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## Group Benefits Quotation Request

Company Name
Contact Name & Title
Company Address

Phone
Fax
Email
Website

### Employee Data

Employee Name	Occupation	Birth Date			Gender		Prov. of res.	Annual Salary	Date Employed			Covered for			Coverage Type*	Waive H&D**	Hours Worked/Week
		MM	DD	YYYY	M	F			MM	DD	YYYY	WCB	EI	S			

*Please indicate related employees, seasonal employees and independent contractors.  
 \*Coverage Type - (S) Single or (F) Family.  
 \*\*Only employees with duplicate coverage may waive health and/or dental coverage.*