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**BANKRUPTCY'S MONTHLY STATEMENT OF INCOME AND EXPENSES
 FOR THE MONTH OF: _____**

Name: _____ Spouse: _____

Address: _____

	<u>Age</u>	<u>Sex</u>
Dependents: _____	_____	_____
_____	_____	_____
_____	_____	_____

Monthly Net Family Income

	<u>Bankrupt</u>	<u>Spouse</u>
Employment Income:	\$ _____	\$ _____
Pension Income:	\$ _____	\$ _____
E. I. Benefits:	\$ _____	\$ _____
Social Assistance:	\$ _____	\$ _____
Child Tax Benefit:	\$ _____	\$ _____
Univ. Child Care Benefit:	\$ _____	\$ _____
Self-Employment Income:	\$ _____	\$ _____
Spousal/Child Support:	\$ _____	\$ _____
Other Income:	\$ _____	\$ _____
Total Income:	\$ _____	\$ _____

Monthly Non-Discretionary Expenses

Medical Condition Expenses:	\$ _____
Child Support Payments:	\$ _____
Spousal Support Payments:	\$ _____
Child Care:	\$ _____
Fines or other Court Penalties:	\$ _____
Employment Expenses:	\$ _____
Total Expenses:	\$ _____

OTHER MONTHLY LIVING EXPENSES

Living Expenses

Food/Groceries:	\$ _____	Rent/Mortgage:	\$ _____	Internet:	\$ _____
Laundry/Dry Cleaning:	\$ _____	Heating Costs:	\$ _____	Telephone:	\$ _____
Clothing:	\$ _____	Electricity:	\$ _____	Property Tax:	\$ _____
Cable:	\$ _____	Other:	\$ _____		

Transportation Costs

Car Lease/Loan Payment	\$ _____	Gas/Repairs/Maintenance:	\$ _____
Public Transportation:	\$ _____		

Personal Expenses

Lunches/Restaurants:	\$ _____
Smoking:	\$ _____
Alcohol:	\$ _____
Sports/Recreation/Movies:	\$ _____

Insurance:

Vehicle:	\$ _____
Home/Belongings:	\$ _____
Life:	\$ _____

Medical:

Prescriptions:	\$ _____
Dental:	\$ _____

Payments:

To the Estate:	\$ _____
Other:	\$ _____

Medical Insurance:	\$ _____
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Total of all Expenses: \$ _____

I certify that the above information is true and correct to the best of my knowledge: Signed: _____

Date: _____