



CLIENT DISCOVERY QUESTIONNAIRE

ADVISOR: DEBRA BRENNAN TAGG

CLIENT

Full Name:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:		Previous Marriages?:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status: (Single, Married, Separated, Divorced, Domestic Partnership, Widow, Widower)		Special Needs?:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Citizenship: (U.S. Citizen, Resident Alien, Non-Resident Alien)		In Good Health?:	<input type="checkbox"/> Yes <input type="checkbox"/> No

SPOUSE

Full Name:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:		Previous Marriages?:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status: (Single, Married, Separated, Divorced, Domestic Partnership, Widow, Widower)		Special Needs?:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Citizenship: (U.S. Citizen, Resident Alien, Non-Resident Alien)		In Good Health?:	<input type="checkbox"/> Yes <input type="checkbox"/> No

CONTACT INFO

Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:	Fax:	
Spouse Cell Phone:	Spouse Email:	

EMPLOYMENT - CLIENT

Employer Name:			
Employer Address Line 1:			
Employer Address Line 2:			
City:	State:	Zip:	
Work Phone:	Cell Phone:		
Work Email:	Work Fax:		
Title/Position:	Years Employed:		
Previous Employer:	Previous Title/Position:		
Years Employed (Previous):			

EMPLOYMENT - SPOUSE

Employer Name:			
Employer Address Line 1:			
Employer Address Line 2:			
City:	State:	Zip:	
Work Phone:	Cell Phone:		
Work Email:	Work Fax:		
Title/Position:	Years Employed:		
Previous Employer:	Previous Title/Position:		
Years Employed (Previous):			

CHILDREN

Full Name:		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Marital Status:
From Previous Marriage?: <input type="checkbox"/> Yes <input type="checkbox"/> No	In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No

Full Name:		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Marital Status:
From Previous Marriage?: <input type="checkbox"/> Yes <input type="checkbox"/> No	In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No

Full Name:		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Marital Status:
From Previous Marriage?: <input type="checkbox"/> Yes <input type="checkbox"/> No	In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No

Full Name:		
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Marital Status:
From Previous Marriage?: <input type="checkbox"/> Yes <input type="checkbox"/> No	In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No

GRANDCHILDREN

Full Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Full Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Full Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Full Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
In Good Health?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Financially Dependent?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

ADVISORS (Attorneys, CPAs, etc.)

Advisor Type:		Full Name:	
Company:			
Address:			
Email:		Phone:	Fax:

Advisor Type:		Full Name:	
Company:			
Address:			
Email:		Phone:	Fax:

Advisor Type:		Full Name:	
Company:			
Address:			
Email:		Phone:	Fax:

CHARITIES

Name	
	<input type="checkbox"/> Active Funding <input type="checkbox"/> Volunteer Activity
	<input type="checkbox"/> Active Funding <input type="checkbox"/> Volunteer Activity
	<input type="checkbox"/> Active Funding <input type="checkbox"/> Volunteer Activity
	<input type="checkbox"/> Active Funding <input type="checkbox"/> Volunteer Activity

REAL ESTATE	Primary Residence	Secondary Residence	Investment Property	Investment Property
Address Line 1:				
Address Line 2:				
City:				
State:				
Zip:				
Purchase Year:				
Purchase Amount:				
Current Value:				
Owner: (Client, Spouse, Joint, etc.)				

MORTGAGES	Primary Residence	Secondary Residence	Investment Property	Investment Property
Loan Type: (Mortgage, Home Equity Loan)				
Institution Name:				
Original Loan Amount:				
Date of Loan:				
Current Balance:				
Balance as of Date:				
Interest Rate:				
Loan Term (years):				
Payment Frequency: (Monthly, Quarterly, Semi-Annually, Annually)				
Repayment Type: (Principal and Interest, Interest Only)				
Payment:				
Balloon Period (years):				
Is Interest Deductible?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

LOANS

Loan Type: (Auto, Personal, Student Loan, Credit Card, Debt Consolidation, Other)				
Institution Name:				
Original Loan Amount:				
Date of Loan:				
Current Balance:				
Balance as of Date:				
Owner: (Client, Spouse, Joint, etc.)				
Interest Rate:				
Number of Payments:				
Payment Frequency: (Monthly, Quarterly, Semi-Annually, Annually)				
Repayment Type: (Principal and Interest, Interest Only)				
Payment:				
Is Interest Deductible?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loan Collateralized?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paid off at death of: (Client, Spouse, First to Die)				

CASH

	(1)	(2)	(3)	(4)
Asset Type: (Cash, CDs, Checking, Savings, Money Market, etc.)				
Institution Name:				
Total Value:				
Owner: (Client, Spouse, Joint, etc.)				
Annual Contribution Amount:				

TAXABLE INVESTMENTS (Non-IRA Accounts)

If applicable, please bring statements.	(1)	(2)	(3)	(4)
Asset Type: (Mutual Fund, Brokerage Account, Stocks)				
Institution Name:				
Total Value:				
Owner: (Client, Spouse, Joint, etc.)				
Annual Contribution Amount:				

QUALIFIED RETIREMENT

(401(k), IRA, Money Purchase, Profit Sharing, 403(b), Pension, SEP, Other)

If applicable, please bring statements.	(1)	(2)	(3)	(4)
Type: (401(k), IRA, Pension, etc.)				
Institution Name:				
Total Value:				
Owner: (Client, Spouse)				
Beneficiary:				
Contingent Beneficiary:				

ROTH IRAS

If applicable, please bring statements.	(1)	(2)	(3)	(4)
Institution Name:				
Total Value:				
Owner:				
Beneficiary:				
Contingent Beneficiary:				

EMPLOYEE CONTRIBUTIONS

IRA/ROTH IRA

If applicable, please bring statements.	Client	Spouse
Traditional IRA Annual Amount:		
ROTH IRA Annual Amount:		

401(k) or 403(b)

If applicable, please bring statements.	Client	Spouse
Type: (Percent of Salary, Fixed Amount, Maximum, etc.)		
Percent:		
Dollar Amount:		

EMPLOYER CONTRIBUTIONS

(401(k), Money Purchase, 403(b), SEP, or Profit Sharing)

If applicable, please bring statements.	Client	Spouse
Type: (Percent of Salary, Fixed Amount, Maximum, etc.)		
Employer Percent Match of Employee Contribution:		
Maximum Employer Contribution Percent of Employee Salary:		
Amount:		

529 PLANS

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Beneficiary Name:				
Institution Name:				
Total Value:				
Owner: (Client, Spouse, Joint, etc.)				
Annual Contribution Amount:				

STOCK OPTIONS

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Institution Name:				
Ticker Symbol:				
Description:				
Current Stock Price:				
Vest at Death?: (yes/no)				
Owner:				

GRANTS

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Grant Number:				
Grant Date:				

OPTION LOTS

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Dates Purchased:				
Shares Purchased:				

ANNUITIES (Fixed/Variable)

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Institution Name:				
Asset Type: (Fixed/Variable)				
Type of Funds: (Qualified, Non-Qualified)				
Total Value:				
Tax Basis:				
Owner:				
Beneficiary:				
Contingent Beneficiary:				

DEFERRED COMPENSATION

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Institution Name:				
Total Value:				
Owner:				
Beneficiary:				
Contingent Beneficiary:				

BUSINESS INTERESTS

	(1)	(2)	(3)
Business Name:			
Base Value:			
Owner:			
Business Type: (Sole Proprietorship, Partnership, LLC, etc.)			
Pass Thru Enabled?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

RELATED QUESTIONS

Client active in the business?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse active in business?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
# of Children Active in the Business:			
Future Plans for Business: (Retain with family, Sell to employees, Liquidate, Unsure, etc.)			
Relatives active in the business?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shareholder, Partnership or Operating Agreement?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does current agreement permit gifting?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Buy/Sell Agreement funded with life insurance?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How much coverage (if applicable)?:			

LIFE INSURANCE

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Policy Number:				
Institution Name:				
Employer Plan?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Purchase Date:				
Policy Type: (Whole Life, Universal, Term, etc.)				
Term (years) (Term Life Only):				
Insured: (Client, Spouse, Survivorship, etc.)				
Owner:				
Beneficiary:				
Contingent Beneficiary:				
Current Death Benefit:				
Current Cash Value:				
Annual Premium				
Premium Term: (years)				

LONG TERM CARE POLICY

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Policy Number:				
Institution Name:				
Purchase Date:				
Insured: (Client, Spouse, Joint, etc.)				
Owner: (Client, Spouse, Community)				
Elimination Period: (0, 20, 30, 45, 50, 60, 90, 100, 120, 180 Days, 1 Year)				

PREMIUM

Annual Premium:				
Premium Term (Years):				
Premium Payer: (Client, Spouse, Joint, Community, Employer Paid)				

BENEFIT

Benefit Amount:				
Period for Benefit Amount: (Annually, Quarterly, Monthly, Weekly, Daily)				

DISABILITY POLICY

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
PERSONAL DISABILITY				
Policy Name:				
Policy Number:				
BUSINESS DISABILITY				
Policy Name:				
Policy Number:				

PROPERTY/CASUALTY

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Policy Type: (Auto, Homeowners, Umbrella, Flood, Rental, Condo, Boat, Other)				
Institution Name:				
Policy Number:				
Annual Premium:				
Insured Asset:				
Owner: (Client, Spouse, Joint, Charity, etc.)				

MEDICAL

If applicable, please bring statements.

	(1)	(2)	(3)	(4)
Institution Name:				
Group Health Plan Sponsor:				
Policy Number:				
Policy Type: (Primary, Other)				
Plan Type: (Individual, Family)				
Deductible Amount:				
Annual Premium:				

SALARY & BONUS	(1)	(2)	(3)	(4)
Source:				
Annual Income Amount:				
Annual Bonus Amount:				
Bonus Frequency: (Annual, Semi-Annual, Quarterly, Monthly)				
If annual, Bonus date:				
Owner: (Client, Spouse, Joint)				
Self-Employment?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Guaranteed?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PENSIONS If applicable, please bring statements.	SOCIAL SECURITY/TRS		GOVERNMENT/MILITARY PENSION		CORPORATE PENSION	
	CLIENT	SPOUSE	CLIENT	SPOUSE	CLIENT	SPOUSE
Source Name:						
Has benefit started?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what age? If no, target age?						
Benefit Amount:						
Notes:						

LIVING EXPENSES

Current Annual Expenses:	
Projected Retirement Expenses, if applicable:	

RETIREMENT

	Client	Spouse
Retirement Age/Goal Retirement Age:		

EDUCATION EXPENSES

University/Institution Name	Education for	Annual Amount	Start Year	End Year

TRUSTS & PARTNERSHIPS

If applicable, please bring documents. Check all that apply:

<input type="checkbox"/> Wills	<input type="checkbox"/> Revocable Trusts	<input type="checkbox"/> Irrevocable Trusts	<input type="checkbox"/> QPRTs	<input type="checkbox"/> ILITs	<input type="checkbox"/> FLPs
<input type="checkbox"/> Bequests	<input type="checkbox"/> Planned Gifts	<input type="checkbox"/> QTIPs/QDOTs	<input type="checkbox"/> CRTs	<input type="checkbox"/> CLTs	<input type="checkbox"/> GRTs

RETIREMENT/INVESTMENT*Rate the importance of each item according to the following scale:*

	Low	Med	High
Your retirement goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Directing a portion of your personal savings or investment portfolio to a tax advantaged vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having all of your portfolios consolidated and analyzed to make sure your overall plan is on track	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Matching your risk tolerance to that of your investment portfolio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing your investment performance against that of an index	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing your investment performance against your plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing alternative retirement methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minimizing the taxes on your investment accounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing techniques to save income tax and estate taxes on deferred money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asset protection in the result of serious illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protecting assets in the event that you require long term care in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving adequate income in the event of disability during your working years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for income for your spouse in the event of your premature death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generating a guaranteed retirement income stream during retirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for income for your children in the event of your premature death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ESTATE*Rate the importance of each item according to the following scale:*

	Low	Med	High
Distributing assets equally to your children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protecting your assets transferred to your children from creditors, divorce, and bankruptcy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing your insurance portfolio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing different methods of meeting your estate tax liabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minimizing estate taxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Charitable planning to your estate's planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gifting to your children if it doesn't interfere with your financial independence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for your grandchildren's education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing your current will structure to eliminate unnecessary taxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protecting your residence and/or vacation home from estate taxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having your estate in trust for your spouse in order to protect your children's inheritance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>