Fax to:
GROUP LOCKHART INC.
Fax No. 519-673-6657
Phone No. 1-800-265-1224

MANULIFE HOSPITALITY BENEFIT PROGRAM
QUESTIONNAIRE - PAGE 1 OF 3

NAME OF COMPANY: _____

ADDRESS: _____
PROVINCE: _____
POSTAL CODE: _____

PHONE #: _____
FAX #: _____

CONTACT NAME: _____
TITLE: _____

ASSOCIATION MEMBERSHP NUMBER#: _____
YEARS IN BUSINESS (Minimum 1 year): _____ **# OF EMPLOYEES:** _____

CHECK THE FOLLOWING BENEFITS CURRENTLY IN PLACE
EIC: _____ **CPP:** _____ **WCB:** _____

ARE YOU CURRENTLY PROVIDING A BENEFIT PLAN:
YES: _____ **NO:** _____

ARE YOU CURRENTLY PROVIDING GROUP RRSP:
YES: _____ **NO:** _____

***If you have answered YES to any of the above please complete the following information:**

NAME OF INSURANCE COMPANY: _____

RENEWAL DATE: _____

ADDITIONAL COMMENTS:

MANULIFE BENEFIT PROGRAM
PAGE 2 OF 3
(To be completed in FULL for ALL quotations.)
2 - 10 LIVES

NAME OF COMPANY: _____

BENEFIT OPTIONS

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT:

$25,000 Flat: _____ $50,000 Flat: _____ 1x Annual: _____ 2x Annual: _____

DEPENDENT LIFE:

DEP1: SPOUSE $10,000/CHILD $5,000 _____ DEP2: SPOUSE $5,000/CHILD $2,500 _____

LONG TERM DISABILITY (Management Only):

2 Year: _____ To Age 65: _____ (120 Day Elimination Period)

EXTENDED HEALTH:

EHC1:	0/0/100%	_____
EHC2*:	0/0/80%	_____
EHC3:	$25/$50/100%	_____

(Above 3 Options Include $100/24 month Vision Care)

EHC4:	0/0/100%	_____
EHC5*:	0/0/80%	_____
EHC6:	$25/$50/100%	_____

(Above 3 Options Include $200/24 month Vision Care)

DENTAL COVERAGE:

DEN1:	0/0/100%	_____
DEN2*:	0/0/80%	_____
DEN3:	$25/$50/100%	_____
DEN4*:	$25/$50/80%	_____

IF NO COVERAGE CURRENTLY GROUPS ARE LIMITED TO 80% CO-INSURANCE

ELIGIBILITY: Applicants must be under age 65 with 3 months of service and working a minimum of 25 hours per week

FOR QUESTIONS PLEASE CONTACT: 1-800-265-1224

HOSPITALITY BENEFIT PROGRAM

Administered by Group Lockhart
195 Dufferin Avenue, Suite 450, London, Ontario, N6A 1K7
Fax: 519-673-6657 Telephone: 519-672-3890

Employee I.D.	Salary	Salary Type *	Sex	Dependent Status (S)(F)	Date of Birth (dd/mm/yy)	Prov.	Job Title	Class	EHC S, F, N/A	Dental S, F, N/A	Employment Date (dd/mm/yy)	Currently Disabled (Y/N)
1												
2												
3												
4												
5												
6												
7												
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17												
18												
19												
20												

The purpose for which this information is being gathered is to confirm employment, date of birth and salary information in order to provide an accurate quotation for employee benefit programs.

*** Salary Type – Please indicate: H – Hourly, W – Weekly, B – Bi-weekly, M – Monthly, Y – Yearly**

Use additional sheet if required.