Living Benefits

Financial security in the event of disability

How much income do you need on a monthly basis to meet your financial obligations? _____

If you were to lose your income, how soon would serious financial difficulties arise? _____

How soon must this income begin? _____ How long must this income last? _____

Should your long-term savings and retirement goals be jeopardized due to disability? Yes ☐ No ☐

Should your spending power be maintained in the event of disability? Yes ☐ No ☐

Should it keep pace with inflation? Yes ☐ No ☐ Should savings and retirement plans continue? Yes ☐ No ☐

Is this an area you would like to improve? Yes ☐ No ☐

Client	
Retirement goal to cover: _____%	Expenses to cover: _____%
Business owner: y / n	Eligible for EI: y / n
Self-employed: y / n	Eligible for WCB: y / n

Financial security in the event of disability

Member	Expense	Annual amount	Indexed to inflation	Number of years or end date	Lump sum need	Amount	Indexed to inflation
client/ co-client			y / n	yy or mm / yyyy			y / n

(Additional Expense: Child care, Parent care, Lifestyle adjustments. Lump Sum Need Expense include: special appliances, home modifications, wheelchair van)

Coverage owned (existing disability insurance policies)

Insured member	Client/co-client					
Policy						
Type of coverage	STD/LTD/ Ind DI					
Benefit formula						
Max benefit	$ _____					
Frequency						
Taxable	y / n					
Indexed to inflation						
Waiting period						
Beneft period						
Premium						

Notes

Living Benefits (continued)

Financial security in the event of critical illness

Is there a history of critical illness in your immediate family? (i.e.: cancer, heart attack, stroke)

_____

In the event of a critical illness, would you want the ability to seek timely non-insured treatment outside Canada?

Yes ☐ No ☐ _____

In the event of a critical illness, would you require funds to pay outstanding debts/mortgages?

Yes ☐ No ☐ _____

In the event of a critical illness, would you want to have choices?

Example: Choice for your spouse to take time off work, choice to seek alternative treatments etc.

Yes ☐ No ☐ _____

Group insurance

Do you have group insurance? Client Yes ☐ No ☐

Group Insurance

Owner	Insured	Company	Plan	Coverage	Purchase Date	Premium

What is the name of the group benefits administrator at work?

_____ Phone #: _____

Notes