

GROUP OFFICE OVERHEAD EXPENSE DISABILITY INSURANCE

EASY FINANCIAL WORKSHEET TO HELP DETERMINE YOUR MONTHLY BENEFIT AMOUNT

Use the average monthly office operating expenses incurred for the preceding 12 months to calculate the average monthly amount of Eligible Overhead Expenses.
Benefits are payable to help cover these operating expenses.

How To Determine Your Monthly Benefit Amount

Use this chart to calculate the monthly benefit amount you may need to maintain the operation of your office if you become Totally Disabled. Keep in mind that benefits are based on *your actual monthly expenses during the six months before your covered total disability begins*, up to the amount for which you are insured. Therefore, you should apply only for the coverage amount you expect you will need.

ELIGIBLE OFFICE OVERHEAD EXPENSE (Please print in ink or type all answers)		
Office Rent:		\$ _____
Interest Payments on Outstanding business debts:		\$ _____
Utilities (heat, water, telephone, electricity, etc.):		\$ _____
Employees' salaries and payroll taxes:		\$ _____
Equipment maintenance:		\$ _____
Postage and stationery:		\$ _____
Rental, lease or depreciation of office equipment:		\$ _____
Monthly average of taxes on premises:		\$ _____
Insurance Premiums for:		\$ _____
Workers' Compensation:	\$ _____	
Employee Medical Plans:	\$ _____	
Employee Taxes:	\$ _____	
General Liability:	\$ _____	
Professional Liability/Malpractice:	\$ _____	
Total:	\$ _____	
Accounting fees, to the extent that such expenses are normal and customary in the conduct and operations of the business:		\$ _____
Professional Membership and/or subscription dues:		\$ _____
Such other fixed expenses as are normal and customary in the conduct and operation of the insured's office:		\$ _____
Total Eligible Overhead Expenses:		\$ _____

I understand that this plan does not cover the salary, fees, drawing accounts, profits, or any compensation for me or any member of my profession employed by or working for me; nor income taxes, personal expenses, charitable contributions, the cost of the purchase of office equipment, goods or merchandise, or the payment of principal on any indebtedness. I also understand that benefits are based on my actual average monthly expenses during the six months before a covered total disability, up to the benefit amount for which I am insured.

I declare that, to the best of my knowledge and belief, the above information is truthful and complete.

Member's Signature x _____ **Date** ____ / ____ / ____
(Please sign in ink)