EDMOND FINANCIAL GROUP

Group Benefits – Client Information Form

Please return by email to efg@efgi.com or by fax to 204-488-6575

Name _____ Company Name _____

Phone _____ E-mail _____ Fax _____

Section A

1. What is the exact nature of your business? _____
2. How many years has your company been in business? _____
3. Are there any subsidiaries or affiliates to be covered? Yes □ No □
   If "Yes" provide names: _____
4. Are all eligible employees participating in this plan? Yes □ No □
   If "No" please explain: _____
5. At the present time, are any employees absent from work due to disability, maternity leave or other leaves of absence?
   Yes □ No □ If "Yes" please explain: _____
6. Have there been any employees on disability in the last five years? Yes □ No □
   If "Yes" please explain: _____
7. Do all employees work at least 24 hours a week? Yes □ No □
8. Are your employees covered by Workers' Compensation? Yes □ No □
9. Are any of your employees seasonal?[1] Yes □ No □
10. What percentage of your employees are related? _____ %
11. Are there any independent contractors seeking coverage? Yes □ No □
12. Are any employees regularly working or traveling outside Canada? Yes □ No □
13. Are you, the employer, willing to contribute at least 25% toward the cost of this plan? Yes □ No □
14. Will this plan include coverage for partners or sole proprietors? Yes □ No □

Section B

What is the most important aspect of a group benefit plan to you?

□ Price □ Service □ Financial stability of the insurance company

What areas of protection are most significant to you and your employees?

□ Death □ Disability □ Healthcare □ Dentalcare □ Confidential counseling

Section C (complete only if group benefits currently exist)

Who is your current insurance carrier?[2] _____

When did your coverage begin with your current insurance carrier? _____

Have you been with any other insurance carriers in the last five years? _____

What is the primary reason for requesting a proposal? _____

[1] A seasonal employee must work at least nine full months over a 12 month period

[2] If available, please provide benefit plan booklet, rate history and claims experience

Plan Design

1. **Term Life Insurance** Flat Amount _____ 1 – 5 x salary _____

2. **AD & D** Yes □ No □ **Optional life**[3] Yes □ No □

3. **Dependant Term Life** (child ½ amount) □ $5,000 □ $10,000 □ $15,000 □ $20,000 □ $25,000
   Child coverage from: □ Birth □ 15th day

4. **Short-term Disability** □ Non-taxable (55% or 60-66.67%) _____% □ Taxable (66.67 -75%) _____%
   Benefit period: □ 15 weeks □ 17 weeks □ 26 weeks
   First Day hospital: Yes □ No □ Overall maximum: _____

5. **Long-term Disability** □ Regular Occupation □ "Own job"
   Period: □ 6 months □ 24 months Taxable: Flat (66.67-75%) _____%
   Non-Taxable: □ Flat (60-66.67 -75%) _____% □ Graded: Yes □ No □
   Waiting Period: □ 105 days □ 120 days □ 180 days
   Benefit Period: □ 2 years □ 5 years □ to age 65 years
   Inflation Protection: □ 0% □ 2% □ 3% □ 4% □ 5% Overall maximum: _____

6. **Healthcare**
   Deductible (single/family) □ 0/0 □ 25/25 □ 25/50 □ 50/50 □ 50/100 □ 100/100 □ 100/200 □ 250/250 □ 250/500
   Is the healthcare deductible combined with the dentalcare deductible? Yes □ No □
   Reimbursement (overall) (50-100%): _____%
   Drug plan type: □ paper claims □ Drug card (point-of-sale reimbursement)
   Drug reimbursement (50-100%): _____%
   Drugs: □ Prescribed □ Prescription by law □ Formulary
   Is coverage for erectile dysfunction drugs included under this plan? Yes □ No □
   Paramedical maximum: □ $150 □ $200 □ $250 □ $300 □ $350 □ $400 □ $500 □ $750 □ $1000
   Per visit maximum: □ $10 □ $20 □ $25 □ $30 □ $35 □ usual & customary
   Visioncare maximum: □ $100 □ $150 □ $200 □ $250 □ $300
   Hospital type: □ semi-private □ private □ ward
   Best Doctors® Yes □ No □ Employee Assistance Program Yes □ No □

7. **Dentalcare**
   Prior year fee guide coverage? Yes □ No □
   Deductible (single/family) □ 0/0 □ 25/25 □ 25/50 □ 50/50 □ 50/100 □ 100/100 □ 100/200 □ 250/250 □ 250/500
   Basic reimbursement (50-100%): _____%
   Maximum: □ $1,000 □ $1,500 □ $2,000 □ $2,500 □ unlimited
   Scaling time unites: □ 6 □ 10 □ 14
   Recall exams: □ 2 every 12 months □ 1 every 9 months □ 1 every 12 months
   Major[4]:
   Reimbursement (50-80%): _____% Combined basic & major max: Yes □ No □
   Maximum: □ $750 □ $1,000 □ $1,500 □ $2,000 □ $2,500 □ unlimited
   Orthodontic[5]
   Reimbursement (50-60%): _____% Maximum: □ $1,000 □ $1,500 □ $2,000 □ $2,500

8. **Critical Illness**
   Basic Critical Illness
   Type of plan: □ Standard □ Enhanced
   Benefit: □Multiple of salary □1-5x salary to max of $250,000 □Flat amount to max of $250,000 _____
   Dependent? Yes □ No □ (Spouse $10,000, child $5,000)
   Optional Critical Illness Yes □ No □ If "Yes", type of plan: □ Standard □ Enhanced

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[3] Over twenty plan members only
[4] When five or more plan members have this coverage
[5] When ten or more plan members have this coverage