



# 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: \_\_\_\_\_

**Existing Planning:**

<u>Existing Planning:</u>	<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: <span style="float: right;"><input type="checkbox"/> Monthly <input type="checkbox"/> Annually</span>	\$	\$	\$
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:	\$	\$	\$

