Client Data Collection Sheet

Personal Information

Name (First, Middle, Last): ____

Address: ____

City/State/Zip: ____

SSN: ___________________________ DOB: ______________________________

Primary Phone: ________________ Secondary Phone: _______________________

Email: ____

Employer: ___________________________ Occupation: _____________________

Marital Status: __________________ # of Dependents: _______________________

Driver's License #: ___________________________ Expiration: ________________

Investment Experience

Net Worth: $_____________________ Liquid Net Worth: $_____________________

Annual Income: $_________________________ Tax Rate: ___________________%

Of Years of Previous Investment Experience: _______________________________

Of Years Working with a Financial Advisor: ________________________________

Product Investment Experience:

Stocks: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Bonds: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Options: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Margin: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Mutual Funds: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Annuities: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Real Estate: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Other: ❑ None ❑ < 5 years ❑ 5-10 years ❑ > 10 years

Client Data Collection Sheet

Beneficiary Designation (For Retirement Accounts Only)

Primary Beneficiary: % of Benefits: _______________

Name (First, Middle, Last): ____

Address: ____

City/State/Zip: ____

SSN: ___________________ DOB: _____________ Primary Phone: ______________________

Primary Beneficiary (if more than one): % of Benefits: _______________

Name (First, Middle, Last): ____

Address: ____

City/State/Zip: ____

SSN: ___________________ DOB: _____________ Primary Phone: ______________________

Contingent Beneficiary: % of Benefits: _______________

Name (First, Middle, Last): ____

Address: ____

City/State/Zip: ____

SSN: ___________________ DOB: _____________ Primary Phone: ______________________

Contingent Beneficiary: % of Benefits: _______________

Name (First, Middle, Last): ____

Address: ____

City/State/Zip: ____

SSN: ___________________ DOB: _____________ Primary Phone: ______________________