# Personal Financial Review

Client 1 _____ DOB_____ Client 2 _____ DOB_____

Email _____ Email _____

Number (_____)_____ Smoker No Number (_____)_____ Smoker No

Child_____ DOB_____ Child_____ DOB_____

Child_____ DOB_____ Child_____ DOB_____

Do you have a Trust? ○ **YES** ◉ **NO** Do you have a Will? ○ **YES** ◉ **NO**

| Taxable | | Tax Deferred | | Tax Advantaged | |
|---|---|---|---|---|---|
| Monthly Input | $_____ | Monthly Input | $_____ | Monthly Input | $_____ |
| Savings | $_____ | IRAs | $_____ | Roth IRAs | $_____ |
| Checking | $_____ | 401(k), 403(b) and | | Cash Value Life Ins. | $_____ |
| CDs | $_____ | Other Pension Assets | $_____ | 529 Plan or College | |
| Mutual Funds | $_____ | Variable Annuities | $_____ | Savings Programs | $_____ |
| Stocks | $_____ | Fixed Annuities | $_____ | | |
| Bonds | $_____ | Savings Bonds | $_____ | **Total** | **$**_____ |
| Treasuries | $_____ | Other | $_____ | | |
| Other | $_____ | | | | |
| | | **Total** | **$**_____ | | |
| **Total** | **$**_____ | **Total Refund** | **$** _____ | | |

Are you properly diversified?
Are you structured for a maximum income in retirement?
How much do you have in each bucket?

| DIME & Retirement Goals | Client 1 | Client 2 |
|---|---|---|
| **D**ebt | $ | $ |
| **I**ncome (Annual x10) | $ | $ |
| **M**ortgage Balance | $ | $ |
| **E**ducation for Children | $ | $ |
| **S**ubtract Current Insurance | $<br>Type:<br>Company: | $<br>Type:<br>Company: |
| **T**otal Insurable Need | $ | $ |
| **What are some of your GOALS & DREAMS in retirement?** | | |
| **What AGE would you like to retire?**<br>**How many years will you be retired?** | Age:<br>Years: | Age:<br>Years |
| **How much INCOME PER MONTH would you NEED to maintain YOUR goals/dreams for the rest of your life?** | $ | $ |
| **How much money should you have SAVED TOTAL when you reach your retirement age?** | Years x Monthly Income x 12 =<br>$ | $ |
| **If we can put together a plan to show you how to achieve all this, would you be open to seeing it?** | ◉ **Yes** | ○ **No** |

Next Appointment:

CRIS

For Internal Use Only

Client Signature: Date:

DATE:

# CLIENT INFORMATION SHEET

| Insured Last Name: | First Name: | | Middle Name/Initial: |
|---|---|---|---|
| SSN: | Date of Birth: | Age: | Male ☐ Female ☐ |
| Height: / Weight: | DL # / State / Exprire Date: | | Marital Status: Married |
| Home Address: w/ City/State/Zip | How long at address? | Country of Birth: | City of Birth: |
| | Phone: | US Citizen: YES ☐ NO ☐ | Smoker ☐ Non-Smoker ☐ |
| | Email Address: | | |

## EMPLOYMENT INFO

| Employer Name: | | | How long with employer? |
|---|---|---|---|
| Employer Address: | | | Phone: |
| Type of Business | Occupation | Annual Income | Net Worth |

## BACKGROUND INFO

| Any Felonies, Misdemeanors or DUIs ***EVER? Explain:*** ***YES*** ☐ ***NO*** ☑ | | Date of occurance: | Date expunged or completed: |
|---|---|---|---|
| If Yes - Describe/Give Status: | | | |
| Driving Violations / License Suspensions: | | | |

## BENEFICIARY

| Name: | | Relationship to Insured | DOB |
|---|---|---|---|
| Primary ☑ or Secondary ☐ | | % | SS# |
| Name: | | Relationship to Insured | DOB |
| Primary ☐ or Secondary ☐ | | % | SS# |
| Name: | | Relationship to Insured | DOB |
| Primary ☐ or Secondary ☐ | | % | SS# |
| Name: | | Relationship to Insured | DOB |
| Primary ☐ or Secondary ☐ | | % | SS# |

## Banking/Payment Information

| Option 1 -- Level ☐ | Option 2 -- Increasing ☑ | Rating Quoted: | Premium: | ☑ Monthly ☐ Annual |
|---|---|---|---|---|
| Bank Name: | | Routing Number: | | Draft Day: |
| Name on Bank Acct: | | Acct Number: | | **Med Exam Date:** |

## Coverage Information

| Provider: | | Product: | IF Nationwide, health interview by: Select One | LTC/LB Rider: ◉ YES ○ NO |
|---|---|---|---|---|
| Total Coverage Amount: | | BASE Amount: | Additional rider: | LTC Amount or %: |
| Other Policies: ○YES ○NO | Company: | | Policy # | $ Coverage: |
| Year Issued: | REPLACING? ○YES ○NO | Total In-Force: | 1035 Amount: | Any lapsed last 3 yrs |

## Agent Information

| Writing Agent: | Writing Agent Code: | Writing Agent Last 4 of Social: | Split Agent: ○ YES ○ NO |
|---|---|---|---|
| Writing Agent Phone #: | Writing Agent Email Address: | | |
| Split Agent: | Spit Agent Code: | Spit Agent Last 4 of Social: | Trainee: |

**Medical Questions**

| Dr. Name | Phone | Date Last Seen |
|---|---|---|
| Address: | Reason: | |
| | Treatment or Medication Given: | |

**CHECK IF YES -- then note explanation for all YES answers**

Any health issues AT ALL? Heart, Diabeties, Kidneys, Cancers, Arthritis, Anything: (give detailed explaintions including time frames, prognosis, etc)

**Following ONLY if LTC or LB included**

| Other LTC: ◯YES ◯NO | Company | Policy # | Policy # | Benefit $: |
|---|---|---|---|---|
| Year Issued: | Lapse Date: | How Many miles driven/yr? | Who do you live w/? | |

Any parents, siblings or grandparents have cancer, heart disease, diabetes, mental illness, attempted suicide? ◯ YES ◯ NO

Details:

Any die before age 60? ◯ YES ◯ NO

**Family Information - for both parents and every sibling:**

| | | |
|---|---|---|
| **Father:** | Age if Living: | Present Health: |
| | Age of Death if not living: | Cause of Death: |
| **Mother:** | Age if Living: | Present Health: |
| | Age of Death if not living: | Cause of Death: |
| **Sibling 1:** | Age if Living: | Present Health: |
| Select One | Age of Death if not living: | Cause of Death: |
| **Sibling 2:** | Age if Living: | Present Health: |
| Select One | Age of Death if not living: | Cause of Death: |
| **Sibling 3:** | Age if Living: | Present Health: |
| Select One | Age of Death if not living: | Cause of Death: |

| | | | |
|---|---|---|---|
| Do you live alone? If no, with whom? ◯YES ◯ NO | | Athletics (Team or Individual)? ◯ YES | ◯ NO |
| Do you participate in reg weekly exercise? ◯ YES | ◯ NO | Regular Annual Dental Exams? ◯ YES | ◯ NO |
| Regular Health Care Examinations? ◯ YES | ◯ NO | Do you have a pet? ◯ YES | ◯ NO |
| Member of social group or volunteer for charity? ◯ YES | ◯ NO | Do your own house work? ◯ YES | ◯ NO |

**JUVENILE CLIENT Or OTHER THAN INSURED POLICY OWNER INFO - This section is for owner of policy information**

| Last Name: | | First Name: | | Middle Name: |
|---|---|---|---|---|
| Home Address: | | City/State/Zip | Phone: | US Citizen: ☑ YES ☐ NO |
| Date of Birth: | Age: | Place of Birth: | DL # / State: | DL Exprires: |
| **Employer Name:** | | | | How long with employer? |
| Employer Address: | | | | Phone: |
| Type of Business | | Occupation | Annual Income | Net Worth |

Client Name: Date:

Additional Notes:

SAVING

MIN: $
MAX: $

Mortgage - $ Extra $ Interest- Term - 30 Year
Internet - $
Cable - $
Food - Dining In - $ Dining Out - $
Gas - $
Car Insurance - $
Car Payment - $ Interest- Term -
Medical Insurance - $
Dental Insurance - $
Cell Phone - $
Lights - $
Water - $
Trash - $
Lawn Care - $
Subscriptions - $
Child Care - $
Credit Card - $ Min Payment - $ Actual Payment - $ Interest -
Credit Card - $ Min Payment - $ Actual Payment - $ Interest -
Credit Card - $ Min Payment - $ Actual Payment - $ Interest -
Credit Card - $ Min Payment - $ Actual Payment - $ Interest -
Personal Loan - $ Interest- Term -
Personal Loan - $ Interest- Term -
Personal Loan - $ Interest- Term -
Boat Payment $1000 Interest

# Personal Financial Review Summary

| CLIENT INFORMATION | | | | |
|---|---|---|---|---|
| Name/Age: | _____ | _____ | _____ | _____ |
| Estimated Rate Class: | _____ | _____ | _____ | _____ |
| Estimated Insurable Need: | _____ | _____ | _____ | _____ |
| Client Stated Monthly Savings Target: | _____ | _____ | _____ | _____ |
| Goals | | | | |
| Dreams | | | | |

| PLAN RECOMMENDATIONS | | |
|---|---|---|
| ☐ | **Premium Plan for _____** | $ |
| ☐ | **Premium Plan for _____** | $ |
| ☐ | **Premium Plan for _____** | $ |
| ☐ | **Premium Plan for _____** | $ |
| ☐ | **Total Plan Investment (Monthly/Annually)** | **$** |