



madison
FINANCIAL GROUP

Insurance Personal Questionnaire

Name of Client 1:

Name of Client 2:

This section is completed by your Adviser

Adviser Name:

Adviser Code:

Interview Date:

FSG Version Number Provided:

Adviser Profile Number Provided:

Referral Details:

MADISON FINANCIAL GROUP PTY LTD
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Australian Financial Services License No. 246679

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IMPORTANT NOTICE TO CLIENT

This Data Collection Form has been designed to help you describe your own current personal circumstances and financial objectives. It assists your adviser to gain a clear picture of your situation and to understand your attitudes to issues such as risk, security and investment types. To have a complete Statement of Advice prepared for you, you need to provide full details of your financial position. If you require only restricted advice and/or do not wish to provide full financial details, you should strike out any unanswered sections of this form. The Client Acknowledge to be signed by you explains the possible consequences of providing incomplete or inaccurate information. Our privacy statement explains about the collection, use and access to your personal information.

How Can We Help?

This section of the Confidential Questionnaire is designed to help you describe your expectations of the service we are to provide you in determining the most appropriate means of meeting your needs.

Scope of Advice

- ❖ Protecting you and your family by minimizing the risk of financial loss by ensuring that adequate insurance is sourced to meet your specific needs and objectives. Yes No
- ❖ Advice designed to protect the financial needs of your business from insurable events. Yes No
- ❖ Advice relating to life insurance only. Yes No
- ❖ Advice relating to life and total and permanent disability insurance only. Yes No
- ❖ Advice relating to income protection only. Yes No
- ❖ Advice relating to trauma insurance only. Yes No
- ❖ Advice relation to key person insurance only. Yes No
- ❖ Advice in relation to business expenses only. Yes No
- ❖ Source suitable income protection insurance to the value of \$ _____ Monthly
- ❖ Source suitable life and total permanent disability insurance to the value of \$ _____
- ❖ Source suitable trauma insurance to the value of \$ _____
- ❖ Review income protection insurance needs. Yes No
- ❖ Review life and total permanent disability insurance. Yes No
- ❖ Review business expenses insurance needs. Yes No
- ❖ Review business insurance needs. Yes No

Other insurance requirements not covered above:

Please note that this Confidential Questionnaire has been designed to collect relevant information necessary in order to provide you with advice and assistance to meet for your insurance needs. If you have any concerns that your needs are not covered in the list above, please let your adviser know immediately.

Personal Details		
	Client 1	Client 2
Mr / Mrs / Miss / Ms / Dr / Other:		
Surname:		
Given Names:		
Preferred Names:		
Material Status:	Married / Defacto / Single	Married / Defacto / Single
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Smoker within the last 12 months:	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many? Per week / month / year (circle)	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many? Per week / month / year (circle)
Date of Birth:	/ /	/ /
Address:		
City/Suburb/ Postcode::		
Home Telephone No:		
Work Telephone No:		
Mobile:		
Fax:		
Email:		
Mailing Address:		
Preferred Contact Method:	Home / Work / Mobile Email / Mail	Home / Work / Mobile Email / Mail
Retirement Date:		
Are you a permanent resident of Australia?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you plan to travel overseas, live or work in another country?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Children / Dependants Support to be provided							
Name	DOB	Financial Dependant		Primary/Secondary School		Tertiary School	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Annual Fees	Years	Annual Fees	Years
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$		\$	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$		\$	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$		\$	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$		\$	

Costs should be in today's dollars.

Please advise if you have been previously married or have children to a previous relationship.

Employment Details			
	Client 1		Client 2
Occupation:			
Industry:			
Tertiary or Trade Qualification:			
Employment Status (part time, full time, casual):			
Employer's Business Name:			
Employment Commencement Date:			
Salary / Wages (gross):			
Brief List of General Duties:			
Do your work duties require heavy manual work?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you work underground or underwater?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you work at heights over 10 meters?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you able to salary package?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there likely to be a change in employment status?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please provide details:			

Other Professional Advisers

Client 1

Service	Name	Company	Contact Details
Accountant			
Solicitor			
Permission to contact		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Client 2

Service	Name	Company	Contact Details
Accountant			
Solicitor			
Permission to contact		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Employment Details (Self Employed)						
Name of Business	Structure eg Sole Trader. Partnership, Own Company	% Ownership		Length of Time Business Established	No of Employees	
		Client 1	Client 2		Full Time	Part Time
Occupation/Industry:						
Tertiary or Trade Qualification:						
Employment Status (part time, full time, casual)						
PERSONAL INCOME						
Income per Annum:		Client 1		Client 2		
Salary:	\$			\$		
Family Trust Distribution:	\$			\$		
Interest Income:	\$			\$		
Dividend Income:	\$			\$		
Rental Income:	\$			\$		
Pension Income:	\$			\$		
Government Assistance Payments:	\$			\$		
BUSINESS INCOME						
Income per Annum:						
Income Drawings from Business:	\$			\$		
Directors Fees:	\$			\$		
Dividends:	\$			\$		
Shares of Business Profit:	\$			\$		
Other Income (do not include investment income here)	\$			\$		
Fringe Benefit Amount:	\$			\$		
TOTAL INCOME	\$			\$		

Current Assets & Liabilities

***Owner C1, C2, Company, Trust, Partnership, Other**

Assets	*Owner	Available for Liquidation in event of a claim?	Current Value \$	Comments
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
TOTAL		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Loan Purpose	*Owner	Company / Lender	Amount Owing \$	Remaining Term / Maturity Date	Interest Only / P & I	Comments

Have you ever gone Guarantor for anyone?

Client 1		Client 2	
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, please provide details:

Personal Insurance Schedule
***Owner CI, C2, Company, Trust, Partnership, Other**

Policy Type:				
Insurance Company:				
Policy Owner:				
Life Insured:				
Beneficiary:				
Policy Number:				
Policy Type:				
Date Commenced:	/ /	/ /	/ /	/ /
Renewal Date:	/ /	/ /	/ /	/ /
Policy Status	Underwriting/In Force/Lapsed	Underwriting/In Force/Lapsed	Underwriting/In Force/Lapsed	Underwriting/In Force/Lapsed
Payment Frequency:				
Premium:	\$	\$	\$	\$
Exclusions / Loadings:				
Payment Type:	Level / Stepped	Level / Stepped	Level / Stepped	Level / Stepped
Level of Death Cover:	\$	\$	\$	\$
Level of TPD	\$	\$	\$	\$
Level of Trauma:	\$	\$	\$	\$
Indexed to CPI	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Continuation Option?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retain Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*Within Super?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Comments				

*Where Insurance is included in Super, please complete Super details section.

Income Protection / Business Insurance

***C1 = CLIENT, C2 = CLIENT 2, J = JOINT**

Insurance Company:				
Policy Owner:				
Life Insured:				
Purpose:				
Policy Number:				
Guarantee / Indemnity:				
Date Commenced:	/ /	/ /	/ /	/ /
Renewal Date:	/ /	/ /	/ /	/ /
Policy Status:	Underwriting/In Force/Lapsed	Underwriting/In Force/Lapsed	Underwriting/In Force/Lapsed	Underwriting/In Force/Lapsed
Payment Frequency:				
Monthly / Weekly Benefit:				
Benefit Period:				
Waiting Period:				
Escalation Benefit:				
Premium:	\$	\$	\$	\$
Exclusions / Loadings:				
Indexed to CPI:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Continuation Option?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within Super?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Comments:				

Existing Superannuation Benefit (only required where Lump Sum Insurance is included in Super)			
Owner:			
Fund Name:			
Is it a self managed super fund?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current value:	\$	\$	\$
Non Concessional			
Personal:			
Spouse:			
Concessional			
Super Guarantee:	<input type="checkbox"/> 9% <input type="checkbox"/> Other: _____	<input type="checkbox"/> 9% <input type="checkbox"/> Other: _____	<input type="checkbox"/> 9% <input type="checkbox"/> Other: _____
Employer (Salary Sacrifice):	\$ _____ pa	\$ _____ pa	\$ _____ pa
Deductible:	\$ _____ pa	\$ _____ pa	\$ _____ pa
Tax Free component:	\$	\$	\$
Taxable (Taxed Amt):	\$	\$	\$
Taxable (untaxed Amt):	\$	\$	\$
Tax Free component:	\$	\$	\$
Exit Fee:	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Death Benefit:	\$	\$	\$
Disability Benefit:	\$	\$	\$
Continuance Option:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Beneficiary:	<input type="checkbox"/> None <input type="checkbox"/> Binding <input type="checkbox"/> Nominated	<input type="checkbox"/> None <input type="checkbox"/> Binding <input type="checkbox"/> Nominated	<input type="checkbox"/> None <input type="checkbox"/> Binding <input type="checkbox"/> Nominated
Client wishes to retain?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contributions to continue?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date Last Reviewed:	/ /	/ /	/ /
Sum Insured (amount):	\$	\$	\$
Insurance Included (type):			
Continuation Option Available:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
To Be Retained:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

NOTE: Attach information regarding any other Funds.

Permanent Disability		
	Client 1	Client 2
Maintain current income levels as far as possible.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provide your partner with the option of not having to work.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retain your own home and existing lifestyle.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Repay debts, especially the mortgage on your family home.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ensure there is sufficient capital to pay for ongoing medical costs.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provide for your children's future education needs.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Trauma		
	Client 1	Client 2
Repay debts, especially the mortgage on your family home.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ensure there is enough capital to cover medical costs (beyond health insurance cover)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retain your own family home and existing lifestyle.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provide your partner with the option of not having to work.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ensure that capital and income needs are taken care of for a period of time to allow a recovery period.	Recovery Time Period	Recovery Time Period
Reduce the need to sell assets to cover medical expenses.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Other comments / objectives not captured above:

Income Protection (temporary disablement)

Income	Client 1	Client 2
Annual income required to maintain own / family lifestyle (refer income and Expenses)	\$	\$
How long can your family afford to last without your regular income?	for days (eg 14, 30, 90, 180)	for days (eg 14, 30, 90, 180)
How long should replacement income continue for?	for years (eg 2yrs, 5yrs to 60, age 65)	for years (eg 2yrs, 5yrs to 60, age 65)

Income Replacement Table: Lump Sum Insurance required

Assumes: 7.5% pa investment earnings (after fees before tax) and 3% pa inflation rate
 Therefore 4.5% pa net rate of return (after fees before tax)
 Annual income amount required is before income tax and is in future dollar terms.

Income Replacement (Years)	Annual Income Required (before tax)					
	\$20,000	\$30,000	\$40,000	\$60,000	\$80,000	\$100,000
5	\$88,000	\$132,000	\$175,000	\$263,000	\$351,000	\$439,000
10	\$158,000	\$237,000	\$317,000	\$475,000	\$633,000	\$791,000
15	\$215,000	\$322,000	\$430,000	\$644,000	\$859,000	\$1,074,000
20	\$260,000	\$390,000	\$520,000	\$780,000	\$1,041,000	\$1,301,000
25	\$297,000	\$445,000	\$593,000	\$890,000	\$1,186,000	\$1,483,000
30	\$326,000	\$487,000	\$652,000	\$977,000	\$1,303,000	\$1,629,000
35	\$349,000	\$524,000	\$698,000	\$1,048,000	\$1,397,000	\$1,746,000
40	\$368,000	\$552,000	\$736,000	\$1,104,000	\$1,472,000	\$1,840,000

Lifestyle / Education Expenses

- To provide funds for investment to maintain your family's lifestyle expenses of \$_____ p.a. (after tax) *OR* to provide an income of \$_____ p.a. (before tax) on Death or Permanent Disability of the main income earner.
- To provide \$_____ p.a. per child to age ____ to meet education costs.
- To clear ____% of debt on the family home on Death or Permanent Disability of the main income earner
- To clear ____% of investment debt on Death or Permanent Disability of the main income earner
- To clear ____% of debt on the family home on Death or Permanent Disability of your spouse
- To clear ____% of investment debt on Death or Permanent Disability of your spouse
- To clear ____% of debt on the family home upon the main income earner experiencing a Medical Trauma
- To clear ____% of investment debt upon the main income earner experiencing a Medical Trauma
- To clear ____% of debt on the family home upon the spouse experiencing a Medical Trauma
- To clear ____% of investment debt upon the spouse experiencing a Medical Trauma

Retirement Funding

- To provide funds for investment to generate a retirement income of \$ _____ p.a. from the main income earner's intended retirement age of _____
- To provide funds for investment to generate a retirement income of \$ _____ p.a. from your spouse's intended retirement age of _____

Income Replacement

- To protect _____% of income in the event of an illness or accident resulting in temporary disability

Estate Planning Considerations

The scope of the advice to be provided through the use of this document does not allow for more than a very cursory consideration of the issue surrounding Estate Planning. If you have issues or questions not addressed here or if you are using personal life insurance to achieve a particular outcome for your beneficiaries/dependants, then you should consider a broader scope of advice to include information that considers tax and investments in full.

	Client 1	Client 2
Client has declined Estate Planning discussion?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a Will?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date Will last reviewed	/ /	/ /
Does your insurance need to flow through your will to fund your estate planning needs and objectives?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a Power of Attorney?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so which type is it?	Enduring / General Limited	Enduring / General Limited

Client Acknowledgment

Privacy Disclosure Declaration

In order to comply with the requirements of the Privacy Act, we are required to advise you that this firm holds personal information about you. The information has been and will continue to be collected by us for the purpose of providing you with financial services including:

- preparation of your financial plan;
- provision of financial planning advice to you;
- making securities and investment recommendations;
- reviewing your financial plan, securities and investment recommendations.

We are required, pursuant to the Corporations Act, certain regulations issued by the Australian Securities and Investments Commission and the Rules of Professional Conduct of the Financial Planning Association, of which this organisation is a member, to collect information about you for the purpose of providing you with the services referred to above. If you do not provide us with the information requested by us, we may not be able to provide you with the services you require of us.

We will from time to time disclose information about you to authorised representatives of this firm and to other professionals, insurance providers, superannuation trustees and product issuers in connection with the purposes detailed above. In the event we consider it necessary to use or disclose information about you for purposes other than those detailed above or related purposes, we will seek your consent.

Limited Advice Declaration

Madison Financial Group and its representatives have a responsibility under Corporations Act to provide advice based on an individual's needs and circumstances. In certain situations, Madison Financial Group is able to provide advice of a more limited nature, however in doing so, it is necessary for you to understand the limitations of this advice.

By declining to provide full personal information to your Adviser, your Adviser is not able to comprehensively assess your financial and personal circumstances, needs and objectives, before making recommendations. As a result, the recommendations made may not be appropriate to your circumstances. Therefore you should carefully assess the recommendations in light of your personal situation before proceeding with implementation.

Client Acknowledgment

I/We give permission for my/our tax file number(s) provided to you, to be retained on file by my adviser.

I/We give permission for my adviser to provide this information to financial institutions as requested or as necessary.

I/We hereby declare that the information set out in this form is true and correct to the best of my/our knowledge.

I/We give permission for the information contained in this form to be used in the preparation of my/our financial plan.

I/We confirm that I/We have received a copy of Madison's Financial Services Guide and Adviser Profile.

I/We give authority for you to send me/us emails at the address supplied which relate to investment opportunities and/or information you become aware of which may be of interest to me/us.

Client Name: Signed: Client (1) Date/...../.....

Client Name: Signed: Client (2) Date/...../.....

Adviser Acknowledgment

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

Adviser Name: Signed: Date/...../.....

Letter of Authority to Seek Information

Date / /

Client Name

Address
.....
.....

Dear Sir/Madam,

Policy Number 1:

Policy Number 2:

Please be advised I hereby authorise the following Financial Adviser to make enquiries on my behalf in relation to my personal financial information.

.....
of

An authorised representative of Madison Financial Group Pty Ltd

.....
.....

Phone:

Fax:

Adviser Number:.....

Madison Financial Group Number:

Should you have any further queries, please contact my adviser on the details mentioned above.

Yours sincerely,

Name:

Signature:

Identification Record

ID Record	Document 1		Document 2	
Verified From	<input type="checkbox"/> Original	<input type="checkbox"/> Certified Copy	<input type="checkbox"/> Original	<input type="checkbox"/> Certified Copy
Copy of ID Document	<input type="checkbox"/> Attached	<input type="checkbox"/> AML Form Completed	<input type="checkbox"/> Attached	<input type="checkbox"/> AML Form Completed
Date Verified				
Adviser Name				

Outstanding Information

Information still to be supplied:

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

ADVISER NOTES