

An insurance plan underwritten by
 Desjardins Financial Security and offered by:

Sogemec
ASSURANCES
 Financial services firm

IDENTIFICATION OF INSURED

Insured's last name and first name		Division No.
Certificate No.	Identification No.	

INFORMATION ON OVERHEAD EXPENSES

• **PLEASE ENTER** the month of disability covered by this claim, your gross income and the reasonable, everyday monthly expenses actually incurred for each of the items listed below.

 Month of disability Gross income received \$

• **PLEASE ATTACH** supporting documents for each of the overhead expenses listed below.

Overhead expenses	Amount
Salary of your employees	\$ _____
Public services (telephone, water, electricity)	\$ _____
Rent, property taxes or monthly mortgage payment on the part of the building where your firm is located.	\$ _____
Laundry, concierge service and housekeeping	\$ _____
Fees for professional services	\$ _____
Lease contract payments (if this contract is not insured)	\$ _____
Amortization	\$ _____
Equipment leasing	\$ _____
Interest charges and periodic capital payments (other than mortgage)	\$ _____
Professional association fees and liability insurance	\$ _____
Other usual fixed expenses (specify) :	\$ _____
.	\$ _____
.	\$ _____
TOTAL EXPENSES	\$ _____

To determine the net income earned for the purposes of calculating the partial disability benefit, please subtract your total expenses from your gross income.	Gross income	\$ <input type="text"/>
	Total expenses	\$ <input type="text"/>
	Net income earned	\$ <input type="text"/>

I DECLARE THAT all the above information is complete and true.

**First and last names of the person
 completing the form (in capital letters)** _____

Signature of the person completing the form _____ **Date** _____

Signature of the insured _____ **Date** _____