

Confidential Questionnaire



\$WISS AMERICAN
FINANCIAL SOLUTIONS

Planning Your Retirement Paycheck



Please return the completed questionnaire to:

Swiss American Financial Solutions

Retirement Plan Personal Information

Retiree Full Name		Date of birth	Age	Social Security (Not required initially)	
Spouse Name		Date of birth	Age	Social Security (Not required initially)	
Children		Grandchildren			
Street Address		City		State	Zip
Best Phone	2nd Phone		E-Mail		

Retirement Plan Parameters & Assumptions

At what age would you like to retire?	_____	Do you currently own a business or plan to?	_____
Your estimated annual income need at retirement?	\$ _____	Do you have a written will?	_____
As a percentage, how prepared are you for retirement?	_____ %	If yes, when was it last updated?	_____
Assumed inflation rate to use in your retirement plan?	_____ %	Do you have a Trust?	_____
Assumed rate of return on Lifestyle Savings in your plan?	_____ %	If yes, when was it last updated?	_____

Planning Priorities & Preferences

	High	Medium	Low	None
Creating a detailed retirement income plan	☐	☐	☐	☒
Protecting against outliving our savings and income due to longevity	☐	☐	☐	☒
Creating a retirement paycheck guaranteed for life	☐	☐	☐	☒
Protecting current standard of living in retirement	☐	☐	☒	☒
Safeguarding retirement savings from loss due to market risk	☐	☐	☐	☒
Providing for surviving spouse at first death	☐	☐	☐	☒
Minimize income taxes wherever possible	☐	☐	☐	☒
Protecting against potential cost of long term / chronic care	☐	☐	☐	☒
Planning to leave an inheritance to heirs	☐	☐	☐	☒
What is your comfort level with exposure to market risk for your savings	☐	☐	☐	☒
Safeguarding retirement income against the effects of inflation	☐	☐	☐	☒
Other:	☐	☐	☐	☒

NEW CARS or Other Big Ticket Items (In today's dollars)	Purchase Year	Total Cost	Trade-In	Finance Type	Years	Monthly Payment
Description:		\$	\$			\$
Description:		\$	\$			\$
Description:		\$	\$			\$
Description:		\$	\$			\$

REAL ESTATE PURCHASES (In today's dollars)	Purchase Year	Total Cost	Downpayment & Closing Costs	Finance Type	Years	Monthly Payment
Description:		\$	\$			\$
Description:		\$	\$			\$

REAL ESTATE SALES (In today's dollars)	Sell Year	Sales Price	Closing Costs	Mortgage Payoff	Net Proceeds
Description:		\$	\$	\$	\$
Description:		\$	\$	\$	\$
Description:		\$	\$	\$	\$

Retirement Spending Plan

REQUIRED EXPENSES				LIFESTYLE EXPENSES			
RESIDENCE - MORTGAGE / RENT				OTHER REAL ESTATE			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
1. ☐ RENT Mortgage (P&I): ☐ Fixed Rate ☐ Variable				11. ☐ RENT Mortgage (P&I): ☐ Fixed Rate ☐ Variable			
HOUSING COSTS				OTHER HOUSING COSTS & TRAVEL			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
2. Housing Costs - Repairs, Insurance, Taxes, Assoc Dues)				12. Housing Costs - Repairs, Insurance, Taxes, Assoc Dues)			
3. Utilities & Services (Gas, Electric, Water, Sewer, Yard, Pool)				13. Utilities & Services (Gas, Electric, Water, Sewer, Yard, Pool)			
4. Communications (Phone, Internet,Cable, Satellite)				14. Communications (Phone, Internet,Cable, Satellite)			
ADDITIONAL HOUSING COSTS				TRAVEL			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
Other:				Travel Tickets & Passes			
Other:				Travel Food & Entertainment			
Other:				Other:			
5. Total				15. Total			
0				0			
FOOD & SUPPLIES				ENTERTAINMENT			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
Groceries				Dining out			
Drugstores				Movies, Shows, Sporting Events			
Hardware				Memberships, Licenses, Sport Fees			
Clothes & Accessories				Hobby Costs			
Dry cleaning & other services				Shopping - Purchases for Fun			
Miscellaneous				Other:			
Other:				Other:			
6. Total				16. Total			
0				0			
TRANSPORTATION				TOYS & EQUIPMENT			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
Auto Loan - Monthly Car Payment				Loan - Monthly Payment (Boats, RVs, Bikes etc.)			
Auto Loan - Monthly Car Payment				Loan - Monthly Payment (Boats, RVs, Bikes etc.)			
Auto Fees - Tax, Registration, Insurance, AAA				Docking, Storage & Other fees			
Gasoline				Tax, Insurance & Registration			
Repairs & Service				Gasoline, Repairs & Service			
Other:				Other:			
Other:				Other:			
7. Total				17. Total			
0				0			
MEDICAL				FAMILY & FRIENDS			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
Medical/Dental Premium				Education expenses for kids / grandkids			
Long Term Care Premium				Allowance or Gifts for kids / grandkids			
Doctor/Hospital cost (Not covered)				Birthday, graduation, Wedding & holiday gifts			
Deductible/Co-Pay (Out-of-pocket)				Wedding expenses			
Medications & Supplements (Out-of-pocket)				Other:			
Nursing/Therapy (Not covered)				Other:			
Other:				Other:			
Other:				Other:			
8. Total				18. Total			
0				0			
CREDIT & FINANCIAL				CHARITY & PHILANTHROPY			
		MONTHLY	STOP YEAR			MONTHLY	STOP YEAR
Life Insurance Premiums				Charitable Donations			
Credit/Charge Card Payments				Sponsorships			
Other Loan / Credit Payments				Educational Endowments:			
Other:				Other:			
Other:				Other:			
9. Total				19. Total			
0				0			

IMPORTANT - Please enter 0 or N/A if either of these do not apply.

OTHER INCOME (Not from Savings)		MONTHLY	RECIPIENT	START YEAR	STOP YEAR	SPOUSE SURVIVOR	COST OF LIVING
Social Security	\$					Greater of both	%
Social Security	\$					Greater of both	%
Pension	\$					%	%
Employment: ☐ Full-Time ☐ Part-Time:	\$					%	%
Employment: ☒ Full-Time ☐ Part-Time:	\$					%	%
Other:	\$					%	%
Other:	\$					%	%
Other:	\$					%	%
Other:	\$					%	%
Total	\$ 0						

[illegible]

OTHER ASSETS (Not for Income)	Owner	Details / Notes	Current Value	Part of Estate	Ayñual Growth
Primary Residence			\$		%
Vacation / 2nd Home			\$		%
Other Real Estate			\$		%
Vehicles & Equipment			\$		%
Artwork & Collectibles			\$		%
Jewelery			\$		%
Furniture & Fixtures			\$		%
Other:			\$		%
Other:			\$		%
Total			\$ 0		

MORTGAGES & LOANS	Institution	Terms (Start, Years, Rate)	Current Balance	Fixed or Variable	Year To Be Paid Off
Primary Mortgage			\$		
Vacation / 2nd Home Mortgage			\$		
Other Mortgages			\$		
Credit & Charge Cards			\$		
Credit & Charge Cards			\$		
Line of credit			\$		
Personal Loans			\$		
Other:			\$		
Other:			\$		
Total			\$ 0		

LIFE INSURANCE	Insured	Beneficiaries	Type	Year Ends	Cash Value	Death Benefit
Company:					\$	\$
Company:					\$	\$
Company:					\$	\$

Long Term Care Questionnaire

LONG TERM CARE INSURANCE	Insured	Type of policy	Benefit Trigger	Benefit Years	Monthly Benefit	Policy Maximum
Company:					\$	\$
Company:					\$	\$
Company:					\$	\$

1. If you do not have Long Term Care Insurance (listed above) have you ever looked into it or applied for it? ☐ Yes ☐ No
2. If not, why not or if declined please provide details
3. Do you have a family member or loved one receiving home health care, assisted living, or nursing home care? ☐ Yes ☐ No
4. Do you have a loved one who in the past needed home health, assisted living, or nursing home care? ☐ Yes ☐ No
5. If you got sick and needed long term care where would you want to receive your care? ☐ Home ☐ Nursing home / facility
6. If at home, do you have someone willing to care for you at home? ☐ Yes - Who? ☐ No
7. If yes, how much support can they provide - days per week / hours per day?
8. Do you need your Required Minimum Distributions to pay for living expenses or can they be used for care costs? ☐ Living Expenses ☐ Care Costs
9. If you needed to pay for long term care, which asset(s) would you liquidate first?
10. What are your primary concerns about Long Term Care?

Medicare Questionnaire

1. Are you currently on Medicare? ☐ Yes ☐ No If yes, type of plan? ☐ Medicare Advantage ☐ Medicare Supplement
2. If not, are you familiar with Medicare Advantage Plans and Medicare Supplements? ☐ Yes ☐ No ☐ Check here if you would like more information
3. How do you feel about getting referrals and working with a network
4. Are you familiar with the HMO and PPO plan structure? ☐ Yes ☐ No Which do you prefer? ☐ HMO ☐ PPO
5. What do like or dislike about your current health coverage?
6. How do plan to pay for medical expenses not covered by your plan?
7. What is most important to you in a health plan?

Long Term Care or Medical Details & Notes:

Would you like us to provide a recommendation and a quote for new or comparative coverage? *(Please check all that apply.)*

☐ Disability
 ☐ Life Insurance
 ☐ Medicare
 ☐ Long Term Care
 Other:

Please note it is your health that qualifies you for these products so please complete the Pre-Screening Health Statement on the next page. If you have concerns due to some health issues there are a number of guaranteed issue, hybrids and alternative products that may provide benefits for you. The more details you provide on your health the better we can prepare the rights solutions for you.

*The information contained in this document is to be used solely for the purpose of creating a Retirement Plan or providing coverage options for you. This information will be maintained in the **strictest confidence** and will only be shared with those individuals who participate in putting this plan together. Your privacy is important to us and we hold ourselves to the highest standards in the safekeeping and use of your personal information.*

Pre-Screening Health Statement

1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?
2. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?
3. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?
4. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?
5. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer's disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease) Parkinson's disease, down syndrome, organ transplant (other than kidney) or active cancer?

Client ☐ Yes ☐ No

Spouse ☐ Yes ☐ No

Client ☐ Yes ☐ No

Spouse ☐ Yes ☐ No

Client ☐ Yes ☐ No

Spouse ☐ Yes ☐ No

Client ☐ Yes ☐ No

Spouse ☐ Yes ☐ No

Client ☐ Yes ☐ No

Spouse ☐ Yes ☐ No

Client

Height:

Weight:

In the past 5 years has there been any history of the following: (Check all that apply and provide details below for any checked items).

- | | |
|--|---|
| ☐ Diabetes | ☐ Leukemia |
| ☐ Heart Disease | ☐ Heart Attack |
| ☐ Stroke | ☐ Cardiomyopathy Organ |
| ☐ Cancer | ☐ Failure/Disease Alcohol/ |
| ☐ Depression | ☐ Drug Abuse |
| ☐ Congestive Heart Failure | |
| ☐ Uncontrolled High Blood Pressure Amyotrophic | |
| ☐ Lateral Sclerosis (ALS) | |
| ☐ Chronic Obstructive Lung Disease (COLD) Chronic | |
| ☐ Obstructive Pulmonary Disease (COPD) | |
| ☐ Other: | |

Spouse

Height:

Weight:

In the past 5 years has there been any history of the following: (Check all that apply and provide details below for any checked items).

- | | |
|--|---|
| ☐ Diabetes | ☐ Leukemia |
| ☐ Heart Disease | ☐ Heart Attack |
| ☐ Stroke | ☐ Cardiomyopathy Organ |
| ☐ Cancer | ☐ Failure/Disease Alcohol/ |
| ☐ Depression | ☐ Drug Abuse |
| ☐ Congestive Heart Failure | |
| ☐ Uncontrolled High Blood Pressure Amyotrophic | |
| ☐ Lateral Sclerosis (ALS) | |
| ☐ Chronic Obstructive Lung Disease (COLD) Chronic | |
| ☐ Obstructive Pulmonary Disease (COPD) | |
| ☐ Other: | |

Client Current Medications

Medication	Dose & Frequency	Reason

Spouse Current Medications

Medication	Dose & Frequency	Reason

Medical Details:

[illegible]