



VISION MEETING FORM

**FAX TO: (919)324-6987 or EMAIL TO: info@carolinafep.com
or MAIL TO: 51 Kilmayne Dr., Suite 203, Cary, NC 27511
or UPLOAD TO: https://upload.carolinafep.com**

Please complete to the best of your ability. This information helps us prepare for your meeting. Estimates are sufficient. If you have any questions regarding an item, simply leave that section blank and we will discuss during your meeting.

All information provided is confidential.

Full Name: _____ Age: _____

Address: _____

Phone: _____ Email: _____

Spouse Name (if applicable): _____ Age: _____

Phone: _____ Email: _____

If you are completing this form on behalf of someone else, please provide your information:

Care of Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

How did you first hear about our firm? _____

Existing Planning:

<u>You</u>	<u>Spouse</u>	<u>Other Info:</u>
Will <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____ State: _____
Trust <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____ <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____ State: _____
Health Care Power <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year: _____ State: _____
Long-Term Care Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Daily benefit: \$ _____ Term _____ (yrs) Premium: \$ _____

Your current health: Good Concern (Details) _____

Spouse's current health: Good Concern (Details) _____

How many children do you have? _____ Are any of your children disabled or have special needs? Yes No

Please tell us your children's names and ages: _____

Veteran? No Yes, Me Yes, My Spouse Yes, Both of Us Dates of service: _____

INCOME	CLIENT	SPOUSE	JOINT
Wages (Annually)	\$	\$	\$
Social Security (Monthly)	\$	\$	\$
Pension (Monthly)	\$	\$	\$
Other: <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	\$	\$	\$
ASSETS	CLIENT	SPOUSE	JOINT
Cash, Checking, Savings, CDs, Money Market, etc.	\$	\$	\$
Retirement Accounts (IRAs, 401k, 403b, SEP, etc.)	\$	\$	\$
Brokerage Accounts, Stocks, Bonds	\$	\$	\$
Life Insurance (Total Death Benefit):	\$	\$	\$
Annuities:	\$	\$	\$

