

# Client Questionnaire

Client's Name \_\_\_\_\_

## Important Notice to Clients

The Corporations Law requires that an adviser making investment recommendations must have reasonable ground for making those recommendations. This means that an adviser must conduct an appropriate investigation of your financial objectives, situation and particular needs as a client. The information requested in this form is necessary to enable recommendations to be made and will be used solely for that purpose.

Evolution Financial Planning accepts no liability for any advice given on the basis of inaccurate or incomplete information.

All information contained in this document is confidential and will be treated as such at all times.

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## PERSONAL DETAILS

	Client	Partner
Name		
Date of birth		
Marital status		
Health		
Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
No. of dependents		
Age of dependents		

## CONTACT DETAILS

Address	State	Postcode
Phone	Fax	
Mobile (client)	Mobile (partner)	
Email (client)		
Email (partner)		

## EMPLOYMENT DETAILS

	Client	Partner
Occupation		
Employer		
Job status		
Gross salary		
Details of any salary packaging arrangements (eg super, car etc)		
Expected retirement date		

## EXPENSES

Current living expenses	\$	Emergency funds needed	\$
Current mortgage repayments	\$	Estimated retirement income	\$
Capital expenses (please provide details eg new car \$20K in 2 years)			

## GOALS AND OBJECTIVES

### Short/medium term (next 5 years)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

### Long term (after 5 years)

7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

## INVESTMENT AND FINANCIAL OBJECTIVES

Rank your goals from 1 (highest) to 8 (lowest)	Rank	Target Value	Target Date
Income protection against sickness or accident		\$	
Protect family and assets in the event of death		\$	
Protect against serious illness or trauma		\$	
Retirement planning		\$	
Short term saving (eg property deposit, holiday)		\$	
Long term investments and wealth creation		\$	
Minimise tax		\$	
Reduce existing liabilities		\$	

Are there any investments or insurance companies that you like or dislike?  Yes  No

Details \_\_\_\_\_

Do you have any environmental, social or ethical considerations to take into account?  Yes  No

Details \_\_\_\_\_

Are any of your investments from borrowed funds?  Yes  No

Details \_\_\_\_\_

### What services are you looking for from your financial adviser?

- Portfolio management   
  Ongoing strategic advice   
  Choice of investments   
  Self Managed Super  
 Lower fees   
  More contact and services   
  Greater understanding of asset allocation & investment risk

## ASSETS

Investment assets	Details	Owner	Value
Principle residence			\$
Investment properties	Rent		\$
	Rent		\$
Cash at bank			\$
Term deposits			\$
Shares			\$
			\$
			\$
Managed funds			\$
			\$
			\$
Other			\$
			\$
<b>Total assets</b>			<b>\$</b>

\*\*Please provide latest Portfolio Statements and/or attach spreadsheet with additional information and account numbers

## LIABILITIES

Details	Owner	Date commenced	Term	Interest rate	Repayments	Tax deductible	Amount owing
					\$		\$
					\$		\$
					\$		\$
					\$		\$
<b>Total liabilities</b>							<b>\$</b>
<b>NET WORTH (Assets - Liabilities)</b>							<b>\$</b>

## SUPERANNUATION

Client			Partner		
Super fund	Account no.	Value	Super fund	Account no.	Value
		\$			\$
		\$			\$
		\$			\$
		\$			\$
<b>Total super</b>		<b>\$</b>	<b>Total Super</b>		<b>\$</b>

Do you have a self managed super fund?

Yes  No

Are you expecting any employment termination payments?

Yes  No

Do you have an existing annuity or pension?

Yes  No

\*\* Please provide latest Superannuation Statements and any ETP, annuities and pension statements

## INSURANCE DETAILS

Type of cover	Client			Partner		
	Insurer	Policy No.	Benefit	Insurer	Policy No.	Benefit
Private Health						
Term Life			\$			\$
Total & Permanent Disability			\$			\$
Trauma			\$			\$
Income Protection			\$			\$

Do you require more advice and assistance to secure your financial future for you and/or your family in the event of serious illness, accident or death? \*\*  Yes  No

*If 'No', you are acknowledging that you will take full responsibility for any consequences to your financial situation in the case of serious illness, accident or death.*

## ESTATE PLANNING

	Client		Partner	
Do you have a will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your will up to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date last review	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have Power of Attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you require further assistance in estate planning?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

## CENTERLINK BENEFIT

	Client		Partner	
Do you receive Centrelink benefits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If "Yes" please indicate type of benefit and amount?

Type

Amount

## OTHER DETAILS

<b>Accountant name</b>		<b>Company</b>	
Address		State	Postcode
Phone	Fax	Email	

<b>Solicitor name</b>		<b>Company</b>	
Address		State	Postcode
Phone	Fax	Email	

## CLIENT AUTHORISATION FOR ADDITIONAL INFORMATION

This is to allow Evolution Financial Planning to access additional information from other institutions or advisors

### To whom it may concern

I/we (client) \_\_\_\_\_ and (partner) \_\_\_\_\_

whose date(s) of birth are (client) \_\_\_\_\_ and (partner) \_\_\_\_\_

of (client address) \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

request that all information relating to my investments, insurances, superannuation, bank accounts or other financial information be released to Evolution Financial Planning on request.

Yours faithfully

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Partner Signature \_\_\_\_\_ Date \_\_\_\_\_

Account/policy no \_\_\_\_\_ Account/policy no \_\_\_\_\_

Account/policy no \_\_\_\_\_ Account/policy no \_\_\_\_\_

Account/policy no \_\_\_\_\_ Account/policy no \_\_\_\_\_

Accountant \_\_\_\_\_ Solicitor \_\_\_\_\_

### Adviser contact details:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Authorised representative number \_\_\_\_\_

## ADDITIONAL NOTES

## ACKNOWLEDGEMENTS

**Client Declaration:**

I/We hereby declare that the information provided in this form is true and correct to the best of my/our knowledge. I/We understand that incomplete or inaccurate information may result in advice which is not appropriate for my/our situation.

Client signature

Date

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Partner signature

Date

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**Adviser Declaration:**

I acknowledge that the information contained in this form is an accurate and complete record of the information obtained from the above named clients.

Adviser signature

Date

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**Please sign and return your Client Questionnaire at least 48 hours prior to your appointment.**

**Thank you!**