



MEMBER: FINRA ■ SIPC

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# CONFIDENTIAL INSURANCE PROFILE

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To begin the Insurance Review process, please complete the enclosed questionnaire and discuss it with your Presidential Financial Consultant or forward it to Presidential's corporate offices at:

**PRESIDENTIAL BROKERAGE, INC.**

CORPORATE OFFICES  
5445 DTC PARKWAY, SUITE 1100  
GREENWOOD VILLAGE, CO 80111

**[www.presidentialbrokerage.com](http://www.presidentialbrokerage.com)**

# CONFIDENTIAL PROFILE

This comprehensive, personal financial planning summary is designed to help you take inventory and assign realistic values to your personal assets and liabilities. It is the essential first step in organizing a sensible financial plan for your future. Once you have completed the following information, please return this packet in the enclosed, postage-paid envelope.

<b>FAMILY INFORMATION</b>	Your Name	Nickname	Age	Birth date	Social Security # (Optional)	
	Spouse's Name	Nickname	Age	Birth date	Social Security # (Optional)	
	Children's Names & Ages:					
	1) _____			3) _____		
	2) _____			4) _____		
	Residence Address			City	State	Zip Code
	Mailing Address			City	State	Zip Code
	Home Phone	Cell	Fax	Email		
	Referred By: _____			<input type="checkbox"/> TV	<input type="checkbox"/> Radio	<input type="checkbox"/> Print
	Client Name _____					

<b>OCCUPATION</b>	Your Job Title	Employer (last, if retired)	# of Years	Work Phone	Retirement Date
	Spouse's Job Title	Employer (last, if retired)	# of Years	Work Phone	Retirement Date

<b>PERSONAL ADVISORS</b>	Financial Advisor's Name: _____	Firm: _____
	Do you have a preference or a commitment to this advisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Attorney's name: _____	Firm: _____
	Do you have a preference or a commitment to this advisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Accountant's Name: _____	Firm: _____
	Do you have a preference or a commitment to this advisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Insurance Agent's Name: _____	Firm: _____
	Do you have a preference or a commitment to this advisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stockbroker's Name: _____	Firm: _____	
Do you have a preference or a commitment to this advisor? <input type="checkbox"/> Yes <input type="checkbox"/> No		

# Objectives & Concerns

## General:

Are you anticipating any major lifestyle changes?  
(i.e., marriage, divorce, retirement, moving, job change, job loss, etc.)  Yes  No  Uncertain

If so, what changes are you expecting? \_\_\_\_\_

Are you comfortable with your current cash flow?  Yes  No  Uncertain

## Retirement Planning:

Are you contributing to an IRA?  Yes  No

Are you covered by any company retirement plans?  Yes  No

Type of company pension plan? \_\_\_\_\_

What minimum income will you need at retirement (in today's dollars)? \$ \_\_\_\_\_

If you plan on working after retirement, estimate your expected income: \$ \_\_\_\_\_

Stocks \_\_\_\_\_ Bonds \_\_\_\_\_ Mutual Funds \_\_\_\_\_

## Protection:

### Health Insurance

Named Insured	Individual/Group	Style (HMO/PPO)	Deductible	Office Co-pay	Carrier	Premium	Date Started

### Fundamental questions about health care needs

1. Other than regular check-ups, how many times do you visit a doctor in a year?

\_\_\_\_ 0-1 \_\_\_\_ 2-4 \_\_\_\_ 5 or more

2. How many prescription medications do you take daily?

\_\_\_\_ 0-1 \_\_\_\_ 2-4 \_\_\_\_ 5 or more

3. Does your family have any chronic health conditions? \_\_\_\_ Y \_\_\_\_ N

\_\_\_\_ Diabetes \_\_\_\_ Cancer \_\_\_\_ Heart disease \_\_\_\_ Other

4. If Group Health, how much does your employer pay toward your premium?

\_\_\_\_ 25% \_\_\_\_ 50% \_\_\_\_ 75% \_\_\_\_ 100%

## Current Life Insurance

Named Insured	Beneficiary	Face Amount	Group or Individual	Type Perm Term	Cash Value	Loans against policy	Carrier	Premium	Date Started
						Y N			
						Y N			
						Y N			
						Y N			

## Fundamental questions about life insurance

1. How did you arrive at the amount of life insurance you carry now?

\_\_\_\_\_

2. What is the purpose for your current life insurance? (Check where applicable)

\_\_\_\_\_ Pay off home      \_\_\_\_\_ Pay off debt      \_\_\_\_\_ Provide income

\_\_\_\_\_ Pay estate tax      \_\_\_\_\_ Leave to a special cause      \_\_\_\_\_ Other \_\_\_\_\_

3. How long since you last reviewed your coverage? \_\_\_\_\_

## How Much Life Insurance Is Enough

A. CASH NEEDS	YOU	YOUR SPOUSE
Final Expenses (funeral, medical, legal)		
Mortgage—1 <sup>st</sup> and 2 <sup>nd</sup>		
Debt liquidation (credit cards, bank loans, auto loans, business debt, etc.)		
Other (education fund, parent care, charity, etc.)		
Income: ( For spouse or children)		
TOTALS		

## Current Disability Insurance

Named Insured	Group / Individual	Monthly Benefit amount	Elimination Days	Benefit Period years	Carrier	Premium	Date Started
			30 60 90	1 5 10 age 65			
			30 60 90	1 5 10 age 65			
			30 60 90	1 5 10 age 65			
			30 60 90	1 5 10 age 65			

## Fundamental questions about disability needs

1. If you were injured and unable to work for an extended time, how would that affect you/your family's lifestyle?  No effect at all  Some what  Drastically
2. Could you maintain your lifestyle solely on your spouse's income?  Yes  No
2. How long could you get by without income?  30 days  60 days  90 days+
3. How much income would you need to cover your basics living expenses? ( Food, Clothing, Home etc.) \_\_\_\_\_
4. What other sources could you rely on to supplement lost income?  
 Spouse income  Savings  Family  Borrow / Loans  Social Security

## Current Long Term Care Insurance

Named Insured	Daily/ Monthly Amount	Elimination Days	Benefit Period	Inflation Protection	Carrier	Premium	Date Started
		30 60 90		Y N			
		30 60 90		Y N			
		30 60 90		Y N			
		30 60 90		Y N			

## Fundamental questions about long term care needs

1. In 2008, average annual nursing home costs exceeded \$66,000 or \$5500 per month (semi-private room). How many months could you/your spouse meet these costs without significantly impacting your family's overall financial picture? \_\_\_\_\_ (Average nursing home stay is 2.4 years, but this varies widely)
2. In 2008, average annual assisted care living (moderate facility) exceeded \$36,000 or \$3,000 a month. How many months could you/your spouse meet these costs without significantly impacting your family's overall financial picture? \_\_\_\_\_ (Average nursing home stay is 2.4 years, but this varies widely)
3. If you or your spouse would need care, where would you rather have it provided?  
 Your Home  A Facility ( Nursing or Assisted Living )  Other \_\_\_\_\_
4. If at home, who would provide care?  
 Spouse  Family member  Friend  Other \_\_\_\_\_
5. How would you cover the cost of care?  
 Income  Savings  Sell Assets  Family  Government Assistance

## Personal Auto/Home Insurance

	Carrier	Limit of Liability	Medical Payments	# Claim Last 5 years	Renewal Date
Auto		50/100 100/300 250/500	1K 5K 10K 25K		
Home		100k 300K 500K	1K 2K 5K		
Umbrella		\$1,000,000 \$2,000,000 \$5,000,000			
Other					

## Fundamental questions about Personal Insurance needs

1. When was the last time you reviewed your insurance amounts and coverages \_\_\_\_\_

## Business Insurance

	Carrier	Limit of Liability	Medical Payments	# Claim Last 5 years	Renewal Date
Liability		\$500,000 \$1,000,000 \$2,000,000	1K 5K 10K 25K		
Property					
Building					
Workers Comp					
Other					

## Fundamental questions about Business Insurance needs

1. When was the last time you reviewed your insurance amounts and coverages \_\_\_\_\_

2. Number of Owners \_\_\_\_\_ Date business started \_\_\_\_\_  
 a. If multiple owners, is there a funded Buy Sell Agreement? \_\_\_\_\_ Life \_\_\_\_\_ Disability \_\_\_\_\_

3. Do you have an exit plan for retirement? \_\_\_\_\_ Yes \_\_\_\_\_ No

4. Number of employees? \_\_\_\_\_

## Employment/Military Service Benefits

I have the following disability and/or death benefits where I have worked or served.

Retirement Plan(s) \_\_\_\_\_

Military Retirement Benefits \_\_\_\_\_

Military Survivor Benefits \_\_\_\_\_

Life Insurance \_\_\_\_\_

Health Insurance \_\_\_\_\_

Long Term Health Insurance \_\_\_\_\_

Disability Insurance \_\_\_\_\_

Deferred Compensation \_\_\_\_\_

Stock Ownership \_\_\_\_\_

Stock Options \_\_\_\_\_

Cafeteria Plan \_\_\_\_\_

Flexible Spending Accounts \_\_\_\_\_

Other \_\_\_\_\_

**Thank you for taking the time to complete this profile!**