Employee Data

Employer: _____

Address: _____

Telephone: _____ Contact Person: _____

Fax: _____ Email: _____

Full-Time Employee's Name or Code	Occupation	Sex	Dep. Children? Y/N	Date of Birth D/M/Y	*Marital Status	Earnings ❑ Weekly ❑ Monthly ❑ Yearly

* Please indicate if two employees are married to each other, or if an employee is exempt for Extended Health Care and/or Dental.

Do you currently have a group insurance plan? ❑ Yes ❑ No

Please check the benefits you would like us to include in your quote:

- ❑ Employee Life Insurance
- ❑ Dependent Life Insurance
- ❑ Accidental Death & Dismemberment
- ❑ Extended Health Care
- ❑ Short Term Disability
- ❑ Dental Care
- ❑ Long Term Disability

We also specialize in:

- ❑ RRPSs
- ❑ RESPs
- ❑ Optional Life insurance
- ❑ Individual Health Insurance
- ❑ Individual Dental Insurance
- ❑ Travel Insurance

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