

## DISABILITY BUSINESS OVERHEAD EXPENSE SUPPLEMENT APPLICATION

### BUSINESS OVERHEAD EXPENSE SUPPLEMENT APPLICATION

1. Name of Proposed Insured:

\_\_\_\_\_

First

\_\_\_\_\_

Middle

\_\_\_\_\_

Last

2. Proposed Insured's Social Security number: \_\_\_\_\_

3. For applicants, other than those who bill directly for time, please describe the personal services that you provide to your business without which its ability to produce revenue would be substantially reduced.

4. How many are employed in the business? (Excluding Yourself) \_\_\_\_\_

5. How many of these employees are members of your profession? (Excluding Yourself) \_\_\_\_\_

6. How many of these employees are members of your immediate family? \_\_\_\_\_

7. List your average monthly business overhead expenses during the past 6 months. If you share monthly business expenses with others, list only your share. Exclude salaries, fees, drawing accounts, profits or any other remuneration for: You; any partners; any member of your profession or person performing duties similar to yours; any person to whom you are related by blood or marriage; shareholders:

Rent \$ \_\_\_\_\_

Taxes (not income taxes) and mortgage interest payments \$ \_\_\_\_\_

Other interest on business **indebtedness** \$ \_\_\_\_\_

Utilities:

Electricity \$ \_\_\_\_\_

Telephone \$ \_\_\_\_\_

Maintenance Services \$ \_\_\_\_\_

Property & Liability Insurance \$ \_\_\_\_\_

Depreciation of Business Equipment \$ \_\_\_\_\_

Employee's salaries (excluding items in 7 above) \$ \_\_\_\_\_

Other normal and customary fixed office expenses (specify below): \$ \_\_\_\_\_

Total \$ \_\_\_\_\_

Details of other normal and customary fixed office expenses:

8. Business Overhead Insurance being applied for:

Maximum Monthly Benefit for Covered Monthly Expense: \$ \_\_\_\_\_

Elimination Period:  30 days  60 days  90 days

Maximum Benefit Period:  12 months  18 months  24 months

9. Rider:

Guaranteed Insurability Rider:  Yes  No \$ Amount \_\_\_\_\_

This Supplemental Application will become part of my Disability Income Insurance Application and any policy issued. I have read this application and agree that all statements and answers given are true and complete to the best of my knowledge and belief.

X \_\_\_\_\_  
(Signature of Proposed Insured)

X \_\_\_\_\_  
Date (Month/Day/Year)

X \_\_\_\_\_  
(Witness Signature)

X \_\_\_\_\_  
Date (Month/Day/Year)

