Preventable Realities

To achieve your lifestyle and retirement goals

Client Information

First Name _____ Last Name _____ Birth Date _____ /_____ /_____

Spouse _____ Last Name _____ Birth Date _____ /_____ /_____

Address _____ City _____ State ____ Zip _____

Employer (Retired □) _____ Spouse Employer (Retired □) _____

Email _____ Phone ____-____-_____ Alt Phone ____-____-_____

Children	Age	City	Children	Age	City
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

Ages of Grandchildren _____

Appointment Source / Reason For Visit _____

Agent Name _____

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Understanding Your Concerns

Because what's important to you is important to us!

Health Expenses:	*Not Concerned*				*Very Concerned*
Choose your physician	1	2	3	4	5
Coverage when traveling	1	2	3	4	5
Personal agent	1	2	3	4	5
Affordability	1	2	3	4	5
Critical illness coverage	1	2	3	4	5

Final Expenses:	*Not Concerned*				*Very Concerned*
Funeral expenses	1	2	3	4	5
Survivorship income	1	2	3	4	5
Legacy giving	1	2	3	4	5
Charitable giving	1	2	3	4	5
Living benefits	1	2	3	4	5

Recovery Care:	*Not Concerned*				*Very Concerned*
Remaining independent	1	2	3	4	5
Protecting assets	1	2	3	4	5
Choice of care location	1	2	3	4	5
Not burdening family	1	2	3	4	5
How you're remembered	1	2	3	4	5

Retirement Income:	*Not Concerned*				*Very Concerned*
Safety of principal	1	2	3	4	5
Transferring assets	1	2	3	4	5
Minimizing taxes	1	2	3	4	5
Accessibility of money	1	2	3	4	5
Rate of return	1	2	3	4	5
Outliving assets	1	2	3	4	5

Health Expenses

1. Tell us about your current health insurance coverage(s).

Applicant	Spouse
Company: _____	Company: _____
Plan Type: □ HMO □ PPO Premium: _____	Plan Type: □ HMO □ PPO Premium: _____
□ Major Medical □ Group □ VA □ Tri-Care	□ Major Medical □ Group □ VA □ Tri-Care
□ Medicare □ Medicare Advantage □ Med Supp	□ Medicare □ Medicare Advantage □ Med Supp
□ Medicaid □ None □ Other _____	□ Medicaid □ None □ Other _____
Favorite Benefits: _____	Favorite Benefits: _____
What would you change? _____	What would you change? _____
Supplemental: □ Dental □ Vision □ Life Insurance	Supplemental: □ Dental □ Vision □ Life Insurance

2. How do you anticipate paying for medical expenses not covered by your current insurance?

_____	_____

3. So that I can get to know you a little better, tell me about your health in the last five years.

Condition	Date Diagnosed	Condition	Date Diagnosed
	____ /____ /_____		____ /____ /_____
	____ /____ /_____		____ /____ /_____
	____ /____ /_____		____ /____ /_____
	____ /____ /_____		____ /____ /_____

4. What medications are you currently taking?

Medication	Refill Amt	Dosage	Frequency	Medication	Refill Amt	Dosage	Frequency

5. Do you know anyone who has had cancer, stroke, or a heart attack? How did it affect the family and finances?

_____	_____
_____	_____

6. Family History

Father Living □ Yes □ No If no, cause and age _____	Father Living □ Yes □ No If no, cause and age _____
Mother Living □ Yes □ No If no, cause and age _____	Mother Living □ Yes □ No If no, cause and age _____

Final Expenses

1. Do you have a will or trust? ☐ Yes ☐ No **If yes**, when was this last reviewed? ____ /____ /_____

2. Do you own life insurance? ☐ Yes ☐ No **If yes**, please provide details below.

	Applicant		Spouse	
	Policy 1	Policy 2	Policy 1	Policy 2
Date Purchased	____ /____ /_____	____ /____ /_____	____ /____ /_____	____ /____ /_____
Face Amount				
Company				
Premium				
Policy Type	☐ WL ☐ UL ☐ IUL ☐ T	☐ WL ☐ UL ☐ IUL ☐ T	☐ WL ☐ UL ☐ IUL ☐ T	☐ WL ☐ UL ☐ IUL ☐ T
Beneficiary Type	☐ Per Stirpes ☐ Per Capita	☐ Per Stirpes ☐ Per Capita	☐ Per Stirpes ☐ Per Capita	☐ Per Stirpes ☐ Per Capita
Cash Value				
Surrender Value				
Last Reviewed	____ /____ /_____	____ /____ /_____	____ /____ /_____	____ /____ /_____

3. How did you determine the type(s) and amount? _____

4. Do you have other accounts specifically to cover final expenses? ☐ Yes ☐ No **If yes**, what? _____

5. If one of you were to pass away, how would it impact your family's lifestyle? _____

Recovery Care

1. Do you have an insurance policy to cover extended or long-term care? ☐ Yes ☐ No **If yes**, please provide details below.

	Applicant	Spouse
Date Purchased	____ /____ /_____	____ /____ /_____
Policy Type	☐ STC ☐ LTC ☐ RC ☐ Life/LB ☐ Life/LTC ☐ Other _____	☐ STC ☐ LTC ☐ RC ☐ Life/LB ☐ Life/LTC ☐ Other _____
Company		
Premium		
Benefit Amount	Benefit Duration	Benefit Duration
Benefit Type	☐ Reimbursement ☐ Indemnity	☐ Reimbursement ☐ Indemnity
Last Reviewed	____ /____ /_____	____ /____ /_____

2. What do you like most about your plan(s)? _____

3. When you need extended or long-term care, who will help you? _____

4. Do you know anyone who has needed extended or long-term care at home or in a facility? ☐ Yes ☐ No
   How did it impact the family emotionally and financially? _____

5. If you don't have an insurance policy to cover extended or long-term care charges, have you looked into it? ☐ Yes ☐ No
   If no, why not? _____ **If yes**, why didn't you sign up? _____

Retirement Income

Note: Do not give advice on or discuss investment-based products unless properly licensed

1. What are your current sources of (regular) income on a monthly basis?

	SS	Pension*	Employment	Real Estate	Investment	Other	Total
Applicant							
Spouse							

*Does your pension have survivor benefits? □ Yes □ No **If yes**, what percentage? _____

2. At your current income level, are you still paying income tax? □ Yes □ No **If yes**, current tax bracket? _____%

3. Total household monthly expenses? $_____ 3b. Monthly disposable income? (#1 minus #3) $_____

4. Three to six months of expenses is recommended for emergency cash reserves. Many people use checking, savings and/or money market accounts for this purpose. How many months of savings do you have set aside? _____

	Checking	Savings	Money Market	Total
Applicant				
Spouse				

5. Now that we've looked at your income and expenses, what would you say is your total household net worth?

□ $0 - $100,000 □ $100,000 - $250,000 □ $250,000 - $500,000 □ $500,000 - $1,000,000 □ $1,000,000+

6. Estimated value of your primary residence? $_____ 6b. Total value of all owned real estate? $_____

7. Do you own any CD's at the bank? □ Yes □ No

	Bank Name	Value	Interest Rate	Maturity Date	Penalty
Applicant	_____ _____	$_____ $_____	_____% _____%	_____ /_____ _____ /_____	_____ _____
Spouse	_____ _____	$_____ $_____	_____% _____%	_____ /_____ _____ /_____	_____ _____

8. Do you own any SEP, 401(k), 401(a), 403(b) or 457(b) plans? □ Yes □ No

	Company	Investment Firm	Value
Applicant			
Spouse			

9. Do you own any Annuities and/or IRA's? □ Yes □ No

IRA	Owner	Company	FIA / VA	Q/NQ	Cash Value	Surrender Value	Death Benefit	Interest Rate
□								
□								
□								

10. What other investments do you have? _____