Disability Insurance Needs Analysis

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

Make sure that the full financial needs analysis is done before submitting the current needs analysis.

A. Personal Information

First name: _____ Last name: _____

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

Number of dependents: _____ Their age: _____ Net worth: _____

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: **0.00**

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**,

a) indicate the percentage of work you do from home in a year: _____ %

b) if you have regular clients, do they go to your home each week to receive your services? ☐ Yes ☐ No

c) after deducting employment expenses, did you earn an annual income of at least $50,000 in 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.)	**Salary (excluding dividends)**		
Percentage of common shares held: _____	**Your share of corporation's profits or losses**		
Number of employees: _____			
Corporation creation date: MM/DD/YYYY	**Total**	**$ 0.00**	**$ 0.00**

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: $ _____ Child support: $ _____

Car loan/lease payments: $ _____ Medical and dental care: $ _____ Other: $ _____

Car/transportation expenses: $ _____ Childcare and school fees: $ _____ TOTAL: $ **0.00**

E. Monthly Sources of Income

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

☐ Employment insurance: $ _____
(Benefits paid for 26 weeks only)

☐ Group disability insurance: $ _____

☐ Individual disability insurance: $ _____

☐ Mortgage insurance: $ _____

☐ Loan insurance: $ _____

☐ Spouse: $ _____

☐ Other: $ _____

TOTAL: $ **0.00**

F. Monthly Amount Required in Case of Disability

Monthly disability insurance needed [(total section D) - (total section E)]: $ **0.00**

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: MM/DD/YYYY

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 MM/DD/YYYY.
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.

200 Rue des Commandeurs, Lévis, QC G6V 6R2 / 1-866-647-5013

Desjardins Insurance
Life • Health • Retirement

(2024-04)