Case (Client Profile) Submission Form for Analysis and Design Development

(Complete all information pertinent to the case)

Date: _____ Advisor Name: _____

Phone: _____ E-Mail: _____

1) Client Name: _____ M ( ) F ( ) D/O/B _____

Smoker: ( ) N ( ) Y General Health: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Major Health Problems (if any): _____

2) Client Name: _____ ( ) M ( ) F D/O/B _____

Relationship to Client **#1**: _____

Smoker: ( ) N ( ) Y General Health: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Major Health Problems (if any): _____

State of Residence: _____ Married: ( ) Y ( ) N Children: ( ) Y ( ) N if Yes: ( ) Minor ( ) Adult

Net Worth of Client: $_____ Annual Income: $_____ Tax Bracket: _____

How long have you known the client(s): _____

What financial services do you provide for the client(s)? _____

Is the compensation relationship with this client: ( ) Fee-Only ( ) Fee & Commission ( ) Commission Only

Client(s) have the following Executed Documents:

( ) Wills ( ) Revocable Living Trust ( ) Durable Power of Attorney ( ) Irrevocable Life Insurance Trust

( ) Health Advocacy Forms ( ) Other: _____

Is this activity in regard to:

( ) Personal Planning ( ) Business Planning ( ) Both Personal & Business Planning ( ) Estate Planning

If Business Planning:

Business Structure:

( ) Corporation > ( ) *"C" Corp Tax Election* ( ) *"S" Corp Tax Election*

( ) LLC > ( ) *Taxed as Partnership* ( ) *Taxed as Corporation*

( ) Sole-Proprietorship

( ) Partnership

Ownership Percentage: _____ Number of additional owners: _____

Are family members involved with the business: ( ) Y ( ) N and/or ownership of the business: ( ) Y ( ) N

Objective of Analysis / Plan Design:

( ) Analyze Current Policies ( ) Analyze Proposed Insurance Illustrations ( ) Create Planning Concepts

( ) Review Existing Financial Plan / Strategy ( ) Other: _____

( ) Development of Life Insurance Needs / Death Benefit, for the purpose of:

- ( ) Income Replacement
- ( ) Estate Taxes
- ( ) Education
- ( ) Wealth Transfer
- ( ) Retirement
- ( ) Business Planning
- ( ) Other: _____

( ) Development of Life Insurance / Tax-Advantaged Asset Accumulation, for the purpose of:

- ( ) Education
- ( ) Retirement
- ( ) Wealth Transfer
- ( ) Charitable
- ( ) Tax Reduction
- ( ) Other: _____

Initial Documents needed:

- Inventory list of all life insurance and annuity products.
- Copy of existing life insurance policies (first 3 to 5 pages that contain policy information).
- Copy of initial illustration proposal, if available.
- Copy of any sales material presented to client with regard to policy and/or planning concept.
- Copy of any in-force illustrations that have been run.

For Single Life, Survivorship Universal Life, or Participating Whole Life:

- Copy of last anniversary policy statement

For Single Life or Survivorship Variable Universal Life

- Copy of last anniversary policy statement and a copy of last quarterly policy statement.

Documents that may be needed:

- Authorization to insurance company(ies) to obtain documents and/or in-force illustrations.
- Copy of any documents created for advanced planning strategies (i.e., Split-Dollar, Promissory Notes, Buy & Sell Agreement, Deferred Compensation Agreement, etc.).

Additional Notes:

Next appointment scheduled with this client: _____

Desired timeframe for completion of this project: _____

Bronze Members: Revenue Share Option Selected > Option A: 40% ( ) Option B: 25% / Client Direct ( )

For initial and exploratory discussion, fax pages 1 & 2 only to (248) 250-6833 or e-mail to: FiduciaryCare@aol.com

Upon engagement, mail this completed packet (pages 1-4) and all necessary documentation to:

Joseph W. Maczuga / Fee Advisors Network / 237 Carter Drive / Troy, MI 48098

Or, scan all documents and e-mail to: FiduciaryCare@aol.com

COMPREHENSIVE ANALYTICS

~ **Health Summary** ~

1. Proposed Insured A *(First, Middle, Last)*	2. Date of Birth *(mm/dd/yy)*	3. Have you engaged in tobacco use in the last 3 years? ( ) Y ( ) N
		If YES, type and last date of use:

▶ **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

	YES	NO
4. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
5. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
6. Have you ever had any indication of, or been treated by a licensed medical professional for:		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis, or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
7. In the past 10 years, have you been diagnosed by a licensed medical professional as having human immune deficiency virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a licensed medical professional for AIDS?	☐	☐
8. Do you use alcoholic beverages? *(if "Yes", provide Type, Frequency and Amount.)*	☐	☐
Type: _____ Frequency: _____ Amount: _____		
9. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
10. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐
11. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.		
_____ _____ _____		
_____ _____ _____		

12. Details: *(For each question answered "Yes", please specify question number and details below.)*

COMPREHENSIVE ANALYTICS

~ **Health Summary** ~

1. Proposed Insured B *(First, Middle, Last)*	2. Date of Birth *(mm/dd/yy)*	3. Have you engaged in tobacco use in the last 3 years? ( ) Y ( ) N
		If YES, type and last date of use:

▶ **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

	YES	NO
4. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
5. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
6. Have you ever had any indication of, or been treated by a licensed medical professional for:		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis, or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
7. In the past 10 years, have you been diagnosed by a licensed medical professional as having human immune deficiency virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a licensed medical professional for AIDS?	☐	☐
8. Do you use alcoholic beverages? *(if "Yes", provide Type, Frequency and Amount.)*	☐	☐
Type: _____ Frequency: _____ Amount: _____		
9. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
10. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐
11. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.		
_____ _____ _____		
_____ _____ _____		

12. Details: *(For each question answered "Yes", please specify question number and details below.)*