500-5000 Yonge Street
Toronto, ON M2N 7J8
www.ivari.ca

Pre-Disability Self Employed Profile

Insured	Policy Number(s)

1 Business Arrangements

What is/are your present occupation(s)? _____

Employer (if applicable): _____

What legal entity is your business operating as? ○ Sole Proprietorship ○ Partnership

○ Corporation: Name _____ % of ownership _____

In your business, do you share any income or expenses with others? ○ Yes ○ No

If ***"Yes"***, please describe: _____

2 Work Location

	HOME OFFICE	CLINIC OR BUSINESS OFFICE	OTHER LOCATION	SPECIFY OTHER LOCATION
a) Where do you normally conduct your business?	○	○	○	
b) How much of your time is spent at each location?	50 %	%	%	
c) Do you or a related party own the premises where you work?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
What percentage of the premises do you own, if applicable?	%	%	%	
What percentage does your related party own, if applicable?	%	%	%	
d) Do you lease any of your space to others?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	If ***"Yes"***, _____% and $ _____ Amount

3 Employees

EMPLOYEE NUMBER	WHAT IS THIS EMPLOYEE'S POSITION AND/OR FUNCTION?	THIS PERSON, ON AVERAGE, WORKS:	IS THIS PERSON RELATED TO YOU?	WHAT IS YOUR SHARE OF THIS PERSON'S MONTHLY SALARY?
1		hrs/wk	○ Yes ○ No	$
2		hrs/wk	○ Yes ○ No	$
3		hrs/wk	○ Yes ○ No	$
4		hrs/wk	○ Yes ○ No	$

Additional Comments: _____

4 Management Company

a) Do you pay any management company fees? ○ Yes If ***"Yes,"*** how much do you pay? $ _____ /month
○ No If ***"No,"*** skip this section

b) Provide the name and address of the management company you use: _____

_____

c) What services are provided by this management company? _____

_____

d) Do you or a related party have any financial stake or interest in, or relationship to, this company or its ownership?
○ Yes ○ No If ***"Yes,"*** please describe: _____

_____

_____

5 Principal Activities

PLEASE INDICATE AND DESCRIBE YOUR USUAL OCCUPATIONAL DUTIES. FOR EACH ACTIVITY, PROVIDE APPROXIMATE FIGURES BASED ON YOUR MONTHS AVERAGES.	HOURS SPENT ON THIS ACTIVITY PER MONTH	APPROXIMATE EARNINGS PER MONTH	OR	PERCENTAGE OF EARNINGS PER MONTH
Occupational Duty		$		%
Description				
Occupational Duty		$		%
Description				
Occupational Duty		$		%
Description				
Occupational Duty		$		%
Description				
Occupational Duty		$		%
Description				
Occupational Duty		$		%
Description				

Attach a separate page if you require more room to complete this section.

6 Other Income

a) Excluding investment income, and excluding income earned from your principal activities, do you generate any other income? ○ Yes ○ No

b) If ***"Yes"***, please indicate your other source(s) of income — Approximate monthly income from this source

_____ $ _____

_____ $ _____

7 Typical Schedule

a) How many weeks of vacation do you take per year? _____

b) How much time do you spend on Continuing Education per year? _____ ○ Days ○ Weeks

c) Enter the number of hours you usually work (in a typical week) in the time slots indicated:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Mornings							
Afternoon							
Evenings							

Total number of hours worked per week, on average: _____

d) What is your call schedule (if applicable)? _____

8 Motor Vehicle

a) Please indicate the year and model of your vehicle: _____

b) Is this vehicle owned or leased? ○ Owned ○ Leased Date lease terminates: D D / M M / Y Y Y Y

c) What is your total monthly leasing or depreciation cost? $ _____

d) What percentage of this amount is for business use? _____%

9 Additional Details

Please provide any additional comments or information regarding your income, expenses or business arrangements that would assist us in understanding your pre-disability self employed profile. If there are any special occupational requirements or demands you would like us to know about, please also provide details in this space.

10 Financial Records

Please identify the custodian and location of your financial records.

Name/Company _____

Address _____ Apt./Suite _____

City _____ Province _____ Postal Code _____

Telephone _____ Fax _____

Please Note: Information provided on this form will be treated with the utmost confidentiality and will not be released without your specific, written permission.

11 Declaration

Claimant's Declaration: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I hereby agree to refund to *ivari*, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim for benefits.

Insurer Authorization: I authorize the Insurer to collect, use and disclose personal information (including financial and personal health information) about me for insurance purposes.

Authorization to Exchange Personal Information: I hereby authorize any person with relevant information about me, including but limited to any physician or other health care provider, hospital or other health care institution or medically related facility, any insurance company or reinsurance company, accountant(s), employer, workers compensation board or similar plan and any governmental department, to release and exchange with *ivari*, or a representative thereof, all personal information (including personal health information, benefit payment or financial information), about me in its possession that is requested by *ivari* for insurance purposes.

This authorization does not have any expiry date and it will remain valid for as long as I am claiming eligibility for benefits or services from *ivari*. I, the undersigned, agree that a photocopy or electronic copy of this authorization as executed by me will be valid as the original.

PRINT TO SIGN
Claimant signature

PRINT TO SIGN
Witness signature

Claimant name (Please print)

Witness name (Please print)

Date: D D / M M / Y Y Y Y

Date: D D / M M / Y Y Y Y

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