McKITTERICK.ca

# ORGANIZATIONAL BACKGROUND

group

| | | | |
|---|---|---|---|
| Name of Organization: (legal name) | | | |
| Address: | | | |
| Phone: | | Fax: | |
| Email: | | Web: | |
| Contact Name: | | Legal Status: ❑ Corporation | |
| Nature of Organization: | | | |
| Year established | Unionized: ❑ No | Number of **Covered** Employees Full time:____ Part time:_____ | How many hours do part-time employees work (consistently)? _____ (Only include those who are eligible for the benefits plan) |

**Employee profile: Please complete the following. For "yes", please provide details in the blank space below or attach a separate page.**
**For questions 1 to 4 list the employees, indicate date of disability, age, cause of disability, and expected date of return to work.**
**For questions 6 to 9 list employees.**

| | | |
|---|---|---|
| 1. | Are any employees currently receiving disability benefits under a group plan, WSIB or any other source? | ❑ Yes ❑ No |
| 2. | Are any employees currently absent from work due to sickness or injury? | ❑ Yes ❑ No |
| 3. | Has any employee been absent from work due to any one injury or illness for 14 consecutive days in the past 12 months? | ❑ Yes ❑ No |
| 4. | Has any employee been absent from work on 6 or more occasions over the past 12 months? | ❑ Yes ❑ No |
| 5. | Are any employees not covered by Worker's Compensation? | ❑ Yes ❑ No |
| 6. | Are any employees not covered by Employment Insurance? | ❑ Yes ❑ No |
| 7. | Are any employees related to one another (i.e., spouse, parent, child, etc) | ❑ Yes ❑ No |
| 8. | Are any employees paid in full or in part by commission? | ❑ Yes ❑ No |
| 9. | Has there been any significant change in the number of employees in the past 3 years? If yes, why? | ❑ Yes ❑ No |
| 10. | Does the organization receive outside funding? If yes, from where and what percentage? | ❑ Yes ❑ No |

11. Please list any LTD claims made over the past five years including date and nature, outcome or prognosis of the claims

**Premiums: The employer will be paying the following percentage of premium for each benefit**

| | | |
|---|---|---|
| Life/AD&D _____% | Dependent Life _____% | Long-term Disability _____% |
| Weekly Indemnity _____% | Extended Health Care _____% | Dental Care _____% |

**Proposed Effective Date of Coverage:** _____

## Existing Plan Information

| | | |
|---|---|---|
| Name of current Carrier: | How long with present carrier? | How many carriers in the last 5 years? |

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