Planning 4 Longevity

Securing Lifetime Solutions

Longevity Fact Finder

Client name________________ Spouse's name________________

Client date of birth________________ Spouse date of birth________________

Mailing address________________ City________________ State______ Zip________

Phone numbers: Home________________ Cell________________ Work________________

E-mail address________________ ________________

Children names and ages________________

Section 1: Income

Monthly income in retirement

	Client	Spouse
What is your projected monthly retirement income from all sources? (List sources)	$________	$________
	________	________
	________	________
	________	________
Is the projected monthly income sufficient?	❑ Yes ❑ No	❑ Yes ❑ No
If not, how much additional income do you need?	$________	$________
Are you aware of the effect that interest rates and inflation have on your future retirement income?	❑ Yes ❑ No	
In the event of your death or your spouse's death, would the survivor have sufficient income?	❑ Yes ❑ No	

Assets that can be used to generate income

	Client	Spouse
Money Market Funds/Savings	$________	$________
CDs	$________	$________
Stocks	$________	$________
Bonds	$________	$________
Mutual Funds	$________	$________
Annuities	$________	$________
Life Insurance Cash Value	$________	$________
IRAs/401(k) Plans	$________	$________
Defined Benefit Plans	$________	$________
Total assets available	$________	$________
What are your current total monthly expenses?	$________	$________

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Client name________________________ Spouse's name________________________

Section 2: Long-Term Care

Long-Term Care planning	Client	Spouse
Do you currently own Long-Term Care insurance?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please answer these questions:

Client long-term care carrier____________ Daily coverage__________ ❑ 3-Year ❑ 5-Year ❑ Lifetime

Spouse long-term care carrier____________ Daily coverage__________ ❑ 3-Year ❑ 5-Year ❑ Lifetime

If you ever needed extended care, do you see it as a possibility that you may not have sufficient income or assets to cover your financial commitments, and pay for care at the same time? ❑ Yes ❑ No

Do you see it as a possibility that, if the illness lasted long enough, it could threaten the financial viability of your spouse and children who may depend on an inheritance? ❑ Yes ❑ No

Section 3: Medical Condition

Health

	Client	Spouse
What is your assessment of your current medical condition?	❑ Excellent ❑ Good ❑ Poor ❑ Very Poor	❑ Excellent ❑ Good ❑ Poor ❑ Very Poor
Are you aware of your projected medical costs during retirement?	❑ Yes ❑ No	❑ Yes ❑ No
At what age do you expect to retire?	________	________

Section 4: Insurance and Wealth Transfer

Insurance (please list current life insurance coverage)

	Client	Spouse
Term Insurance (Death Benefit/Company)	$__________	$__________
Universal Life (Death Benefit/Company)	$__________	$__________
Variable Life (Death Benefit/Company)	$__________	$__________
Whole Life (Death Benefit/Company)	$__________	$__________
Annuities (Account Value/Company)	$__________	$__________

Wealth Transfer

Do you have a plan for transferring your remaining assets to your family? ❑ Yes ❑ No

Do you know what your potential estate costs could be? ❑ Yes ❑ No

Is there a plan in place for college funding for any children or grandchildren? ❑ Yes ❑ No

Authorization for Release of In-Force Policy Information

Please submit one (1) per Carrier, per policyowner.

Policyowner Name:____

Social Security or Tax ID #____

I hereby authorize LifeVentures Corp and its staff to obtain and/or request information regarding my existing life insurance policy(ies) listed below. This information shall include but not be limited to: In-force ledgers, policy dates, cash value information, interest/dividend history and underwriting classifications.

Insurance Carrier	Policy Number	Issue Date	Insured	Date of Birth

The information above will be held in confidence. The policy data may be reviewed and assessed by qualified personnel consisting of medical, underwriting and actuarial resources or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of LifeVentures Corp affiliated insurance companies and their reinsurers.

The records may be transmitted via U.S. regular mail, various overnight mail services and/or through the use of secured electronic devices.

This authorization shall be valid for six months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorozation.

I understand that I may revoke this authorization at any time and that the revocation will take efect when my Representative receives my written request.

Signed on the ____ day of ____________________, the year _________ at _______________________________.

Policyowner signature:____

Agent/Representative signature:____