Disability Insurance Needs Analysis

SOLO™ Disability Income
SOLO™ Essential Disability Income
SOLO™ Loan Insurance

A. Personal Information

First name: ______________________ Last name: ______________________

Gender: ☐ M ☐ F Date of birth: YYYY / MM / DD ☐ Non-smoker ☐ Smoker

B. Employment Profile

Profession or occupation: ______________ Level of education: ______________ Industry: ______________

Name of company: ______________________ Website: ______________________

How long have you been in your current profession or occupation? ______________________

How long have you been self-employed or working for your current employer? ______________________

Number of hours per week: ______________ Number of weeks per year: ______________

Responsibilities	% of time	Details (list the specific activites involved, especially for manual or physical duties)
Manual/Physical		
Management/Office work		
Sales		
Supervision		
Other (specify):		
TOTAL:	100%	

Do you have other employment? ☐ Yes ☐ No

If **Yes**, please provide a job description: ______________________

Number of hours per week: ______________ Number of weeks per year: ______________ Annual income: $ ______________

Do you work from home? ☐ Yes ☐ No

If **Yes**, indicate:

a) percentage of time: ______________ %

b) if you have a separate entrance with a sign displayed: ☐ Yes ☐ No

c) if you have visible customer traffic: ☐ Yes ☐ No

d) if you have earned at least $25,000 after expenses for each of the last 2 years: ☐ Yes ☐ No

C. Annual Earned Income

Insurable net annual earned income profile (earned income after deductible overhead expenses but before taxes):

Your current situation	Income to date (current year)	Annual income (last year)	Annual income (year prior to last year)
☐ Employee ☐ Self-employed worker on commission ☐ Self-employed worker ☐ Partner			
☐ Owner of a corporation (Inc.) Percentage of common shares held: ______ Number of employees: ______ Corporation creation date: YYYY / MM / DD	Salary (excluding dividends)		
	Your share of corporation's profits or losses		
	Total		

Desjardins Insurance
Life • Health • Retirement

D. Monthly Expenses

Rent or mortgage payments: $ ____________ Loan/credit card repayment: $ ____________ Clothing: $ ____________

Municipal and school taxes: $ ____________ Insurance: $ ____________ Personal care: $ ____________

Utilities (electricity, heating): $ ____________ Savings: $ ____________ Entertainment: $ ____________

Telephone, cable, internet: $ ____________ Meals/groceries: $ ____________ Other: $ ____________

Car loan/lease payments: $ ____________ Medical and dental care: $ ____________

Car/transportation expenses: $ ____________ Childcare and school fees: $ ____________ TOTAL: $ ____________

E. Monthly Sources of Income

In the event of disabililty, what sources of income could you rely on?

- ☐ Employment insurance: $ ____________
  (Benefits paid for 4 months only)
- ☐ Group disability insurance: $ ____________
- ☐ Individual disability insurance: $ ____________
- ☐ Mortgage insurance: $ ____________
- ☐ Loan insurance: $ ____________
- ☐ Spouse: $ ____________
- ☐ Other: $ ____________

TOTAL: $ ____________

F. Monthly Amount Required in Case of Disability

Monthly disability insurance needed [(total section D) - (total section E)]: $ ____________

G. Type of Coverage Required

In the event of disability, how long would your emergency fund last?

☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 365 days ☐ 730 days

In the event of an accident, would you like to be covered as of the first day? ☐ Yes ☐ No

How long do you think you would need to replace your income for?

☐ 2 years ☐ 5 years ☐ To age 65

Additional coverages (optional section):

☐ Regular occupation period extender ☐ Future insurability option ☐ Partial disability ☐ Residual disability

☐ Cost of living ☐ Return of premiums ☐ Accidental fracture ☐ Accidental death, dismemberment or loss of use

Do you have any healthcare insurance (other than the provincial healthcare plan)? ☐ Yes ☐ No

Considering your needs, how much are you willing to spend each month to maintain your lifestyle? $ ____________

H. In-force Insurance

Do you have any in-force disability insurance? ☐ Yes ☐ No

If **Yes**, indicate:

Name of insurer: ____________ Type of coverage: ____________ Issue date: YYYY / MM / DD

Monthly amount: ____________ Waiting period: ____________ Benefit period: ____________

I. Additional Information and Signatures

I certify that Mr. or Ms. ____________ completed this financial needs analysis in the event of disability on YYYY / MM / DD.
A copy of this document will be given to me, at the latest, when my contract is issued.

Client's signature ____________ Advisor's signature ____________

Medical Insurability

Your state of health and lifestyle can affect your insurability. For example, practising a dangerous sport, consuming drugs and alcohol, travelling outside of North America, or even declaring bankruptcy, having a criminal record and driving while under the influence, can all have an impact on your insurability. This is why preliminary assessment of your state of health and lifestyle is essential before proposing disability insurance. Your advisor may refer to the pre-screening guide available on Webi.ca for further details.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.
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