GENERAL DATA

Client Name: Partner / Spouse Name:

Date of Birth (Client): Date of Birth (Partner):

Phone: Email:

State: Occupation (Client): Occupation (Partner):

Employer (Client): Employer (Partner):

# of Children: Ages: # of Dependents: Ages:

Referral Source: Date:

Send children/dependents to college? ☐ Yes ☐ No ☐ Maybe Est. Monthly Contribution: $

Current Concerns (select all that apply):

☐ Debt Elimination Current ☐ Retirement Planning ☐ Tax Reduction ☐ Increased Savings

☐ Increased Cash Flow ☐ Legacy / Estate Planning ☐ Special Needs Planning ☐ Business Planning

MONTHLY INCOME & TAX PROFILE

Monthly Income (Client): $ Monthly Income (Partner): $

Filing Status: Est. Tax Bracket:

Work with tax professional? ☐ Yes ☐ No Expect Tax Refund? ☐ Yes ☐ No Amount: $

Self-employed / 1099? ☐ Yes ☐ No Business Owner? ☐ Yes ☐ No Business Name:

FSA / HSA & INSURANCE BENEFITS

Contributing to FSA or HSA? ☐ Yes ☐ No Annual Contribution: $

Health: $ Disability: $ Life: $ DB: $ CV: $

Life Insurance Type: ☐ Term ☐ Whole Life ☐ IUL ☐ Group/Employer Years Left (term):

Policy / Carrier	Type	Face Amount	Cash Value	Beneficiary	Review?

ACCOUNTS (SAVINGS, CHECKING, RETIREMENT, INVESTMENT, 529, IRA, ROTH IRA, UTMA/UGMA, ETC.)

Financial Institution	Account Type	Account Value	Monthly Contribution	Available?

LONG-TERM DEBT — 10 YEARS OR MORE (MORTGAGE, STUDENT LOANS, PERSONAL LOANS, ETC.)

Primary Residence:

Mortgage Payment (P&I): $ _____ Outstanding Balance: $ _____ Rate: _____

Extra Payments: $ _____ ☐ /month ☐ /year

Debt Name	Amount Owed	Interest Rate	Min. Required Payment	Actual Payment

SHORT-TERM DEBT — LESS THAN 10 YEARS (CREDIT CARDS, AUTO LOANS, HELOC, MEDICAL BILLS, ETC.)

Debt Name	Amount Owed	Interest Rate	Min. Required Payment	Actual Payment

ADDITIONAL ACCOUNTS — CONTINUED

Financial Institution	Account Type	Account Value	Monthly Contribution	Available?

ADDITIONAL INSURANCE POLICIES — CONTINUED

Policy / Carrier	Type	Face Amount	Cash Value	Beneficiary	Review?

Completes the client intake and supports appropriate product matching and documentation of suitability.

1. MONTHLY CASH FLOW — SURPLUS AFTER ALL BILLS & LIVING EXPENSES

Estimated monthly surplus: $ _____ / month

Notes: _____

2. EMERGENCY FUND

Months of living expenses in accessible liquid savings: _____ months

Advisory note: Minimum 3–6 months recommended before funding permanent products.

3. RISK TOLERANCE

Risk tolerance: ☐ Low — guarantees preferred ☐ Moderate ☐ High — accepts variability

Comfort with non-guaranteed illustrated projections? ☐ Yes ☐ No

Interest in cash value banking / IBC strategies? ☐ Yes ☐ No ☐ Needs education

4. RETIREMENT ACCOUNT CONTRIBUTION STATUS

Contribution status: ☐ Not contributing ☐ Contributing (not maxing) ☐ Maxing out all accounts

5. LEGACY & ESTATE PLANNING — EXISTING DOCUMENTS IN PLACE

☐ Will / Last Testament ☐ Revocable Living Trust ☐ Irrevocable Trust (ILIT or SNT)

☐ Power of Attorney (POA) ☐ Healthcare Directive / Living Will ☐ None in place

Beneficiary designations aligned with estate documents? ☐ Yes ☐ No ☐ Unknown

6. HEALTH & INSURABILITY

Anticipated underwriting rating: ☐ Preferred Plus ☐ Preferred ☐ Standard ☐ Sub-standard

Known conditions affecting insurability: _____

Existing policy review needed? ☐ Yes ☐ No Carrier / Policy #: _____

7. PRIMARY PLANNING TIME HORIZON

☐ 5 Years ☐ 10 Years ☐ 15 Years ☐ 20+ Years

8. CLIENT PRIORITY RANKING (1 = MOST IMPORTANT · 6 = LEAST IMPORTANT)

☐ Protection / Life Insurance	☐ Debt Elimination	☐ Retirement Accumulation
☐ Liquidity / Cash Access	☐ Legacy / Estate Planning	☐ Tax Efficiency

"If you could eliminate all your debt — including your mortgage — in as little as 5–7 years without increasing your expenses, recapture interest paid to banks, and build liquid wealth — would you want to know how?"

ADVISOR NOTES & INITIAL OBSERVATIONS

IMPORTANT: This section is for clients with a special needs or permanently dependent family member. Accurate completion is essential for benefit coordination, trust design, and long-term care planning.

DEPENDENT INFORMATION

Dependent's Full Name: _____ Relationship: _____ DOB: _____

Diagnosis (general): _____ Functional Level: ☐ Independent ☐ Semi-independent ☐ Dependent support

Co-morbid conditions or medications: _____

CURRENT GOVERNMENT BENEFITS

☐ SSI ☐ Medicaid ☐ IHSS ☐ Regional Center

☐ Section 8 / HUD ☐ SSDI ☐ Medicare ☐ Other

Means-tested benefits at risk from inheritance or gifts? ☐ Yes ☐ No ☐ Unknown

TRUST & LEGAL STRUCTURE

Special Needs Trust (SNT) in place? ☐ Yes — Third-party SNT ☐ Yes — First-party SNT ☐ No ☐ In process

Trustee Name: _____ Successor Trustee: _____ SNT Attorney: _____

Dependent named as DIRECT beneficiary on any policy or account? ☐ Yes ☐ No ☐ Unknown *Direct beneficiary may disqualify benefits!*

EXISTING POLICY ON DEPENDENT

Existing life insurance policy on dependent? ☐ Yes ☐ No

Carrier	Policy Type	Face Amount	Cash Value	MEC Status	Owner	Beneficiary

CARE PLANNING & FINANCIAL PROJECTIONS

Current annual cost of care: $ _____ Est. lifetime support needed: $ _____

Primary caregiver (if parents incapacitated): _____ Secondary: _____

Letter of Intent (LOI) prepared for dependent? ☐ Yes ☐ No ☐ In process

SPECIAL NEEDS PLANNING — ADVISOR NOTES & FOLLOW-UP ITEMS

Referred to SNT Attorney? ☐ Yes ☐ No ☐ Pending Follow-Up Date: _____ Next Appointment: _____