BLUE CROSS®

☐ Application ☐ Claim

Overhead Expenses

IDENTIFICATION

Person to be insured or Claimant's Name:	Application or contract number:

ELIGIBLE OVERHEAD EXPENSES

Expenses related to the place of business prorated to the space used to run the business:

Description	Amount (in $)
- Rent or mortgage payments	
- Property tax	
- Water tax	
- Electricity	
- Heating including natural gas, fuel, etc.	
- Fixed telephone	
- Accounting services	
- Maintenance contract	
- Property, fire and theft insurance	
SUB-TOTAL	0.00

The following are excluded: - Income tax (personal and corporate)

Expenses related to machinery, equipment or any motor vehicle (car or truck) in the proportion used to run the business:

Description	Amount (in $)
- Insurance premiums (monthly amount)	
- License plate (monthly amount)	
- Parking fees contract (monthly amount)	
- For a lease: monthly amount of the lease	
- For a purchase: monthly amount equivalent to interest on the loan and amortization	
SUB-TOTAL	0.00

The following are excluded:
- Maintenance and repair costs
- Driver's licence
- Fuel (petrol, propane, oil)

Expenses related to running the business:

Description	Amount (in $)
- Employees' wages (only for firms with five employees or less)	
- Business taxes and permits	
- Postage and postal charges	
- Communication services, mobile phone, internet	
- Laundering	
- Advertising (contract)	
- Membership and/or registration fee with a professional association (monthly amount)	
- Civil or professional liability insurance (monthly amount)	
- Other usual fixed costs necessary to run a business	
SUB-TOTAL	0.00
TOTAL	0.00

The following are excluded:

- Any portion of a loan or lease covered by another insurer
- Expenses for which the Primary Insured was not liable prior to disability
- Overdue invoices (expenses incurred prior to the Primary Insured's disability)
- Legal fees
- Moving expenses
- Travel expenses
- Representation expenses
- Cost of merchandise, products or services sold
- Professional books
- Accessories, equipment or supplies
- Primary Insured's salary or that of any colleague replacing him/her

COMPANY INFORMATION - TO BE COMPLETED ONLY IN CASE OF A CLAIM

Name of company:	
Address:	
Telephone no.:	Fax no.:
Type of legal entity: ☐ sole proprietorship ☐ general partnership ☐ incorporated business or company	
Total number of partners or shareholders:	
Percentage of shares held in company or percentage holding of general partnership:	
Number of full time employees (excluding shareholders and members):	
Number of part time employees (excluding shareholders and members):	

IMPORTANT: Please include your supporting documents as well as your financial statements of your income and expenses.

STATEMENT

I hereby declare that the above information is complete, true, and current.

For an application, I agree that this information will be used as the basis for the assessment carried out in order to establish my eligibility for Canassurance Hospital Service Association and/or Canassurance Insurance Company and/or Blue Cross Life Insurance Company of Canada insurance coverage. I also understand that, once my application has been assessed and approved, the information contained in this form will be an integral part of the insurance policy that will be issued. Any false statements in this form will lead to legal measures, including policy cancellation.

	day/month/year
Signature of person to be insured or claimant	Date