The Gryphin Group Services Inc.
50 Coreslab Dr. Flamborough, ON **OR**
101 Duncan Mills Rd. Toronto, ON
Tel: 416.493.9977 Fax: 416.756.4655
quotes@gryphings.com

FILLABLE FORM

CLEAR FORM

EMAIL

REQUEST TO QUOTE

Dear Advisor,

Thank you for choosing The Gryphin Advantage Group Services Inc. to act as your MGA in completing a marketing survey for your client.

Kindly fill out the sections of this request to quote form accordingly in order for us to provide an accurate quote. Please note, this is a form filled document that you can complete and submit via e-mail.

Please have ready the following:

- Name of Company
- Contact information for company
- Nature of Business
- Plan Design [Current Booklet(s)]
- Claims Experience and Rates [3 years + *if applicable*]
- Employee Census [Name, DoB, Gender, Occupation, Salary, Coverage Type, DoH]

Should the company have no prior benefits please fill in the benefit sections accordingly or contact us directly to further discuss options available.

NEXT STEPS:

- Fill in the attached request to quote accordingly
- **OR** attach the company's booklet(s), claims history, matching rates and employee census
- Complete RTQ checklist
- Send to quotes@gryphings.com

IMPORTANT NOTES

- Please allow 10 business days for a client ready report once all information required to quote is received on groups 25 lives and under.
- Please allow 10-15 business days for a client ready report once all information required to quote is received on groups 25 lives +.
- We will contact you directly regarding any missing information, clarifications or important notes.

GENERAL COMPANY INFORMATION

Legal Company Name	
Nature of Business	
Company Address	
Years in Business	
Current Carrier	

Broker Name	
Broker Address	50 Coreslab Dr. Flamborough, ON L9H 0B2
Broker Telephone	
Broker E-mail	
Commissions to be quoted	☐ Standard Crown Scale ☐ 10% ☐ 8% ☐ 5% ☐ Other:
Date submitted quote	

FOR GRYPHIN INTERNAL USE ONLY:

Gryphin Primary Contact	
Address	
Telephone	
E-Mail	
Commissions to be Quoted ***plus Standard Override***	
Quote Deadline	

COMPANY INFORMATION

Please complete the following information in order to assist the Carrier's Underwriting Department to assess the risk and quote accurately.

☐ Incorporated ☐ Non – Profit

Sales Employees ☐ Yes ☐ No Union ☐ Yes ☐ No

Employee Contribution 50 Employer Contribution 50

Employee Plan Participation: 100% Other (please specify):

Excluded (please specify): ☐ Part-Time ☐ Contract ☐ Other

Have there been any disability claims within the last 3-5 years? ☐ Yes ☐ No

Are there employees currently on disability? ☐ Yes ☐ No

If yes, please advise:

Date of Birth

Date of Disability

Date Expected to Return to Work

Monthly Benefit Amount

Has the Life Waiver been Approved?

Are all employees covered by WSIB?
(*if applicable*)

Reason for Marketing:

Implementation of a Group Benefits Plan: ☐ Yes ☐ No

Checking market regarding fair renewal action: ☐ Yes ☐ No

Other (*Please specify*):

Further Concerns:

BENEFIT DESIGN SPECIFICATIONS

Class	Description
A	
B	
C	

Life Benefit and AD&D
(Mandatory)

	Class A	Class B	Class C
Flat Amount	☐ $10,000 ☐ $25,000 ☐ $30,000 ☐ Other:	☐ $10,000 ☐ $25,000 ☐ $30,000 ☐ Other:	☐ $10,000 ☐ $25,000 ☐ $30,000 ☐ Other:
Multiple of Earnings	○ 1 x Annual Salary ○ 2 x Annual Salary ○ 3 x Annual Salary	○ 1 x Annual Salary ○ 2 x Annual Salary ○ 3 x Annual Salary	○ 1 x Annual Salary ○ 2 x Annual Salary ○ 3 x Annual Salary
Maximum			
NEM			
Life Reduction Clause	☐ 50% @ age 65 ☐ Other	☐ 50% @ age 65 ☐ Other	☐ 50% @ age 65 ☐ Other
Termination Age	☐ Earlier of Retirement Or Age 75 ☐ Other:	☐ Earlier of Retirement Or Age 75 ☐ Other:	☐ Earlier of Retirement Or Age 75 ☐ Other:
AD&D Coverage	☐ Occupational ☐ Other:	☐ Occupational ☐ Other:	☐ Occupational ☐ Other:
Optional Life	☐ Yes; *provide rates* ☐ No	☐ Yes; *provide rates* ○ No	☐ Yes; *provide rates* ☐ No

Dependent Life
(Optional)

	Class A	Class B	Class C
Coverage Amount	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ $20,000/$10,000	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ $20,000/$10,000	☐ $5,000/$2,500 ☐ $10,000/$5,000 ☐ $20,000/$10,000
Benefit Clause	☐ From Birth ☐ From 14 days	☐ From Birth ☐ From 14 days	☐ From Birth ☐ From 14 days

Critical Illness
(Optional)

	Class A	Class B	Class C
Benefit Amount	☐ $25,000 ☐ $30,000 ☐ Other:	☐ $25,000 ☐ $30,000 ☐ Other:	☐ $25,000 ☐ $30,000 ☐ Other:

Long Term Disability

(Optional)

	Class A	Class B	Class C
Flat Benefit Amount	○60% ○66.66% ○70% ○75%	○60% ○66.66% ○70% ○75%	○60% ○66.66% ○70% ○75%
Graded Benefit Amount	% of the 1st $, % of the next , % of the balance.	% of the 1st $, % of the next , % of the balance.	% of the 1st $, % of the next , % of the balance.
Maximum	○$5,000 ○$10,000 ○Other:	○$5,000 ○$10,000 ○Other:	○$5,000 ○$10,000 ○Other:
Elimination Period	☐119 days ☐180 days ☐Other:	☐119 days ☐180 days ☐Other:	☐119 days ☐180 days ☐Other:
Tax Status:	☐Taxable ☐Non-taxable	☐Taxable ☐Non-taxable	○Taxable ○Non-taxable
Benefit Period	☐Payable for 5 years ☐Payable to age 65	☐Payable for 5 years ☐Payable to age 65	☐Payable for 5 years ☐Payable to age 65
Definition	☐24 month own Occupation ☐Any Occupation	☐24 month own Occupation ☐Any Occupation	☐24 month own Occupation ☐Any Occupation
COLA	☐Nil ☐2% ☐3%	☐Nil ☐2% ☐3%	☐Nil ☐2% ☐3%
Termination Age *(minus the elimination period)*	☐Earlier of Retirement Or Age 65 ☐Other:	☐Earlier of Retirement Or Age 65 ☐Other:	☐Earlier of Retirement Or Age 65 ☐Other:

If the employee pays 100% the LTD premium; the benefit received will be tax free
Plans 70% & 75% must be taxable

Short Term Disability

(Optional)

	Class A	Class B	Class C
Benefit Amount	☐60% ☐66.66% ☐70% ☐75%	☐60% ☐66.66% ☐70% ☐75%	☐60% ☐66.66% ☐70% ☐75%
Maximum *(Maximum $1200)*	☐EI Maximum ☐Other:	☐EI Maximum ☐Other:	☐EI Maximum ☐Other:
Schedule	☐0/7/17 ☐0/7/26 ☐14/14/26	☐0/7/17 ☐0/7/26 ☐14/14/26	☐0/7/17 ☐0/7/26 ☐14/14/26
1st Day Hospital	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Extended Health Care Benefit

	Class A	Class B	Class C
Drugs			
Drug Coinsurance	☐60% ☐70% ☐80% ☐100% ☐Other:	☐60% ☐70% ☐80% ☐100% ☐Other:	☐60% ☐70% ☐80% ☐100% ☐Other:
Drug Maximum	☐Unlimited ☐$10,000 ☐$5,000 ☐Other:	☐Unlimited ☐$10,000 ☐$5,000 ☐Other:	☐Unlimited ☐$10,000 ☐$5,000 ☐Other:
Maximum	☐Per Insured ☐Per Certificate	☐Per Insured ☐Per Certificate	☐Per Insured ☐Per Certificate
Graded Benefit Amount or Tiered Generic/Brand *(Please specify)*			
Drug Plan Type	☐Mandatory Generic ☐Lowest Generic ☐Equivalent ☐Brand Name ☐*Provincial Formulary*	☐Mandatory Generic ☐Lowest Generic ☐Equivalent ☐Brand Name ☐*Provincial Formulary*	☐Mandatory Generic ☐Lowest Generic ☐Equivalent ☐Brand Name ☐*Provincial Formulary*
Per Prescription Deductible	☐Nil ☐$2 ☐$5 ☐Other:	☐Nil ☐$2 ☐$5 ☐Other:	☐Nil ☐$2 ☐$5 ☐Other:
Dispensing Fee Cap	☐Nil ☐$7.50 ☐$10 ☐ Other:	☐Nil ☐$7.50 ☐$10 ☐ Other:	☐Nil ☐$7.50 ☐$10 ☐Other:
Vaccines	☐Included ☐Excluded	☐Included ☐Excluded	☐Included ☐Excluded
Lifestyle Drugs			
Smoking Cessation	◯Included ◯Excluded	◯Included ◯Excluded	◯Included ◯Excluded
Fertility Drugs	◯Included ◯Excluded	◯Included ◯Excluded	◯Included ◯Excluded
Erectile Dysfunction	◯Included ◯Excluded	◯Included ◯Excluded	◯Included ◯Excluded
Major Medical			
Deductible	☐NIL ☐$25/$50 ☐$50/$100 ☐Other:	☐NIL ☐$25/$50 ☐$50/$100 ☐Other:	☐NIL ☐$25/$50 ☐$50/$100 ☐Other:
Flat Coinsurance	☐60% ☐70% ☐80% ☐100% ☐Other:	☐60% ☐70% ☐80% ☐100% ☐Other:	☐60% ☐70% ☐80% ☐100% ☐Other:
Medical Services & Supplies	☐Included ☐Excluded	☐Included ☐Excluded	☐Included ☐Excluded

Extended Health Care Benefit (continued)

	Class A	Class B	Class C
Paramedical Coverage	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Practitioners*	☐Physiotherapist ☐Massage Therapist ☐Social Worker ☐Chiropractor ☐Podiatrist ☐Chiropodist ☐Acupuncture ☐Osteopath ☐Naturopath ☐Dietician ☐Psychiatrist	☐Physiotherapist ☐Massage Therapist ☐Social Worker ☐Chiropractor ☐Podiatrist ☐Chiropodist ☐Acupuncture ☐Osteopath ☐Naturopath ☐Dietician ☐Psychiatrist	☐Physiotherapist ☐Massage Therapist ☐Social Worker ☐Chiropractor ☐Podiatrist ☐Chiropodist ☐Acupuncture ☐Osteopath ☐Naturopath ☐Dietician ☐Psychiatrist
Maximum *Per Insured, Per Practitioner*	☐$300 ☐$500 ☐Other:	☐$300 ☐$500 ☐Other:	☐$300 ☐$500 ☐Other:
OR Maximum *All Practitioners Combined*	☐$300 ☐$500 ☐Other:	☐$300 ☐$500 ☐Other:	☐$300 ☐$500 ☐Other:
Doctor's Note Required	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Per Visit Maximum If yes, please specify:			
Out of Country	☐ Included ☐ Excluded	☐ Included ☐ Excluded	☐ Included ☐ Excluded
Private Duty Nursing	☐ $10,000 ☐	☐ $10,000 ☐	☐ $10,000 ☐
Hospital	☐ Semi Private ☐ Ward	☐ Semi Private ☐ Ward	☐ Semi Private ☐ Ward
Orthotics	☐ Included ☐ Excluded	☐ Included ☐ Excluded	☐ Included ☐ Excluded
Vision Care *NIL Deductible; 100% (per 12 months Child; per 24 months Adult)*	☐NIL ☐$100 ☐$250 ☐Other:	☐NIL ☐$100 ☐$250 ☐Other:	☐NIL ☐$100 ☐$250 ☐Other:
Eye Exams	☐NIL ☐R&C ☐Other:	☐NIL ☐R&C ☐Other:	☐NIL ☐R&C ☐Other:
Termination Age	☐Earlier of Retirement Or Age 75 ☐Other:	☐Earlier of Retirement Or Age 75 ☐Other:	☐Earlier of Retirement Or Age 75 ☐Other:

Dental Care Benefit

(Optional)

	Class A	Class B	Class C
Basic Dental Coinsurance *(Level 1&2)*	☐60% ☐70% ☐80% ☐100% ☐Other:	☐60% ☐70% ☐80% ☐100% ☐Other:	☐60% ☐70% ☐80% ☐100% ☐Other:
Deductible *(Level 1, 2 & 3)*	☐NIL ☐$25/$50 ☐$50/$100 ☐Other:	☐NIL ☐$25/$50 ☐$50/$100 ☐Other:	☐NIL ☐$25/$50 ☐$50/$100 ☐Other:
Basic Dental Maximum *(Level 1 & 2)*	☐$1,000 ☐$1,500 ☐$2,000 ☐Other:	☐$1,000 ☐$1,500 ☐$2,000 ☐Other:	☐$1,000 ☐$1,500 ☐$2,000 ☐Other:
Dental Fee Guide	☐Current ☐Current minus 1 year	☐Current ☐Current minus 1 year	☐Current ☐Current minus 1 year
Dental Recall	☐6 month ☐9 month ☐12 month ☐Twice per year	☐6 month ☐9 month ☐12 month ☐Twice per year	☐6 month ☐9 month ☐12 month ☐Twice per year
Major Dental *(Level 3)*	☐Included ☐Excluded ☐50% ☐Other: ☐$1,500 ☐$2,000 ☐Combined with Basic maximum	☐Included ☐Excluded ☐50% ☐Other: ☐$1,500 ☐$2,000 ☐Combined with Basic maximum	☐Included ☐Excluded ☐50% ☐Other: ☐$1,500 ☐$2,000 ☐Combined with Basic maximum
Orthodontics *(Level 4)*	☐Included ☐Excluded ☐50% ☐60% Maximum:	☐Included ☐Excluded ☐50% ☐60% Maximum:	☐Included ☐Excluded ☐50% ☐60% Maximum:
Scaling Units	☐6 ☐8 ☐10 ☐Other:	☐6 ☐8 ☐10 ☐Other:	☐6 ☐8 ☐10 ☐Other:
Termination Age	☐Earlier of Retirement Or Age 75 ☐Other:	☐Earlier of Retirement Or Age 75 ☐Other:	☐Earlier of Retirement Or Age 75 ☐Other:

HCSA
(Optional)

	Class A	Class B	Class C
Benefit Amount	☐ Excluded ☐ $500 ☐ $1,000 ☐ Other:	☐ Excluded ☐ $500 ☐ $1,000 ☐ Other:	◯ Excluded ◯ $500 ◯ $1,000 ◯ Other:
Balance Carry Forward	◯ NIL ◯ Calendar Year ◯ Benefit Year		

EAP
(Optional)

	Class A	Class B	Class C
Benefit Amount	☐ Included ☐ Excluded	☐ Included ☐ Excluded	☐ Included ☐ Excluded

CLAIMS EXPERIENCE & RATES

Benefit	Rates Effective [Month – Year]	Rates Effective [Month – Year]	Rates Effective [Month – Year]
Life			
AD&D			
Dependent Life			
Short Term Disability			
Long Term Disability			
EHC - Single			
EHC - Family			
Dental - Single			
Dental - Family			
EAP			
Critical Illness			

[Month – Year]	To	[Month – Year]
Benefit	**Paid Premiums**	**Paid Claims**
EHC		
Dental		

[Month – Year]	To	[Month – Year]
Benefit	**Paid Premiums**	**Paid Claims**
EHC		
Dental		

[Month – Year]	To	[Month – Year]
Benefit	**Paid Premiums**	**Paid Claims**
EHC		
Dental		

ALTERNATE QUOTE SPECIFICATIONS

IMPORTANT NOTES/CLARIFICATIONS

AD&D Termination Age -
DGL Termination Age -
C.I. Termination Age - (delete if not applicable)
LTD NEM - $
Hospital - % (delete if not applicable)
Vision - % (delete if not applicable)
Private Duty Nursing - % (delete if not applicable)
Pooling Limit - $
Claims above pooling -
Hearing Aids - $
Orthotics - $
Orthopaedic Shoes - $
Fertility - $ (if no amount, delete)
Smoking Cessations - $ (if no amount, delete)
Out of Country - $ days
Best Doctors included - yes or no (delete one)
Health & Dental survivor benefit - yes or no (delete one)