

Client: \_\_\_\_\_

Agent: \_\_\_\_\_

Date: \_\_\_\_\_

## WHO OFFERS YOU TIME OUT?

Analysis of Immediate  
Cash Needs and Continuing  
Family Income at Death



A PARTNER YOU CAN TRUST.

Getting to Know You!

**1- YOU**

Name \_\_\_\_\_ First name \_\_\_\_\_ Initials \_\_\_\_\_

Address \_\_\_\_\_ Postal code 

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Home tel. 

--	--	--	--	--	--	--	--	--	--

 Work tel. 

--	--	--	--	--	--	--	--	--	--

 E-mail \_\_\_\_\_

Date of birth 


 Marital status \_\_\_\_\_

Owner  Co-owner  Tenant Since \_\_\_\_\_

Smoker  Non-smoker Since \_\_\_\_\_

Employer \_\_\_\_\_ Since \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Cell phone 

--	--	--	--	--	--	--	--	--	--

 Fax 

--	--	--	--	--	--	--	--	--	--

 Do you have: Yes No

Employment income \$ \_\_\_\_\_ Other income \$ \_\_\_\_\_ - a will?

- a mandate in case of inability?

**2- YOUR SPOUSE**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Initials \_\_\_\_\_

Home tel. 

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 Work tel. 

--	--	--	--	--	--	--	--	--	--

 E-mail \_\_\_\_\_

Date of birth 


 Marital status \_\_\_\_\_

Owner  Co-owner  Tenant Since \_\_\_\_\_

Smoker  Non-smoker Since \_\_\_\_\_

Employer \_\_\_\_\_ Since \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Cell phone 

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 Fax 

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 Do you have: Yes No

Employment income \$ \_\_\_\_\_ Other income \$ \_\_\_\_\_ - a will?

- a mandate in case of inability?

**3- YOUR CHILDREN AND/OR DEPENDENTS**

First and last name	Date of birth	Address and telephone																														
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**4- GOALS AND OBJECTIVES (FAMILY, WORK, FINANCES, LEISURE, RETIREMENT)**

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How would you prioritize your objectives? \_\_\_\_\_

Based on your current budget, how much more could you comfortably put aside each week to realize your objectives? \$ \_\_\_\_\_

**A- AVAILABLE CASH**

	YOU	YOUR SPOUSE
Existing life insurance (incl. group, mortgage)	\$ _____	\$ _____
Cash in the bank	\$ _____	\$ _____
Government death benefits	\$ _____	\$ _____
Other liquid assets	\$ _____	\$ _____
<b>TOTAL AVAILABLE CASH</b>	<b>\$ _____</b>	<b>\$ _____</b>

Transfer totals to E-1A

**B- IMMEDIATE CASH NEEDS AT DEATH**

	YOU	YOUR SPOUSE
Funeral and last expenses	\$ _____	\$ _____
Estate settlement costs	\$ _____	\$ _____
Emergency fund	\$ _____	\$ _____
Education fund	\$ _____	\$ _____
Mortgage payment fund	\$ _____	\$ _____
Rental prepayment fund	\$ _____	\$ _____
Charitable donations and bequests	\$ _____	\$ _____
Taxes and other expenses	\$ _____	\$ _____
<b>TOTAL IMMEDIATE CASH NEEDS</b>	<b>\$ _____</b>	<b>\$ _____</b>

Transfer totals to E-1B

**C- TOTAL INCOME TO AGE 65**

	YOU	YOUR SPOUSE
65 - YOUR AGE X 12 X CURRENT MONTHLY INCOME	\$ _____	\$ _____

Use form F13-205A "An opportunity to review your financial situation " to take a 2% annual salary increase into account.

## D- NECESSARY INCOME

	YOU	YOUR SPOUSE
Current gross monthly income (all sources)	\$ _____	\$ _____
Projected necessary income: _____%	\$ _____	\$ _____
Minus: surviving spouse's/orphan's pension	\$ _____	\$ _____
<b>ADDITIONAL INCOME NEEDED MONTHLY</b>	<b>\$ _____</b>	<b>\$ _____</b>
	Transfer totals E-2A	

## E- CALCULATIONS

	YOU	YOUR SPOUSE
<b>1 Additional protection to cover immediate needs at death:</b>		
A) Total available cash	\$ _____	\$ _____
B) Total cash needs at death	\$ _____	\$ _____
C) TOTAL SURPLUS/DEFICIT	<b>\$ _____</b>	<b>\$ _____</b>
<b>2 Continuing family income after death*:</b>		
A) Total additional income needed monthly	\$ _____	\$ _____
B) Interest rate for deposits	_____ %	_____ %
C) Duration * See table on overleaf	_____ years	_____ years
D) ADDITIONAL INSURANCE REQUIRED	<b>\$ _____</b>	<b>\$ _____</b>
<b>3 Total amount of additional insurance needed (add or subtract the following):</b>		
A) Surplus/Deficit to cover immediate cash needs at death (E-1C)	\$ _____	\$ _____
B) Additional insurance required to provide family income needed (E-2D)	\$ _____	\$ _____
C) TOTAL INSURANCE NEEDED	<b>\$ _____</b>	<b>\$ _____</b>
D) AMOUNT OF INSURANCE COVERAGE	<b>\$ _____</b>	<b>\$ _____</b>

I acknowledge the need for additional insurance and agree to obtain coverage for the amount(s) indicated above.  
 Do you wish to obtain critical illness insurance?  YES  NO

## F- RECOMMENDED COVERAGE

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Agent

Date

You

Client signature(s)

Your spouse

**G- CAPITAL REQUIRED FOR A MONTHLY INCOME OF \$1, WITHOUT CAPITAL CONSERVATION**

Term	Factor					
	4.00%	5.00%	6.00%	7.00%	8.00%	9.00%
10	98.77	94.28	90.07	86.13	82.42	78.94
15	135.19	126.46	118.50	111.26	104.64	98.59
20	165.02	151.53	139.58	128.98	119.55	111.14
25	189.45	171.06	155.21	141.49	129.56	119.16
30	209.46	186.28	166.79	150.31	136.28	124.28
35	225.85	198.14	175.38	156.53	140.79	127.55
40	239.27	207.38	181.75	160.92	143.82	129.64
45	250.26	214.59	186.47	164.01	145.85	130.97
50	259.26	220.20	189.97	166.20	147.22	131.83
55	266.64	224.57	192.56	167.74	148.13	132.37
60	272.68	227.98	194.49	168.83	148.75	132.72

**H- REFERRALS**

First and last name \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

First and last name \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Telephone

Leisure activities \_\_\_\_\_

First and last name \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

First and last name \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Telephone

Leisure activities \_\_\_\_\_

First and last name \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

First and last name \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Telephone

Leisure activities \_\_\_\_\_

**I- WOULD YOU LIKE TO OBTAIN QUOTES WHEN IT'S TIME TO RENEW YOUR:**

Car insurance?        
Date

Home insurance?        
Date

Mortgage loan?        
Date

# DETAILS OF IN FORCE COVERAGE

## YOU

### Life Insurance

Issuing company	Year purchased	Type of contract	Death benefit (\$)	Beneficiary	Annual premium (\$)	Accumulated dividends (\$)	Surrender value (\$)	Accumulation fund (\$)

### Disability Insurance

Issuing company	Year purchased	Premium (\$)	Waiting period	Monthly income (\$)	Indexation (%)	Job protected up to (years)

Comments: \_\_\_\_\_

### Critical Illness Insurance

Issuing company	Year purchased	Premium (\$)	Face amount (\$)	Covered illnesses	Premium refund	
				No. _____	<input type="checkbox"/> No <input type="checkbox"/> Yes:	_____ %

## YOUR SPOUSE

### Life Insurance

Issuing company	Year purchased	Type of contract	Death benefit (\$)	Beneficiary	Annual premium (\$)	Accumulated dividends (\$)	Surrender value (\$)	Accumulation fund (\$)

### Disability Insurance

Issuing company	Year purchased	Premium (\$)	Waiting period	Monthly income (\$)	Indexation (%)	Job protected up to (years)

Comments: \_\_\_\_\_

### Critical Illness Insurance

Issuing company	Year purchased	Premium (\$)	Face amount (\$)	Covered illnesses	Premium refund	
				No. _____	<input type="checkbox"/> No <input type="checkbox"/> Yes:	_____ %

## YOUR CHILDREN

### Life Insurance

Issuing company	Year purchased	Type of contract	Death benefit (\$)	Beneficiary	Annual premium (\$)	Accumulated dividends (\$)	Surrender value (\$)	Accumulation fund (\$)

### Disability Insurance

Issuing company	Year purchased	Premium (\$)	Waiting period	Monthly income (\$)	Indexation (%)	Job protected up to (years)

Comments: \_\_\_\_\_

### Critical Illness Insurance

Issuing company	Year purchased	Premium (\$)	Face amount (\$)	Covered illnesses	Premium refund	
				No. _____	<input type="checkbox"/> No <input type="checkbox"/> Yes:	_____ %