



QUOTATION REQUEST FORM

Extended Health & Dental Plans to supplement Provincial Health Insurance

① Whom should we contact with insurance information?

PLEASE PRINT CLEARLY

First Name:	Last (Family) Name:	How did you learn about DCIS? <input type="checkbox"/> I was referred by: _____ <input type="checkbox"/> Online Search <input type="checkbox"/> Other: _____
Telephone Number:	Email Address:	

② List all family members to be included in the insurance proposal/quotations

	First Name	Last Name	Date of Birth mm/dd/yyyy	Sex M / F	Province of Residence	Active provincial health plan? Yes / No
1						
2						
3						
4						
5						

③ What types of Extended Benefits are priorities to you?

<input type="checkbox"/> Prescription drug coverage <input type="checkbox"/> Hospital room upgrade fees <input type="checkbox"/> Private Duty Care Nursing	<input type="checkbox"/> Paramedical services (physio, chiro, etc.) <input type="checkbox"/> Medical supplies and equipment <input type="checkbox"/> Vision care	<input type="checkbox"/> Basic / Preventative Dental Care <input type="checkbox"/> Major/Restorative Dental Other: _____
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④ Additional Details

A. Have you recently, or will you soon be losing *other extended benefits*? No Yes *If YES...*
When did/will your other benefits terminate? _____
What type of extended benefits plan was/is it?
 Group Benefits from Canadian Employer/Organization: Name of Insurer: _____
 Personal Plan: Name of Insurer/Plan: _____

B. *Do you have any pre-existing medical conditions?* No Yes *If yes, please add details on pg 2*
Do you take any prescription drugs? No Yes *If yes, please add details on pg 2*

C. *When would you want the coverage to begin? (Note: it may only be on the 1st of a future calendar month)*
 mm/yyyy _____

D. How long do you plan to have a personal extended health/dental plan:
 Under 12 months 1 – 2 years 2 – 4 years 5+ years

E. *In addition to extended benefits, please indicate if you are interested in quotations for the following:*
 Travel insurance Life Insurance Disability Insurance (Income Protection)



We respect your privacy, and protect all personal information. We will only use the personal information provided for the purpose of responding to your request for an insurance quotation.

Please submit this form to:

David Cummings Insurance Services Ltd.
Email: info@david-cummings.com
Fax: 604-228-9807 Tel: 604-228-8816
www.david-cummings.com



Health History Information

For each family member—use additional page if needed

PLEASE PRINT CLEARLY

NAME	Pre-Existing Medical Conditions <i>(eg. hypertension, asthma, diabetes, lower back injury, etc.)</i>	PRESCRIPTION COSTS <i>(i.e. Annual \$500)</i>
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Respecting your Privacy: David Cummings Insurance Services Ltd. (DCIS) recognizes and respects every individual's right to privacy. When you do business with us, you share personal information so that we may provide you with products and services that best meet your needs. We assume your consent for our firm to use this information in an appropriate manner. When you inquire about and/or apply for insurance coverage we establish a confidential client record of personal information. All employees, associated advisors and suppliers who are granted access to client records understand the need to keep this information protected and confidential. They know they are to use the information only for the purposes intended. We use the information solely for the purpose of responding to your request for insurance services. Unless requested to do so by you, we do not share information with organizations outside of our relationship with you that would use it to contact you about their own products or services. We do not sell client information to anyone. If you have any questions or concerns about the protection of your personal information please contact our Privacy Officer: Jason Cummings. Phone (604) 228-8816 Fax (604) 228-9807 Email: jason@david-cummings.com