Insured Asset Conversion Trust Questionnaire

PERSONAL INFORMATION	YOU	SPOUSE / PARTNER
Your Name / Date of Birth:	_____ ___/___/___	_____ ___/___/___
The Best Contact Phone:	_____	_____
eMail Address:	_____	_____

FINANCIAL PRIORITIES

Rank These Three Key Retirement Priorities - 1,2,3

__ Ensure you don't run out of income in retirement

__ Ensure Long-Term Care needs, if they occur, do not bankrupt your retirement

__ Pass on as much as possible of your remaining assets with the least possible tax burden for your estate & heirs

Other Important Priorities (Check all that apply)

__Increase retirement income now __Reduce Income Taxes Now

__ Reduce market risk on invested assets __Other_____

FINANCIAL ASSUMPTIONS

Average Annual Rate of Return for future value projections _____%

Estimated "Effective" Income Tax Rate (Taxes Paid divided by Adj. Gross Income): _____%

Set amount / specific asset you absolutely want to ensure your heirs receive: $_____

Set amount / specific asset you want to keep for income and emergencies: $_____

RETIREMENT INCOME

	YOU: Monthly Amount	YOU: Growth/ Inflation %	YOU: % Continue to at death	SPOUSE / PARTNER: Monthly Amount	SPOUSE / PARTNER: Growth/ Inflation %	SPOUSE / PARTNER: % Continue to at death
Salary (if still working):						
Social Security:						
Pensions:						
Business/Rental Property:						
Life Insurance You Own:						
Annuities You Own:						
Other:_____						

QUALIFIED RETIREMENT ASSET (401K, IRA, ETC.):

	YOU: Traditional	YOU: Roth	SPOUSE / PARTNER: Traditional	SPOUSE / PARTNER: Roth
Value Today:	$_____	$_____	$_____	$_____
Rate of Return:	_____%	_____%	_____%	_____%
Monthly Income:	$_____	$_____	$_____	$_____

Investment Allocation (approx.): Cash/Equivalent Bonds Stocks/Funds

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LIFE INSURANCE IN-FORCE	Who's Covered	Death Benefit	Cash Value	Loans Balance	Includes Living Benefits	Current Premium	Currently Using for Income
Company:_____	☐You ☐Spouse ☐Joint	$_____	$_____	$_____	☐Chronic / LTC ☐Critical ☐Terminal	$_____	☐ Yes ☐ No
Company:_____	☐You ☐Spouse ☐Joint	$_____	$_____	$_____	☐Chronic / LTC ☐Critical ☐Terminal	$_____	☐ Yes ☐ No
Company:_____	☐You ☐Spouse ☐Joint	$_____	$_____	$_____	☐Chronic / LTC ☐Critical ☐Terminal	$_____	☐ Yes ☐ No

LONG TERM CARE INSURANCE IN-FORCE	Who's Covered	Monthly Benefit	Waiting Period	Benefit Inflation	Cash Refund Feature	Current Premium	Benefit Type
Company:_____	☐You ☐Spouse ☐Joint	$_____	____Days	____%	☐ None ☐ Premium less benefit paid ☐ Other	$_____	☐ Home Care ☐ Nursing Home ☐ Asst. Living ☐ All of Above
Company:_____	☐You ☐Spouse ☐Joint	$_____	____Days	____%	☐ None ☐ Premium less benefit paid ☐ Other	$_____	☐ Home Care ☐ Nursing Home ☐ Asst. Living ☐ All of Above

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HEALTH / LIFESTYLE INFORMATION	YOU	SPOUSE/PARTNER
Height / Weight?	____ foot____ Inches _____ lbs Stable for last 6 months? ☐ Yes ☐ No	____ foot____ Inches _____ lbs Stable for last 6 months? ☐ Yes ☐ No
Tobacco Use?	☐ Never ☐ Currently Date of last use: _____ ☐ Former Type:_____	☐ Never ☐ Currently Date of last use: _____ ☐ Former Type:_____
CURRENT MEDICATIONS: Name, reason, dose & frequency, how long		
FAMILY HISTORY (parents/ siblings), history of disease, or deaths prior to age 60?		
EVER BEEN DECLINED for insurance of any type?		
HOSPITALIZATION/ILLNESS /SURGERY (last 5 years):	☐ Yes ☐ No Date: _____ Reason:_____	☐ Yes ☐ No Date:_____ Reason:_____
ACTIVITIES OF DAILY LIVING: Do you need help with any of the following	☐ Eating ☐ Bathing ☐ Getting dressed ☐ Toileting ☐ Transferring ☐ Continence	☐ Eating ☐ Bathing ☐ Getting dressed ☐ Toileting ☐ Transferring ☐ Continence

DO YOU HAVE/BEEN ADVISED TO GET TESTED FOR ANY OF THE FOLLOWING:	YOU	SPOUSE/PARTNER
A. AIDS (Acquired Immune Deficiency Syndrome), or positive for HIV	☐ Yes ☐ No	☐ Yes ☐ No
B. ALS (Lou Gehrig's disease)	☐ Yes ☐ No	☐ Yes ☐ No
C. Alzheimer's disease, Dementia, memory loss, or other cognitive impairment	☐ Yes ☐ No	☐ Yes ☐ No
D. Amputation due to disease	☐ Yes ☐ No	☐ Yes ☐ No
E. Arthritis with narcotic pain medication	☐ Yes ☐ No	☐ Yes ☐ No
F. Diabetes with Insulin use	☐ Yes ☐ No	☐ Yes ☐ No
G. Diabetes complications (Neuropathy, Retinopathy, Heart Disease or Stroke)	☐ Yes ☐ No	☐ Yes ☐ No
H. Huntington's Chorea (Including family history)	☐ Yes ☐ No	☐ Yes ☐ No
I. Multiple Sclerosis	☐ Yes ☐ No	☐ Yes ☐ No
J. Muscular Dystrophy	☐ Yes ☐ No	☐ Yes ☐ No
K. Myasthenia Gravis	☐ Yes ☐ No	☐ Yes ☐ No
L. Organic Brain Syndrome	☐ Yes ☐ No	☐ Yes ☐ No
M. Osteoporosis w/fractures	☐ Yes ☐ No	☐ Yes ☐ No
N. Organ Transplant (other than corneal)	☐ Yes ☐ No	☐ Yes ☐ No
O. Parkinson's disease	☐ Yes ☐ No	☐ Yes ☐ No
P. Polycystic Kidney Disease (including family history)	☐ Yes ☐ No	☐ Yes ☐ No
Q. Polymyositis	☐ Yes ☐ No	☐ Yes ☐ No
R. Scleroderma	☐ Yes ☐ No	☐ Yes ☐ No
S. Stroke/CVA/TIA (more than 1 or within the past 2 years)	☐ Yes ☐ No	☐ Yes ☐ No
T. Substance in last 3 years (alcohol, drug or Rx, other)	☐ Yes ☐ No	☐ Yes ☐ No

Additional details for any of items on this page, e.g., dates and details of diagnosis/prognosis. Attach pages if needed.