

RENEWAL MEETING QUESTIONNAIRE

Please take a few minutes to complete this form and return it approximately one week prior to our meeting. Section One is primarily contact information and personal data which we would like you to update if anything has changed. Section Two will provide us with current information about your personal and financial concerns and situations that will help us keep your plan current and allow us to make recommendations if needed.

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| Date: | | |
| Client Name: | | |
| Employer Name (if changed): | | |
| Spouse/Partner Name: | | |
| Employer (if changed): | | |
| IF CHANGED: Mailing Address: | | |
| Home phone: | | Cell phone: |
| Client business phone: | Client Email: | Please circle type of contact you prefer: Email Snail Mail |
| Spouse business phone: | Spouse Email: | |
| 1. What are your most important financial concerns at this time? | | |
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| 2. What are your most important <i>non</i> -financial concerns and objectives right now? | | |
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| 3. Have any changes taken place, or have occurred, we should know about? (i.e. new home, new child, new grandchild, bonus, deaths, inheritances, illness, etc.) | | |
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| 4. What changes do you expect in the future, or have occurred, in your finances that you wish to plan for? (bonuses, inheritance, change of job, family obligations, etc.) | | |
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| 5. Any changes in your goals/concerns regarding passing assets to children or others? |
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| 6. Is there anything else we need to talk about? Any "special needs" situations you are responsible for? |
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| 7. How much is your current income? _____ Does this amount represent a substantial change? _____ Itemize sources: |
| 8. Please mark "X" if currently owned: Wills _____ Trusts _____ Life Insurance _____ Disability Insurance _____ |
| 9. What areas would you like to discuss: |
| <input type="checkbox"/> Long Term Care Insurance <input type="checkbox"/> Tax Planning <input type="checkbox"/> Business Planning <input type="checkbox"/> Income Management <input type="checkbox"/> Legacy Planning, Wealth Preservation and Transfer <input type="checkbox"/> Life Insurance <input type="checkbox"/> Goals Funding <input type="checkbox"/> Life Planning <input type="checkbox"/> Retirement Planning <input type="checkbox"/> Investments <input type="checkbox"/> Education Funding <input type="checkbox"/> Other _____ |
| 10. How are you doing in terms of managing your spending and savings in light of your personal goals and values? |
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| 11. Have you made or received financial gifts in the past year? |
| If yes, please provide details: |
| Gift to/from whom: _____ Amount \$ _____ Approx. Date: _____ |
| Gift to/from whom: _____ Amount \$ _____ Approx. Date: _____ |
| Gift to/from whom: _____ Amount \$ _____ Approx. Date: _____ |