check those items included with this RFQ

☐ **Current Booklet(s)** ☐ **Current Billing(s)** ☐ **Claims Experience (3 years)** ☐ **Rate History (3 years)** ☐ **Insurer Renewal Reports (3 years)**

1. **Nature of business (Please be specific)**_____ **How long in business?**_____
2. **Any affiliates or subsidiaries to be included?** ☐ No ☐ Yes (if Yes, provide list)_____
3. **Are all eligible employees participating in this plan?** ☐ No ☐ Yes (if No, explain)_____
4. **At the present time, are any employees absent from work due to disability, maternity/parental leave or other leave of absence?** ☐No ☐ Yes
   (If yes, provide separate listing of employees with date last worked, nature of absence, nature of disability if applicable, and expected date of return to work)
5. **Do all employees work at least 24 hours per week?** ☐ No ☐Yes (if No, explain)_____
6. **Are all employees covered by Workers' Compensation?** ☐ No ☐ Yes (if No, explain)_____
7. **Are any of the employees seasonal?** ☐ No ☐ Yes (if Yes, provide details)_____
8. **What percentage of the employees are related to the owner(s)?** _____**% Provide Employee Name(s) applicable**_____
9. **Are any independent contractors seeking coverage?** ☐ No ☐ Yes (if Yes, provide details)_____
10. **Reason for Quote?** _____

	Quote 1 / Class A / Division 1 (circle)_____	**Quote 2 / Class B / Division 2** (circle)_____
Waiting Period(s)	☐ 0 Months ☐ 3 Months ☐ 6 Months	☐ 0 Months ☐ 3 Months ☐ 6 Months
Basic Life /AD&D	Flat Benefit $_____ ***or*** ____X annual to max $_____	Flat Benefit $_____ ***or*** ____X annual to max $_____
Dependent Life	☐ $10,000/$5,000 ☐ $5,000/$2,500 ☐ Other_____	☐ $10,000/$5,000 ☐ $5,000/$2,500 ☐ Other_____
Short Term Disability	Benefit Amount_____% to a maximum of $_____ /wk Plan Design ☐ 1-8-17 ☐ 1-8-26 ☐ 15-15-15 ☐ 15-15-26 First day hospital? ☐ No ☐ Yes Taxable? ☐ No ☐ Yes	Benefit Amount_____% to a maximum of $_____ /wk Plan Design ☐ 1-8-17 ☐ 1-8-26 ☐ 15-15-15 ☐ 15-15-26 First day hospital? ☐ No ☐ Yes Taxable? ☐ No ☐ Yes
Long Term Disability	Benefit Amount 66.67% to a maximum of _____ /mth ***or*** _____% of the 1st $_____ plus 50% of the balance, to a maximum of $_____ /mth Elimination Period ☐ 120 days ☐ 180 days Benefit Period ☐ to age 65 ☐ 5 years ☐ 2 years Taxable? ☐ No ☐ Yes	Benefit Amount 66.67% to a maximum of _____ /mth ***or*** _____% of the 1st $_____ plus 50% of the balance, to a maximum of $_____ /mth Elimination Period ☐ 120 days ☐ 180 days Benefit Period ☐ to age 65 ☐ 5 years ☐ 2 years Taxable? ☐ No ☐ Yes
Critical Illness	Benefit Amount $_____	Benefit Amount $_____
Extended Health Care	Per Script Deductible? ☐ No ☐ Yes $_____ per prescription Dispensing Fee Deductible? ☐ No ☐ Yes Drug Co-insurance _____% EHC Deductible ☐ No Deductible ☐ $_____Single $_____Family EHC Co-insurance _____% Paramedical Maximum(per practitioner) ☐$300 ☐$500 ☐ Other $_____ Vision Care ☐ No ☐ Yes @ $_____ every 24 mos.	Per Script Deductible? ☐ No ☐ Yes $_____ per prescription Dispensing Fee Deductible? ☐ No ☐ Yes Drug Co-insurance _____% EHC Deductible ☐ No Deductible ☐ $_____Single $_____Family EHC Co-insurance _____% Paramedical Maximum(per practitioner) ☐$300 ☐$500 ☐ Other $_____ Vision Care ☐ No ☐ Yes @ $_____ every 24 mos.
Employee Assistance Plan	☐ Full Services Plan ☐ Telephonic Plan	☐ Full Services Plan ☐ Telephonic Plan
WorldCare International, Inc.	☐ Yes ☐ No	☐ Yes ☐ No
Dental Care	☐ Basic/Preventive Treatments Co-insurance _____% -- maximum per calendar year $_____ -- recall exam frequency _____ /mths ☐ Major Restorative Treatments Co-insurance _____% -- maximum per calendar year $_____ ***Or*** ☐ Combined with basic ☐ Prosthodontics _____% -- maximum per calendar year $_____ ***Or*** ☐ Combined with basic & major ☐ Orthodontic Treatments _____% -- lifetime maximum $_____	☐ Basic/Preventive Treatments Co-insurance _____% -- maximum per calendar year $_____ -- recall exam frequency _____ /mths ☐ Major Restorative Treatments Co-insurance _____% -- maximum per calendar year $_____ ***Or*** ☐ Combined with basic ☐ Prosthodontics _____% -- maximum per calendar year $_____ ***Or*** ☐ Combined with basic & major ☐ Orthodontic Treatments _____% -- lifetime maximum $_____

Please fax completed form to 1-800-364-0754 or email to info@unigroup.ca