La Capitale

ASSESSMENT OF PERSONAL NEEDS FOR ACCIDENT AND SICKNESS INSURANCE

1 PERSONAL INFORMATION AND MEDICAL CONDITION

Last name _____ First name _____ Last name at birth (if different) _____

Sex: ◯ M ◯ F Date of birth: ____ ____ ____ (Year Month Day) ____ ____ (Area code Telephone) ◯ Non-smoker ◯ Smoker _____ Province of residence

Have you ever had a life, critical illness or accident or sickness disability insurance application declined, deferred, modified, cancelled or rated with a higher premium?
◯ Yes ◯ No – If so, why? _____

2 EMPLOYMENT PROFILE

Occupation _____ Line of business _____ Number of years with current employer _____

Duties _____ Number of hours worked per week _____ Number of months worked per year _____ % of your work that is manual or physical _____

2.1 What percentage of your work is performed at home? _____ %

2.2 Are you eligible for workers' compensation benefits? ◯ Yes ◯ No

2.3 Are you eligible for employment insurance? ◯ Yes ◯ No

2.4 Are you covered by other disability insurance plans? ◯ Yes ◯ No – If so, indicate the coverage amount: _____

3 EARNED INCOME

Please check the box that corresponds to your current professional situation and your net annual income for the previous year. The net income corresponds to the income deducted from expenses after taxes.

☐ Salaried employee	$
☐ Commission employee	$
☐ Self-employed worker	$
☐ Associate	$
☐ Business owner	$

4 MONTHLY FINANCIAL NEEDS

Mortgage or rent payments	$
Utilities (electricity, heating)	$
Telephone, cable and Internet	$
Transportation	$
Municipal and school taxes	$
Loan payments	$
Insurance premiums	$

Groceries	$
Savings (RRSP, RESP, emergency funds)	$
Personal expenses (clothing, physical activities, etc.)	$
Childcare and school expenses	$
Leisure	$
Medical and dental care	$
TOTAL MONTHLY FINANCIAL NEEDS (4)	**$** 0.00

5 CURRENT MONTHLY COVERAGE

☐ Employment Insurance	$
☐ Group disability insurance	$
☐ Individual disability insurance	$
☐ Spouse's income	$
☐ Other	$
CURRENT TOTAL MONTHLY COVERAGE (5)	**$** 0.00

6 MONTHLY NEEDS IN THE EVENT OF DISABILITY

Total monthly financial needs (4)		$ 0.00
Current total monthly coverage (5)	–	$ 0.00
MONTHLY NEEDS IN THE EVENT OF DISABILITY	=	**$** 0.00

La Capitale Financial Security Insurance Company
625 Jacques-Parizeau St, Quebec QC G1R 2G5

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7 TYPE OF INSURANCE REQUESTED

7.1 Taking your financial needs into account, how much of your monthly budget are you prepared to set aside to pay for disability insurance and maintain your current standard of living? $ _____

7.2 Which risks do you wish to cover by taking out disability insurance? ◯ Accident ◯ Sickness ◯ Accident and sickness

7.3 If you could no longer work due to a disability, how long would your current savings cover your needs?
◯ 0 days ◯ 14 days ◯ 30 days ◯ 60 days ◯ 90 days ◯ 120 days

7.4 In the event of disability, how long would you wish to receive payments? ◯ 2 years ◯ 5 years ◯ Until retirement

8 ADDITIONAL INCOME PROTECTION COVERAGE

☐ Regular occupation
☐ Future Insurability option
☐ Reimbursement of premiums
☐ Indexation option
☐ Accidental Fracture coverage
☐ ADD or loss of use
☐ Hospitalization Insurance

9 SIGNATURES

I certify that Mr. or Ms. _____
completed this Assessment of personal needs for accident and sickness insurance form in the event of disability on ____ ____ ____ (Year Month Day)

X _____
Client's signature

X _____
Representative's signature

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