



**Geelong Insurance
Brokers**

Life Insurance Fact Find

Prepared for client:

Date completed:

Adviser name

Business name

Business address

.....

.....

Personal Details

Please complete this section.

	Client 1	Client 2
Is English your first language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not, are you fluent in English?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require the assistance of an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Title (eg Mr, Mrs)	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Given name	<input type="text"/>	<input type="text"/>
Preferred name	<input type="text"/>	<input type="text"/>
Gender	<input type="text"/>	<input type="text"/>
Marital status	<input type="text"/>	<input type="text"/>
Date of Birth	<input type="text" value="DD/MM/YYYY"/>	<input type="text" value="DD/MM/YYYY"/>
Are you a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you quit within the last 12 months?	Have you quit within the last 12 months?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred retirement age	<input type="text"/>	<input type="text"/>
Relationship between clients 1 and 2	<input type="text"/>	<input type="text"/>
Are you a permanent resident of Australia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Residential address	<input type="text"/> State <input type="text"/> Postcode <input type="text"/>	<input type="text"/> State <input type="text"/> Postcode <input type="text"/>
Postal address (write 'as above' if same as residential address)	<input type="text"/> State <input type="text"/> Postcode <input type="text"/>	<input type="text"/> State <input type="text"/> Postcode <input type="text"/>
Home telephone	<input type="text"/>	<input type="text"/>
Business telephone	<input type="text"/>	<input type="text"/>
Mobile	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	<input type="text"/>
Preferred contact method	<input type="text"/>	<input type="text"/>

Personal Details (continued)

Employment

	Client 1	Client 2
Occupation	<input type="text"/>	<input type="text"/>
Breakdown of occupation duties (administration, manual, travel etc)	<input type="text"/>	<input type="text"/>
Employment status	<input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/> Homemaker	<input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/> Homemaker
Employer name	<input type="text"/>	<input type="text"/>
Employer address	<input type="text"/> State <input type="text"/> Postcode <input type="text"/>	<input type="text"/> State <input type="text"/> Postcode <input type="text"/>
Date commenced with employer	<input type="text" value="DD/MM/YYYY"/>	<input type="text" value="DD/MM/YYYY"/>
If self-employed, what is the business structure?	<input type="checkbox"/> Sole Trader <input type="checkbox"/> Company <input type="checkbox"/> Partnership split <input type="text"/> %	<input type="checkbox"/> Sole Trader <input type="checkbox"/> Company <input type="checkbox"/> Partnership split <input type="text"/> %
Accrued sick leave days	<input type="text"/>	<input type="text"/>
Accrued annual leave days	<input type="text"/>	<input type="text"/>
Accrued long service leave days	<input type="text"/>	<input type="text"/>

Pre-assessment Process

<p>Do you know of, or have you been made aware of, any issues which may be relevant to the assessment of a life insurance application? For example: known medical conditions; occupational hazards; planned overseas travel; engagement in hazardous pursuits; and/or immediate family medical history concerns.</p> <p>If yes, please provide details or alternatively complete the 'Life Insurance Pre-Assessment Request' and attach as an addendum to this document.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not disclosed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not disclosed
	<input type="text"/>	<input type="text"/>

Personal Details (continued)

Dependants

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

Name	Date of Birth (DD/MM/YYYY)	Age	Gender	Relationship	When would you expect dependency to cease?
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

Are you planning to grow your family? ☐ Yes ☐ No If yes, when?

What health issues, if any, need to be considered for your dependants?

Family Trust Details

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

Name of Family Trust

Australian Company Number (ACN)

Trustees

Trustee 1:

Trustee 2:

Trustee 3:

Trustee 4:

Beneficiaries

Beneficiary 1:

Beneficiary 2:

Beneficiary 3:

Beneficiary 4:

Professional Advisers

Company name	Contact name	Phone number
Accountant:		
Solicitor:		
Doctor:		
Other:		

Income/Expenditure Analysis

Please complete this section or tick box below.

☐ Alternate income and expenses data collection used, refer to Budget Tool.

Select Frequency: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly

Source of Income (Before Tax)	Client 1 (\$)	Client 2 (\$)	Joint (\$)
Salary and wages (exclude Super Guarantee contributions)			
Other			
Total combined income (before tax)			
Less: Estimated tax and/or other deductions (eg salary sacrifice, salary packaging)			
Net combined income			

Expenses

Select Frequency: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Yearly

	Client 1 (\$)	Client 2 (\$)	Joint (\$)
Living expenses			
Rent/home mortgage			
Other			
Subtotal expenses			
Total combined expenses			
Surplus/deficit (total net combined income less total combined expenses)			

Assets and Liabilities

Please complete this section or tick box below.

☐ Alternate assets and liabilities data collection used, refer to Budget Tool.

Lifestyle, Investment and/or Superannuation Assets

	Client 1 Amount (\$)	Client 2 Amount (\$)	Joint Amount (\$)	To be sold in the event of Death/ TPD/Trauma?
Principal residence				<input type="checkbox"/> Yes <input type="checkbox"/> No
Home contents				<input type="checkbox"/> Yes <input type="checkbox"/> No
Motor vehicle				<input type="checkbox"/> Yes <input type="checkbox"/> No
Caravan, boat, etc.				<input type="checkbox"/> Yes <input type="checkbox"/> No
Holiday house				<input type="checkbox"/> Yes <input type="checkbox"/> No
Investment property				<input type="checkbox"/> Yes <input type="checkbox"/> No
Cash and fixed interest				<input type="checkbox"/> Yes <input type="checkbox"/> No
Managed funds				<input type="checkbox"/> Yes <input type="checkbox"/> No
Direct shares				<input type="checkbox"/> Yes <input type="checkbox"/> No
Superannuation 1				<input type="checkbox"/> Yes <input type="checkbox"/> No
Superannuation 2				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other <input type="text"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other <input type="text"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Total				

Liabilities


	Lender	Client 1 Balance (\$)	Client 2 Balance (\$)	Joint Balance (\$)
Mortgage				
What is the mortgage duration?		<input type="text"/>	<input type="text"/>	<input type="text"/>
Is there a fixed interest component?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the duration		<input type="text"/>	<input type="text"/>	<input type="text"/>
Credit cards				
Investment loan				
What is the investment loan duration?		<input type="text"/>	<input type="text"/>	<input type="text"/>
Personal loan				
What is the personal loan duration?		<input type="text"/>	<input type="text"/>	<input type="text"/>
Other <input type="text"/>				
Other <input type="text"/>				
Total				

Goals

Life Insurance Goals

Please complete this section.

I/We require advice in relation to personal insurance only.

☐ Yes ☐ No  **DO NOT PROCEED** – a full Financial Planning Fact Find should be completed to ensure all necessary information is collected in order to provide appropriate advice.

What you want to achieve	Client 1	Client 2
You would like to protect your income. If yes, would you want to protect it for a defined timeframe? Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
In the event of your death you would like to provide financial protection to your family/estate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the event of permanent disablement you would like to provide financial protection for you and your family	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the event of serious illness you would like to provide financial protection for you and your family	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Review existing levels of cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reduce existing insurance premiums	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
You would like to protect your mortgage and/or loan(s) for a defined timeframe If yes, specify timeframe:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>

Please describe any other insurance objectives you want to achieve:

Health and Wellbeing Goals

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

	Client 1	Client 2
I require advice as to how my health and wellbeing can benefit my personal insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When it comes to your health and wellbeing how would you best describe yourself?	<input type="checkbox"/> I'm actively trying to maintain or improve my health <input type="checkbox"/> I have tried to establish some routines and disciplines but wish I could be more persistent and do more <input type="checkbox"/> I pay attention to my health but don't have any particular goals and disciplines <input type="checkbox"/> I don't really pay any attention to it	<input type="checkbox"/> I'm actively trying to maintain or improve my health <input type="checkbox"/> I have tried to establish some routines and disciplines but wish I could be more persistent and do more <input type="checkbox"/> I pay attention to my health but don't have any particular goals and disciplines <input type="checkbox"/> I don't really pay any attention to it
Would you like to be rewarded for your health and wellbeing efforts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Optional section: Health Insurance

	Client 1	Client 2
Do you have health insurance? If yes, complete the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the main reason you have health insurance?	<input type="checkbox"/> a) To save tax <input type="checkbox"/> b) For peace of mind <input type="checkbox"/> c) To get value from your extra's cover	<input type="checkbox"/> a) To save tax <input type="checkbox"/> b) For peace of mind <input type="checkbox"/> c) To get value from your extra's cover
How satisfied are you with your current provider?	<input type="checkbox"/> 1) Unsatisfied <input type="checkbox"/> 2) Neutral <input type="checkbox"/> 3) Satisfied	<input type="checkbox"/> 1) Unsatisfied <input type="checkbox"/> 2) Neutral <input type="checkbox"/> 3) Satisfied
Would you like to be rewarded for your health and wellbeing efforts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to know how your health and wellbeing can benefit your health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish to review your health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Estate Planning

Please complete this section or tick the relevant box.

☐

Not applicable

☐

Not disclosed

	Client 1	Client 2
Power of Attorney		
Do you have a current Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please tick type:	<input type="checkbox"/> Enduring <input type="checkbox"/> Medical <input type="checkbox"/> General <input type="checkbox"/> Other	<input type="checkbox"/> Enduring <input type="checkbox"/> Medical <input type="checkbox"/> General <input type="checkbox"/> Other
Who is the Power of Attorney?	<div></div>	<div></div>
Will		
Do you have a Will?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the date of your Will?	<div>DD/MM/YYYY</div>	<div>DD/MM/YYYY</div>
Is your Will current?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it reflect current wishes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who is the executor?	<div></div>	<div></div>
Testamentary Trust		
Do you have a testamentary trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a letter of wishes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Estate Planning Goals

Please complete this section or tick the relevant box.

☐

Not applicable

☐

Not disclosed

What you want to achieve	Client 1	Client 2
You would like your current Will, PoA's, and Testamentary trust reviewed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
You do not have a full estate plan in place and would like to implement one	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
You have components of your estate plan that need to be implemented: If yes, please state:	<input type="checkbox"/> Yes <input type="checkbox"/> No <div></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No <div></div>

Please describe any other estate planning goals you would like to achieve:

Current Insurance Details

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

Please attach an addendum to the back of this document if you are unable to fit all existing policies below.

Client 1

Protection Need	Policy Number	Insurer	Policy Owner	Insured Benefits		Amount of Cover	Total Premium	Premium Frequency
Lifestyle protection				<input type="checkbox"/> Death		\$	\$	<input type="checkbox"/> Monthly
				<input type="checkbox"/> TPD (own)		\$	<input type="checkbox"/> Stepped	<input type="checkbox"/> Half yearly
				<input type="checkbox"/> TPD (any)		\$	<input type="checkbox"/> Level	<input type="checkbox"/> Yearly
				<input type="checkbox"/> Trauma		\$		
Personal Super				<input type="checkbox"/> Death		\$	\$	<input type="checkbox"/> Monthly
				<input type="checkbox"/> TPD		\$	<input type="checkbox"/> Stepped	<input type="checkbox"/> Half yearly
							<input type="checkbox"/> Level	<input type="checkbox"/> Yearly
Protection Need	Policy Number	Insurer	Policy Owner	Benefit Period	Waiting Period	Monthly Benefit	Premium	Premium Frequency
Income protection						\$	\$	<input type="checkbox"/> Monthly
							<input type="checkbox"/> Stepped	<input type="checkbox"/> Half yearly
							<input type="checkbox"/> Level	<input type="checkbox"/> Yearly
Salary Continuance						\$	\$	<input type="checkbox"/> Monthly
								<input type="checkbox"/> Half yearly
								<input type="checkbox"/> Yearly

Do you have loadings or exclusions on your existing benefits? ☐ Yes ☐ No ☐ Not disclosed

If yes, please provide details:

Employer Sponsored Super

Fund	Insured Benefits	Sum Insured/ Monthly Benefit	Benefit Period (SCI only)	Waiting Period (SCI only)	Nominated Beneficiaries
	<input type="checkbox"/> Death	\$			
	<input type="checkbox"/> TPD	\$			
	<input type="checkbox"/> Salary Continuance	\$			

Notes:

Current Insurance Details (continued)

Client 2

Protection Need	Policy Number	Insurer	Policy Owner	Insured Benefits		Amount of Cover	Total Premium	Premium Frequency
Lifestyle protection				<input type="checkbox"/> Death		\$	\$	<input type="checkbox"/> Monthly
				<input type="checkbox"/> TPD (own)		\$	<input type="checkbox"/> Stepped	<input type="checkbox"/> Half yearly
				<input type="checkbox"/> TPD (any)		\$	<input type="checkbox"/> Level	<input type="checkbox"/> Yearly
				<input type="checkbox"/> Trauma		\$		
Personal Super				<input type="checkbox"/> Death		\$	\$	<input type="checkbox"/> Monthly
				<input type="checkbox"/> TPD		\$	<input type="checkbox"/> Stepped	<input type="checkbox"/> Half yearly
							<input type="checkbox"/> Level	<input type="checkbox"/> Yearly
Protection Need	Policy Number	Insurer	Policy Owner	Benefit Period	Waiting Period	Monthly Benefit	Premium	Premium Frequency
Income protection						\$	\$	<input type="checkbox"/> Monthly
							<input type="checkbox"/> Stepped	<input type="checkbox"/> Half yearly
							<input type="checkbox"/> Level	<input type="checkbox"/> Yearly
Salary Continuance						\$	\$	<input type="checkbox"/> Monthly
								<input type="checkbox"/> Half yearly
								<input type="checkbox"/> Yearly

Do you have loadings or exclusions on your existing benefits? ☐ Yes ☐ No ☐ Not disclosed

If yes, please provide details:

Employer Sponsored Super

Fund	Insured Benefits	Sum Insured/ Monthly Benefit	Benefit Period (SCI only)	Waiting Period (SCI only)	Nominated Beneficiaries
	<input type="checkbox"/> Death	\$			
	<input type="checkbox"/> TPD	\$			
	<input type="checkbox"/> Salary Continuance	\$			

Notes:

Income Protection Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of income protection is to replace income lost through your inability to work due to injury or sickness.

	Client 1	Client 2
For how long would you continue to receive an income if you were unable to work due to an illness or accident?	<input type="text"/>	<input type="text"/>
After that period of time, what would happen to your income if you were still unable to work?	<input type="text"/>	<input type="text"/>
Is that what you would want to have happen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Income Protection Analysis	Client 1	Client 2
<input type="text"/> % of annual income (before tax)*	\$ <input type="text"/>	\$ <input type="text"/>
Plus: <input type="text"/> % super contributions	\$ <input type="text"/>	\$ <input type="text"/>
Maximum level of cover available (per annum)	\$ <input type="text"/>	\$ <input type="text"/>
Less: Existing cover to be retained with:	\$ <input type="text"/>	\$ <input type="text"/>
Level of cover required (per annum)	\$ <input type="text"/>	\$ <input type="text"/>
Level of cover recommended (per month)	\$ <input type="text"/>	\$ <input type="text"/>
How long could you go without your regular income?	<input type="checkbox"/> 14 days <input type="checkbox"/> 12 months <input type="checkbox"/> 1 month <input type="checkbox"/> 2 years <input type="checkbox"/> 3 months	<input type="checkbox"/> 14 days <input type="checkbox"/> 12 months <input type="checkbox"/> 1 month <input type="checkbox"/> 2 years <input type="checkbox"/> 3 months
How long should the monthly benefit be paid for?	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> To age 65/70	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> To age 65/70

* Where the life insured:

- directly or indirectly owns part or all of a business or practice – the business or practice income generated by the life insured's personal exertion after deduction of their share of business or practice expenses in generating that income. Self-employed individuals may be required to produce supporting P&L statements, tax returns and/or group statements.
- is an employee – the total remuneration paid by the employer including salary, superannuation, commissions, fees, regular bonuses, regular overtime and fringe benefits.
- financial evidence supporting the calculations and inclusions is likely to be required at time of underwriting.

Life Cover Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of life cover is to provide a sufficient lump sum amount to your family in the event of your death to help maintain their lifestyle.

	Client 1	Client 2
If we could replace your income stream, how much of it would you want replaced?	<input type="text" value=" %"/>	<input type="text" value=" %"/>
For how many years would this income replacement need to continue?	<input type="text" value=" years"/>	<input type="text" value=" years"/>
Would you want your debts fully paid off?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, specify timeframe:	<input type="text"/>	<input type="text"/>
If no, specify amount:	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Would you want to include funds to cover your final costs and funeral expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would your partner continue to work or return to work in the event of your death?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Life Capital Needs Analysis	Client 1	Client 2
Final and funeral expenses	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Eliminate debt or portion of debt	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Mortgage	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Outstanding debts	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Personal guarantees	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
If applicable: Capital Gains Tax	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Other	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
(A) Subtotal	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Life Income Needs Analysis		
Income replacement x years	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
(B) Subtotal	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Less Existing Resources		
Existing life cover with: <input type="text"/>	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Superannuation (insured benefit)	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Financial assets realised in the event of death	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Lifestyle assets realised in the event of death	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
(D) Subtotal	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
Summary of Needs		
(C) Level of cover required before resources (A + B)	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
(D) Less total existing resources	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>
(E) Level of cover required (C – D)	<input type="text" value=" \$"/>	<input type="text" value=" \$"/>

Total and Permanent Disability (TPD) Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of TPD cover is to provide a sufficient lump sum amount should you become totally and permanently disabled to help pay medical costs and maintain your lifestyle.

	Client 1	Client 2
In the event of prolonged or serious illness or accident, where between 0% and 100% would you want your income to be replaced?	<input type="text"/> %	<input type="text"/> %
For how many years would this income replacement need to continue?	<input type="text"/> years	<input type="text"/> years
Would you want your debts fully paid off?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify amount: <input type="text"/> \$	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify amount: <input type="text"/> \$
Would you want an additional lump sum to cover possible rehabilitation/medical expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would your partner continue to work or return to work in the event of your TPD event?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

TPD Capital Needs Analysis	Client 1	Client 2
Eliminate debt or portion of debt	<input type="text"/> \$	<input type="text"/> \$
Mortgage	<input type="text"/> \$	<input type="text"/> \$
Outstanding debts	<input type="text"/> \$	<input type="text"/> \$
Personal guarantees	<input type="text"/> \$	<input type="text"/> \$
Medical/rehabilitation costs	<input type="text"/> \$	<input type="text"/> \$
If applicable: Capital Gains Tax	<input type="text"/> \$	<input type="text"/> \$
Other	<input type="text"/> \$	<input type="text"/> \$
(A) Subtotal	<input type="text"/> \$	<input type="text"/> \$
TPD Income Needs Analysis		
Income replacement x years	<input type="text"/> \$	<input type="text"/> \$
(B) Subtotal	<input type="text"/> \$	<input type="text"/> \$
Less Existing Resources		
Existing TPD cover with: <input type="text"/>	<input type="text"/> \$	<input type="text"/> \$
Superannuation (insured benefit)	<input type="text"/> \$	<input type="text"/> \$
Financial assets realised in the event of TPD	<input type="text"/> \$	<input type="text"/> \$
Lifestyle assets realised in the event of TPD	<input type="text"/> \$	<input type="text"/> \$
(D) Subtotal	<input type="text"/> \$	<input type="text"/> \$
Summary of Needs		
(C) Level of cover required before resources (A + B)	<input type="text"/> \$	<input type="text"/> \$
(D) Less total existing resources	<input type="text"/> \$	<input type="text"/> \$
(E) Level of cover required (C – D)	<input type="text"/> \$	<input type="text"/> \$

Trauma Cover Needs

Please complete this section or tick the relevant box. ☐ Not applicable ☐ Not disclosed

☐ Alternate needs analysis used and attached.

The purpose of trauma cover is to ease financial stress during the recovery period following diagnosis and/or treatment of a critical illness.

	Client 1	Client 2
In the event of prolonged or serious illness, where between 0% and 100% would you want your income to be replaced?	<input type="text"/> %	<input type="text"/> %
Specify how many years you would want it replaced.	<input type="text"/> years	<input type="text"/> years
Would you want your debts fully paid off?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you want an additional lump sum to cover possible capital/medical expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the event of a prolonged or serious illness, would you want your partner to be off work to support you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Critical Illness Analysis	Client 1	Client 2
Eliminate debt or portion of debt	\$ <input type="text"/>	\$ <input type="text"/>
Income replacement x years	\$ <input type="text"/>	\$ <input type="text"/>
Income replacement for partner off work	\$ <input type="text"/>	\$ <input type="text"/>
Medical/rehabilitation costs	\$ <input type="text"/>	\$ <input type="text"/>
Other	\$ <input type="text"/>	\$ <input type="text"/>
(A) Subtotal	\$ <input type="text"/>	\$ <input type="text"/>
Less Existing Resources		
Existing trauma cover with: <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Financial assets realised in the event of trauma	\$ <input type="text"/>	\$ <input type="text"/>
Lifestyle assets realised in the event of trauma	\$ <input type="text"/>	\$ <input type="text"/>
(B) Subtotal	\$ <input type="text"/>	\$ <input type="text"/>
Summary of Needs		
(A) Total level of cover required before resources	\$ <input type="text"/>	\$ <input type="text"/>
(B) Less total existing resources	\$ <input type="text"/>	\$ <input type="text"/>
(C) Level of cover required (A – B)	\$ <input type="text"/>	\$ <input type="text"/>

Client Acknowledgment and Engagement Authority

Subject matter

At our meeting, we discussed the goals you are seeking to achieve and the strategy for reaching these goals. As part of the process we discussed your needs, objectives and financial situation and agreed on the following:

Scope of advice

After identifying the subject matter above we agreed to cover the following areas of advice, as relevant to your circumstances, within an appropriate advice document:

Where the advice is limited, please state reasons for the limitation:

The following matters will not be included as part of the advice document preparation at this time:

Client Acknowledgement and Engagement Authority continued >

Client Acknowledgment and Engagement Authority (continued)

I/We request that you provide insurance advice based on the information disclosed and acknowledge that you will rely on the information contained in this document.

I/We acknowledge that if I/we provided any incomplete or inaccurate information that I/we will carefully consider the appropriateness of the advice according to our personal objective, before acting on any advice provided.

I/We acknowledge that you will charge a plan preparation fee of \$ (GST inclusive) for the written advice.

I/We have received a copy of the Financial Services Guide and have read and understood it, including the section titled 'Privacy Statement'.

I/We agree to our adviser collecting, using and disclosing my/our personal information in accordance with the Privacy Policy.

I/We will only provide information about other individuals, such as dependants, spouse/partner, guarantors, if those individuals have agreed that I can share that information with you and I will inform them that I/we have provided information about them and make them aware of the information provided in the Privacy Policy.

Where applicable, the personal and sensitive information you provide to your adviser as part of the pre-assessment process may be disclosed to third parties, including the adviser's business, authorising Australian financial services licensee and insurers participating in this process. It will be handled in accordance with the privacy policy of the adviser and those other entities. Please ensure that the adviser gives copies of the relevant privacy policies to you before you disclose personal or sensitive information as part of this pre-assessment process.

If you decline to provide the required information but you proceed to apply for insurance with a particular insurer, that insurer will conduct its own investigations regarding the information it requires to consider your application and you may be required to provide additional information to the insurer, including, for example, a Personal Statement regarding your medical history and other personal information.

Signature of Client 1	<input type="text"/>	Date	<input type="text"/>
Signature of Client 2	<input type="text"/>	Date	<input type="text"/>
Signature of Financial Adviser	<input type="text"/>	Date	<input type="text"/>

The following documents have been supplied:

- ☐ Insurance policy details/Superannuation statements
- ☐ Tax returns
- ☐ PAYG summaries
- ☐ 'Option to Quote Tax File Number' obtained from your Financial Adviser
- ☐ Other

Client Authorisation

Client authorisation (for financial adviser to request additional information from other institutions)

To whom it may concern:

I, whose date of birth is

I, whose date of birth is

Of (insert full address)

Request that all relevant information on my investments, insurances, superannuation, bank accounts or other financial information be released

to

Authorised Representative of on request.

is an Australian Financial Services Licensee
whose Australian Financial Services License number is whose ABN is
and address is

Please accept a photocopy or facsimile copy of this letter as authority, as the original will stay on file.

Your faithfully,

Client signature

Date

Client signature

Date