M Kirsch

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REQUEST FOR QUOTATION
BY

(1)_____
(Full Legal Name of Company)

Street Address: _____

_____
Town/City Province Postal Code Tel. No.

a) Nature of Business (Describe briefly): _____

b) Type of Organization: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other_____

c) Date Commenced Operations/Business

_____

d) Person requesting quotation

Name: _____

Title: _____

e) Language of Proposal

☐ English ☐ French

(2) Associated Company

a) Is there an Associated Company to be included for insurance? Yes ☐ No ☐ b) Is separate billing required? Yes ☐ No ☐

c) Name and address of Associated Company: _____

d) Relationship: ☐ Wholly Owned Subsidiary ☐ Other (Specify) _____

d) Nature of Business (Describe Briefly): _____

(3) a) Is there any seasonal employment involved? Yes ☐ No ☐ b) If yes, number of employees involved
c) Length of Interruption

_____

(4) a) Name(s) of present group plan insurers(s) b) Date(s) of Commencement of Plan(s)

_____ _____

_____ _____

(5) Present Plan Benefits: ☐ Life Ins. ☐ Dep. Life Ins. ☐ Long Term Disability (LTD) Ins. ☐ Dental Plan ☐ Other please Advise
☐ AD & D Ins. ☐ Weekly Indemnity WI Ins. ☐ Extended Health Care (EHC) Ins. ☐ Travel Ins.

(6) Is there an extended Health Care Claim for Private Duty Nursing currently being paid? ☐ Yes ☐ No

(7) Is Worker's Compensation in force? ☐ Yes ☐ No (If No, indicate on data list any employees not covered)

(8) Are any employees currently disabled? ☐ No ☐ Yes (If Yes, complete the following)

Employee Name	Age	Date of Disability	Nature of Disability
_____	_____	_____	_____