

# Fact Finder



**IOWA BANKERS**  
INSURANCE AND SERVICES, INC.



**CLIENT A INFORMATION**

Full Name: \_\_\_\_\_  
*Last First M.I. Informal Name*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Are you a resident at this address year round? YES NO

Home Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Social Security Number or Government ID: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Second Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you smoke or use tobacco products? YES NO Any major health considerations? YES NO

Details: \_\_\_\_\_  
\_\_\_\_\_

**CLIENT B INFORMATION (Spouse)**

Full Name: \_\_\_\_\_  
*Last First M.I. Informal Name*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Are you a resident at this address year round? YES NO

Home Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Social Security Number or Government ID: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Second Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you smoke or use tobacco products? YES NO Any major health considerations? YES NO

Details: \_\_\_\_\_  
\_\_\_\_\_

# Income Information & Financial Goals

Financial Assumptions	Client	Spouse
Salary		
Social Security		
Pension		
Investments		
Other		
RMD		
<b>Total</b>		

Living Expenses
What are your current monthly living expenses?

Economic Impact of Losing a Spouse	If Spouse 1 Dies First	If If Spouse 2 Dies First
Social Security		
Pension		
Other		
<b>Total</b>		

<b>Information Concerning Financial, Estate, and Lifestyle Goals</b>
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1) Strongly Disagree; 2) Disagree; 3) Neutral; 4) Agree; 5) Strongly Agree

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. Leaving the maximum amount of cash to my spouse is important.                  | 1 | 2 | 3 | 4 | 5 |
| 2. Leaving the maximum amount of cash to my/our heirs is important.               | 1 | 2 | 3 | 4 | 5 |
| 3. Eliminating the impact of property taxes is important.                         | 1 | 2 | 3 | 4 | 5 |
| 4. Eliminating or reducing property taxes for our heirs is important.             | 1 | 2 | 3 | 4 | 5 |
| 5. Reducing our capital gains taxes is important.                                 | 1 | 2 | 3 | 4 | 5 |
| 6. Reducing capital gains taxes for my heirs is important.                        | 1 | 2 | 3 | 4 | 5 |
| 7. Reducing our income taxes is important.  | 1 | 2 | 3 | 4 | 5 |
| 8. Reducing the income taxes my heirs will have to pay is important.              | 1 | 2 | 3 | 4 | 5 |
| 9. Reducing state and federal taxes for my heirs is important.                    | 1 | 2 | 3 | 4 | 5 |
| 10. Generating additional income is important.                                    | 1 | 2 | 3 | 4 | 5 |
| 11. Generating additional income in _____ years is important.                     | 1 | 2 | 3 | 4 | 5 |
| 12. Reducing risk in my/our portfolio is important.                               | 1 | 2 | 3 | 4 | 5 |
| 13. Avoiding becoming an emotional or financial burden to my family is important. | 1 | 2 | 3 | 4 | 5 |
| 14. Capturing Gains without risking principle is important.                       | 1 | 2 | 3 | 4 | 5 |
| 15. Leaving a lasting legacy in our community is important.                       | 1 | 2 | 3 | 4 | 5 |
| 16. Leaving money to my/our charities is important.                               | 1 | 2 | 3 | 4 | 5 |

Other Goals/Additional Information: _____

# Insurance

Life Insurance						
Client						
Insurance Company	Policy Type	Primary Insured	Policy Owner	Death Benefit	Annual Premium	Current Value
Spouse						
Insurance Company	Policy Type	Primary Insured	Policy Owner	Death Benefit	Annual Premium	Current Value

Long Term Care Insurance/Other Policies								
Company & Policy Type	Inflation Rider?		Year Purchased	Elim. Period	Daily Benefit	Benefit Term	Return of Premium?	Death Benefit
Client:	Yes	No						
Spouse:	Yes	No						
Client:	Yes	No						
Spouse:	Yes	No						

Medical Insurance								
Company & Policy Type	Co-Insurance		Deductible	Max OOP	Monthly Premium	Med Supp?		Part D?
Client:						Yes	No	Yes No
Spouse:						Yes	No	Yes No

# Estate/Trust

	Client		Spouse	
Do you have a will?	Yes	No	Yes	No
If yes, when was it last reviewed?				
Do you have a living will?	Yes	No	Yes	No
If yes, when was it last reviewed?				
Have you created a trust?	Yes	No	Yes	No
If yes, does it have an A/B provision?	Yes	No	Yes	No
If yes, is it a charitable remainder trust?	Yes	No	Yes	No
Do you have an Irrevocable Life Insurance Trust?	Yes	No	Yes	No
Do you anticipate receiving an inheritance?	Yes	No	Yes	No

Trust Name	Executor/Successor Trustee:
Trust Date	Trust ID#
Notes:	

# Beneficiaries

Please provide information on all children and beneficiaries to your estate.

Name	DOB	Age	Marital Status	# Children

## Family Relationship Notes


## Current Advisors (name, address, phone)

Tax Preparer:
Estate Planning Attorney:
Investment Advisor:
Insurance Advisor:
ILIT Trustee:
Other Trustee or Attorney:

