

# Data Collection

## Your Personal Details

Client 1		Client 2	
Full Name	<hr/>	Full Name	<hr/>
Date of Birth	<hr/>	Date of Birth	<hr/>
Marital Status	<hr/>	Marital Status	<hr/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residential Address	<hr/>	Residential Address	<hr/>
Postal Address	<hr/>	Postal Address	<hr/>
Phone	<hr/>	Phone	<hr/>
Mobile	<hr/>	Mobile	<hr/>
Email	<hr/>	Email	<hr/>
Preferred Method of Contact	<input type="checkbox"/> Phone <input type="checkbox"/> Mobile <input type="checkbox"/> Email	Preferred Method of Contact	<input type="checkbox"/> Phone <input type="checkbox"/> Mobile <input type="checkbox"/> Email
Occupation	<hr/>	Occupation	<hr/>
Qualifications	<hr/>	Qualifications	<hr/>
Employer	<hr/>	Employer	<hr/>
Employment Status	<hr/>	Employment Status	<hr/>
Taxable Income	<hr/>	Taxable Income	<hr/>
Tax File Number	<hr/>	Tax File Number	<hr/>
Health Issues	<hr/>	Health Issues	<hr/>
Smoker Status	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker	Smoker Status	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker
Height / Weight	<hr/>	Height / Weight	<hr/>
Hazardous Pursuits	<hr/>	Hazardous Pursuits	<hr/>

## Dependants / Children

	1	2	3	4	5
Full Name	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Date of Birth	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship (adopted, step children)	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>



### Financial Information (if applicable)

Business Name	_____	ABN / ACN	_____
SMSF Name	_____	SMSF ABN	_____
SMSF Trustee Name	_____	Trustee ABN	_____

### Current Insurances

Life Insured	Policy Owner	Provider Policy No	Cover	Premium
_____	_____	_____	_____	\$
_____	_____	_____	_____	\$
_____	_____	_____	_____	\$
_____	_____	_____	_____	\$

### Estate Planning

Current Will	<input type="checkbox"/> Yes	<input type="checkbox"/> No	PoA in Place	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of Will	_____		Guardianship in Place	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Location of Will	_____		Testamentary Trust	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Comments/Notes

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