Confidential Client Survey

Date Completed:_________________

A time saving tip - when your documents contain the information requested on the Confidential Client Survey, simply write "see documents" in the spaces provided on the form.

Personal Information

Item	Client #1 Male / Female	Client #2 Male / Female
Name (Married / Not Married)		
Social Security Number		
Date of Birth		
Are you a United States citizen?	Yes No	Yes No
Level of Education		
	Primary Residence	**Second Home**
Street Address		
City, State, Zip		
Home Phone (Area Code)	( )	( )
Home E-mail Address		

Children

Name	Birthdate	Social Security Number	# of Grandchildren and Ages

Employment Information

Item	Client #1	Client #2
Occupation/Title		
Company Name		
Company Address		
City, State, Zip		
Business Phone (Area Code)	( )	( )
Work E-mail Address		
Salary	$	$
Bonus	$	$
Length of employment at current employer		
Target Retirement Date		

Other Income e.g., Alimony, Child Support, Rental Property, Disability Benefits, Retirement Plan Distributions, Gifts, etc.

Item	Client #1		Client #2	
	Current	Future	Current	Future
Pensions	$	$	$	$
Social Security	$	$	$	$
Other (Please Identify)	$	$	$	$

REV 5/19/2005

Estate Planning

Wills, Trusts & Other Legal Documents	Client #1	Client #2
Do you have a Will?	Yes No	Yes No
Date of execution or last Will review:		
Do you have a trust? List type and date of execution		
Do you have a Durable Power of Attorney?	Yes No	Yes No
Do you have a Living Will/Health Care Directive?	Yes No	Yes No

Checking, Savings, Money Market Accounts & CDs

Identification of the Account	Monthly Additions	Owner	Beneficiary	Current Value
	$			$
	$			$
	$			$
	$			$
			Total	$

Non-qualified Investments

e.g., Stocks, Bonds, Mutual Funds, Real Estate Investment Trusts, Non-qualified Annuities, Limited Partnerships, Stock Options, Deferred Compensation.

Identification of the Account	Purchase Date	Cost Basis	Monthly Additions	Owner	Beneficiary	Current Value
			$			$
			$			$
			$			$
			$			$
			$			$
			$			$
					Total	$

Primary Bank

Name on Account	Account #	City	State	Zip Code

Qualified Investments

e.g., Traditional IRAs, Roth IRAs, 401(k)s, TSA/403(b)s, 457s, SEP IRAs, Simple IRAs, Profit Sharing Plans, Money Purchase Pension Plans, etc.

Identification of the Account	Type of Account	Mo. Addn's Client	Mo. Addn's Employer	Owner	Beneficiary	Current Value
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
		$	$			$
					Total	$

Other Investments

e.g., UTMAs, UGMAs, Education IRAs, 529 Plans, Notes Receivable, Investment Real Estate, Business Interests, etc.

Identification of the Account	Monthly Additions	Owner	Beneficiary	Current Value
	$			$
	$			$
			Total	$

Personal Assets

Identification	Purchase Price	Owner	Comments	Current Value
Residence	$			$
2nd Home	$			$
Autos/Personal Property	$			$
Other:	$			$
Other:	$			$
			Total	$

Liabilities e.g., Student Loans, 401(k) Loans, Life Insurance Loans, Margin Loans

Identification	Date Loan Taken	Original Loan Balance	Monthly Payment	Length of Loan	Interest Rate	Owner	Current Balance
Home Mortgage		$	$	yrs.	%		$
Home Equity Loan		$	$	yrs.	%		$
Home Equity Line of Credit		$	$	yrs.	%		$
2nd Home Mortgage		$	$	yrs.	%		$
Auto Loan		$	$	yrs.	%		$
Credit Card Debt		$	$	yrs.	%		$
Other:		$	$	yrs.	%		$
						Total	$

Company Sponsored Life Insurance

If none please circle: None

Insured	Beneficiary	Type: Circle One	Death Benefit	Cash Value if Applicable	Annual Employee Cost	Continues after separation of service?*
		Term/UL	$	$	$	Yes No
		Term/UL	$	$	$	Yes No

* If yes, please provide detail

Personal Life Insurance

If none please circle: None

Owner	Insured	Beneficiary	Current Death Benefit	Cash Value	Annual Premium	Carrier Name	Policy Type*	Issue Date
			$	$	$			
			$	$	$			
			$	$	$			

*Policy Type: Whole Life, Term, Universal Life, Variable Univ. Life

Long Term Care Insurance

If none please circle: None

Insured	Private or Employer Spnsd.	Carrier Name	Daily Benefit	Benefit Period	Annual Premium	Cost of Living Adjustment: Circle One	Elimination Period
			$	yrs.	$	Simple/Compound/None	
			$	yrs.	$	Simple/Compound/None	

Disability Insurance

If none please circle: None

Insured	Private or Employer	Carrier Name	Monthly Benefit	Your Annual Premium	Maximum Mo. Benefit
			$	$	$
			$	$	$