*** PLEASE READ ***

This form should only be used if your practice <u>does not</u> have a Profit & Loss Statement. New York Life's preference for paying POE claims is a Profit & Loss statements.

PROFESSIONAL OVERHEAD EXPENSE RECORD

Please answer all questions fully. This will avoid additional correspondence.

MAIL TO: AVMA LIFE
DISABILITY CLAIMS UNIT
PO BOX 228
White Plains NY 10602

MEMBER'S NAME: _____

Claim No.: _____

Business Name: _____

Business Address: _____

Date Recovered/Returned to: _____

- A separate form should be completed for each reported calendar month of Covered Total Disability. Indicate expenses from the first of the month to the end of the month. If recovery has taken place within the month, indicate the date of recovery on the top of the form, but list your entire expenses for the full reported calendar month so that the Policy's pro-rata provision can be applied.
- If you are a partner, joint occupant or member of a professional corporation, indicate ***only your*** share of the expenses. **Percentage of Ownership in Business - %_____**
- If any accrued expenses cover a period of time longer than the reported calendar month, e.g. business taxes, insurance, pro-rate the expenses over that period and include only that portion attributable to the reported calendar month.

REPORTED CALENDAR MONTH: From: _____ To: _____

A. Rent or Mortgage Principal and Interest $ _____

B. Real Estate Taxes $ _____

C. Utilities and Services:

- Electricity $ _____
- Heat $ _____
- Telephone $ _____
- Water $ _____
- Laundry $ _____
- Janitorial Services $ _____
- Postage and stationery $ _____

D.. Employees' salaries including payroll taxes and contributions for employee benefits (**excluding salary, fees, income taxes, drawing account or other remuneration for you, your partner or for any individuals hired after your disability began).**

Position:_____ $ _____
Position _____ $ _____
Position _____ $ _____

D. Principal and interest payments on existing business, equipment and/or furniture loans $ _____

OVER

AVMA LIFE®
Veterinarian Inspired Coverage

Member's Name:_____ Claim No:_____

F. Lease payments on existing equipment and furniture $ _____

G. Insurance Premiums:

- Professional liability $ _____
- Malpractice $ _____
- Property and casualty $ _____
- Worker's Compensation $ _____

H. Maintenance of existing office equipment $ _____

I. Subscriptions $ _____

J. Membership dues/license expense $ _____

K. Accountant's services $ _____

L. Other fixed expenses normal and customary in the conduct and operation of your office, excluding income taxes, and the cost of any equipment, merchandise, goods or pharmaceutical products. (Itemize separately):

_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____

Total of all listed Expenses $ _____

List average monthly salaries of employees prior to your disability:

Position _____ $ _____
Position _____ $ _____
Position _____ $ _____

Is your office or place of business still open? ☐ Yes ☐ No

The above statement of my business expenses is supported by bills and records in my possession.

ANY PERSON WHO KNOWINGLY PRESENTS A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation**.**

_____ _____
(Date) (Member's Signature)

_____
(Print Name)