

Part 1 - Information

For information, please contact us at:

Individual Insurance: Telephone: 450 773-7170 / 514 489-8404 / Toll free: 1 800 773-8404

Group Insurance: Telephone: 450 773-7236 / 514 485-7236 / Toll free: 1 800 818-7236

Fax: 450 778-2519 / Email: claims@humania.ca / **Web site:** www.humania.ca

Our address is: 1555, Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

Part 2 - Identification

Insured's Statement. The Insured must complete and submit the claim form within 90 days following the date disability began.

Policy n°:

Family name:

Given name: Initial: _____

Registered Company Name: _____ Company Registration N°: _____

Your Profession: _____

Company Address: _____ Suite n°: _____

City: _____ Province: _____ Postal Code: _____

Company phone n°: Cell n°:

Fax n°:

Part 3 - Eligible Overhead Expenses

Indicate the amount and percentage participation for the expenses related to the operating costs of your company during the 6 months preceding your disability and as required to practice your profession. Submit supporting documents bearing the Company name, such as: equipment, mortgage, leasing contracts, etc., and include corresponding banking transactions statement. Also, enclose a copy of your financial report detailing your expenses and employment income.



Part 4 - Description

	%	Amount
Employee salaries for occupation other than your own.	_____	_____
Interest on business debts	_____	_____
Public utilities (electricity, heating, telephone, etc.)	_____	_____
Payments on machinery	_____	_____
Rent or mortgage payments	_____	_____
Taxes and insurance	_____	_____
Communication expenses	_____	_____
Stationary and postage	_____	_____
Maintenance costs	_____	_____
Depreciation on office equipment	_____	_____
Leasing of office equipment	_____	_____
Union dues prorated	_____	_____
Professional fees for accounting services	_____	_____
Other regular fixed expenses related to the business operations (please outline):	_____	_____
_____	_____	_____

Part 5 - Excluded Overhead Expenses

Salaries, fees, levies or any other compensation received by you or any member of your profession hired or working for you. Cost of goods, objects, pharmaceutical products or professional books, materials or supplies. Fees of a health professional who is related or associated with you. Expenses covered by another insurance contract.

Part 6 - Declaration

I declare that the above information is exact and complete, and the amounts indicated on the claim form correspond to the eligible overhead expenses as defined under my insurance contract.

Insured's signature _____ Date:

day / month / year