

CLIENT DATA FORM

Financial Planning



PrimeTime
Advisory

CLIENT DATA FORM

Financial Planning

Client details

Date	
Time/Location	
Client name(s)	

Financial adviser and Licensee details

Financial Adviser	
Advice Practice	Prime Time Advisory Pty Ltd

The above mentioned adviser is an authorised representative of Prime Time Advisory

Street Address	Suite 5, 60-64 Railway Road, Blackburn, Victoria 3130
Postal Address	P.O Box 180, Blackburn VIC 3130
Phone Number	03 9894 3449
Email Address	administration@primetimeadvisory.com.au
Website	www.primetimeadvisory.com.au
Licensee Name	Prime Time Advisory Pty Ltd
AFSL	316972
ABN	32 540 166 035

Reasons for seeking advice

Goals & objectives

Objectives should be specific and measurable. Consider time and quantum

Goal and objectives	Owner	Time Frame	Amount	Priority	Current Status

Notes

Personal details

Your details

	Client 1	Client 2
Title		
Surname		
Given name(s)		
Preferred name		
Date of birth		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status		
Australian resident	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, country of residency		
Country of Citizenship		
Other Citizenships/Visa details		
Tax Identification Number (TIN) and country (if applicable)		
Tax File Number (TFN)		

Contact details

Residential address	Client 1	Client 2
Street		
Suburb		
State		
Postcode		
Postal address (please tick if same as above)		
Street		
Suburb		
State		
Postcode		
Phone and email		
Home phone		
Business phone		
Mobile		
Email		
Preferred contact method		
Social networking	<input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> LinkedIn <input type="checkbox"/> Skype	<input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> LinkedIn <input type="checkbox"/> Skype
Personal interests		

Children and/or other dependants - current and expected

Full name	Date of birth	Gender	Relationship	Dependant	Dependant to
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Associated entities

Do you have any of the following structures?	<input type="checkbox"/> Self-Managed Superannuation Fund (SMSF) <input type="checkbox"/> Trust structure <input type="checkbox"/> Company structure <input type="checkbox"/> Partnership structure
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If **Yes**, to any of the above, further details can be collected via the **Other entities** or **SMSF** sections.

Do you have any overseas investments or are you involved in a foreign overseas business?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any business relationships or are you associated with any Political Exposed Person (PEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If **Yes**, please provide details:

Employment details

	Client 1		Client 2	
Occupation/Title				
Job description/duties				
Qualifications				
Employer name				
Employment start date				
Do you work overseas?				
If yes, list relevant countries				
Employment status	<input type="checkbox"/> Full-time <input type="checkbox"/> Casual <input type="checkbox"/> Home duties <input type="checkbox"/> Self-employed	<input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	<input type="checkbox"/> Full-time <input type="checkbox"/> Casual <input type="checkbox"/> Home duties <input type="checkbox"/> Self-employed	<input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired
If part-time how many hours worked?				
If self-employed, what structure?	<input type="checkbox"/> Trust <input type="checkbox"/> Sole Trader	<input type="checkbox"/> Company <input type="checkbox"/> Partnership	<input type="checkbox"/> Trust <input type="checkbox"/> Sole Trader	<input type="checkbox"/> Company <input type="checkbox"/> Partnership

Current position analysis

Assets (excluding superannuation)	Description	Owner	Current balance (\$)
Primary residence			
Household contents			
Motor vehicle			
Cash at bank			
Term deposits			
Managed funds			
Direct shares			
Investment property			
Total assets (excluding superannuation)			\$

Liabilities	Description including loan details (e.g. interest rate, loan type, PI or IO)	Owner	Outstanding balance (\$)
Home loan			
Motor vehicle(s)			
Personal loan(s)			
Investment loan(s)			
Credit card(s)			
Total liabilities			\$

Net worth (excluding superannuation)		

Additional details:

Existing superannuation

Superannuation accumulation funds

Please provide a copy of your most recent statement

Fund name	Owner	Contributions	Has insurance	Fund balance (\$)
		Employer (SGC) \$ Salary sacrifice \$ Personal \$	<input type="checkbox"/> Yes	
		Employer (SGC) \$ Salary sacrifice \$ Personal \$	<input type="checkbox"/> Yes	
		Employer (SGC) \$ Salary sacrifice \$ Personal \$	<input type="checkbox"/> Yes	
		Employer (SGC) \$ Salary sacrifice \$ Personal \$	<input type="checkbox"/> Yes	
		Employer (SGC) \$ Salary sacrifice \$ Personal \$	<input type="checkbox"/> Yes	
		Employer (SGC) \$ Salary sacrifice \$ Personal \$	<input type="checkbox"/> Yes	
Total				\$

Retirement income streams

Please provide a copy of your most recent statement

Fund name	Owner	Income payment & frequency	Fund balance (\$)
Total			\$

Beneficiaries

Owner	Product	Name	Type	Proportion of fund
			<input type="checkbox"/> Nominated beneficiary <input type="checkbox"/> Binding death nomination <input type="checkbox"/> Reversionary	
			<input type="checkbox"/> Nominated beneficiary <input type="checkbox"/> Binding death nomination <input type="checkbox"/> Reversionary	
			<input type="checkbox"/> Nominated beneficiary <input type="checkbox"/> Binding death nomination <input type="checkbox"/> Reversionary	

Annual income and expenses

Income type	Client 1 (or Joint)	Client 2
Gross annual income e.g. salary/wages	\$	\$
Gross annual business income e.g. Profit before tax	\$	\$
Gross annual investment income	\$	\$
Centrelink income	\$	\$
Rental income	\$	\$
Income Streams	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
Total income	\$	\$
Expenses		
Estimated tax liability	\$	\$
Living expenses e.g. consumables, transport, health, housing	\$	\$
Home loan or rent	\$	\$
Credit cards	\$	\$
Personal loans	\$	\$
Investment loans	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
Total expenses	\$	\$
Gross annual surplus cash flow	\$	

Further expense details can be collected via the **Detailed expense analysis** section if required.

Investment considerations

Client 1	Client 2	
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Do you have a preference to access specific investments?

<input type="checkbox"/>	<input type="checkbox"/>	No particular preference
<input type="checkbox"/>	<input type="checkbox"/>	Access to direct shares or ETFs
<input type="checkbox"/>	<input type="checkbox"/>	Access to alternative investments
<input type="checkbox"/>	<input type="checkbox"/>	Access to term deposits
<input type="checkbox"/>	<input type="checkbox"/>	Access to ethical-socially responsible investments
<input type="checkbox"/>	<input type="checkbox"/>	Investment transparency – ability to view the underlying investments
<input type="checkbox"/>	<input type="checkbox"/>	Large range of investment managers and styles

Are product costs and fees an important consideration?

<input type="checkbox"/>	<input type="checkbox"/>	Lowest cost is primary goal
<input type="checkbox"/>	<input type="checkbox"/>	Seeking value for money
<input type="checkbox"/>	<input type="checkbox"/>	Willing to pay for relevant features
<input type="checkbox"/>	<input type="checkbox"/>	Ability to pay for advice via the fund/platform

Which of the following have you previously invested in (you can select more than one answer):

<input type="checkbox"/>	<input type="checkbox"/>	Term deposits/savings accounts
<input type="checkbox"/>	<input type="checkbox"/>	Managed funds
<input type="checkbox"/>	<input type="checkbox"/>	Direct shares
<input type="checkbox"/>	<input type="checkbox"/>	Investment property
<input type="checkbox"/>	<input type="checkbox"/>	Own home
<input type="checkbox"/>	<input type="checkbox"/>	An investment you have borrowed for other than property

If your goals are unlikely to be met, please indicate which options you would consider:

<input type="checkbox"/>	<input type="checkbox"/>	Save more (spend less)
<input type="checkbox"/>	<input type="checkbox"/>	Downsize lifestyle assets
<input type="checkbox"/>	<input type="checkbox"/>	Increase your income resources – e.g. work longer
<input type="checkbox"/>	<input type="checkbox"/>	Increase your investment risk
<input type="checkbox"/>	<input type="checkbox"/>	Borrow to invest
<input type="checkbox"/>	<input type="checkbox"/>	Revise your goals

Additional details:

Centrelink/Department of Veterans' Affairs (DVA)/Family Assistance

	Client 1	Client 2
What benefits do you currently receive from Centrelink/DVA/Family Assistance?		
Do you intend to apply for any Centrelink/DVA/Family Assistance payments in the near future?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you 'gifted' any assets in the last five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you hold a current Seniors Card or Health Card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes to any of the above questions add additional details:

Insurance

[illegible]

General health details

[illegible]

Insurance needs

Client 1

	Death	TPD	Trauma
In the event of death, TPD or a medical event, would you like cover for:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>If so, what are the amounts that you would require?</i>			
Liabilities to clear	\$	\$	\$
Future expenditure required	\$	\$	\$
Future education expenses (present value)	\$	\$	\$
Medical costs/recovery income	\$	\$	\$
Provision for tax	\$	\$	\$
Other	\$	\$	\$
Total Capital Required	\$	\$	\$
Capital Provisions	\$	\$	\$
Disposable assets	\$	\$	\$
Continuing income (present value)	\$	\$	\$
Total Capital Available	\$	\$	\$
Insurance Needs			
Total Cover Required	\$	\$	\$
Existing cover	\$	\$	\$
Surplus/Shortfall	\$	\$	\$

Income protection needs

	Client 1			
In the event of temporary or permanent loss of income, would you like to replace your income?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
What minimum percentage or dollar amount of your gross income would you need to maintain your lifestyle (NB maximum 75%)?	\$		%	
If you were unable to work due to accident or illness, how long could you reasonably last without your income?	<input type="checkbox"/> 14 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days
	<input type="checkbox"/> 180 days	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2 years	<input type="checkbox"/> 3 years
In the event you are unable to work for a long period of time due to illness or accident, how long would you like your income protection payments to continue?	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2 years	<input type="checkbox"/> 3 years	<input type="checkbox"/> 5 years
	<input type="checkbox"/> 10 years	<input type="checkbox"/> to age 55	<input type="checkbox"/> to age 60	<input type="checkbox"/> to age 65
	<input type="checkbox"/> to age 67	<input type="checkbox"/> to age 70	<input type="checkbox"/> to age 80	
Additional details:				

Client 2

	Death	TPD	Trauma
In the event of death, TPD or a medical event, would you like cover for:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>If so, what are the amounts that you would require?</i>			
Liabilities to clear	\$	\$	\$
Future expenditure required	\$	\$	\$
Future education expenses (present value)	\$	\$	\$
Medical costs/recovery income	\$	\$	\$
Provision for tax	\$	\$	\$
Other	\$	\$	\$
Total Capital Required	\$	\$	\$
Capital Provisions	\$	\$	\$
Disposable assets	\$	\$	\$
Continuing income (present value)	\$	\$	\$
Total Capital Available	\$	\$	\$
Insurance Needs			
Total Cover Required	\$	\$	\$
Existing cover	\$	\$	\$
Surplus/Shortfall	\$	\$	\$

Income protection needs

	Client 2			
In the event of temporary or permanent loss of income, would you like to replace your income?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
What minimum percentage or dollar amount of your gross income would you need to maintain your lifestyle (NB maximum 75%)?	\$		%	
If you were unable to work due to accident or illness, how long could you reasonably last without your income?	<input type="checkbox"/> 14 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days
	<input type="checkbox"/> 180 days	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2 years	<input type="checkbox"/> 3 years
In the event you are unable to work for a long period of time due to illness or accident, how long would you like your income protection payments to continue?	<input type="checkbox"/> 1 year	<input type="checkbox"/> 2 years	<input type="checkbox"/> 3 years	<input type="checkbox"/> 5 years
	<input type="checkbox"/> 10 years	<input type="checkbox"/> to age 55	<input type="checkbox"/> to age 60	<input type="checkbox"/> to age 65
	<input type="checkbox"/> to age 67	<input type="checkbox"/> to age 70	<input type="checkbox"/> to age 80	
Additional details:				

Business expense insurance needs

Sole traders only – for other business insurance needs, refer to Client Data Form – Business Insurance

[illegible]

Detailed expense analysis

Please select the column which is easiest for you to capture your expenditure items

Category	Description	Weekly	Fortnightly	Monthly	Annual
Personal debt commitments	Home mortgage repayments	\$	\$	\$	\$
	Credit card repayments	\$	\$	\$	\$
	Car loan/lease repayments	\$	\$	\$	\$
	Personal loan repayments	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
Investment costs	Investment property repayments	\$	\$	\$	\$
	Margin loans	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
Housing	Rent	\$	\$	\$	\$
	Council/shire rates	\$	\$	\$	\$
	Water/electricity/gas	\$	\$	\$	\$
	Internet/telephone connection	\$	\$	\$	\$
	House and contents insurance	\$	\$	\$	\$
	Household repairs/maintenance	\$	\$	\$	\$
	Furnishings/appliances	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
Transport	Running costs/petrol	\$	\$	\$	\$
	Registration and CTP	\$	\$	\$	\$
	Comprehensive insurance	\$	\$	\$	\$
	Maintenance/services/repairs	\$	\$	\$	\$
Consumables	Groceries	\$	\$	\$	\$
	Alcohol/Cigarettes	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
Health	Private health insurance	\$	\$	\$	\$
	Medical/dental/optical/chemist	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
Children	School fees	\$	\$	\$	\$
	Child care	\$	\$	\$	\$
	Child support maintenance	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
Personal	Clothing/footwear	\$	\$	\$	\$
	Entertainment/dining out	\$	\$	\$	\$
	Sport/recreation/hobbies	\$	\$	\$	\$
	Gifts/presents/Christmas	\$	\$	\$	\$
	Vacations/holidays	\$	\$	\$	\$
	Subscriptions/books/newspapers	\$	\$	\$	\$

Estate planning

	Client 1	Client 2
Is there a Will in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, location held?		
Date executed?		
Who is the Executor of the Will and what are their contact details?		
Has a Guardian(s) been appointed for your children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a Power of Attorney (PoA) in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type?	<input type="checkbox"/> Enduring <input type="checkbox"/> Medical <input type="checkbox"/> General <input type="checkbox"/> Other	<input type="checkbox"/> Enduring <input type="checkbox"/> Medical <input type="checkbox"/> General <input type="checkbox"/> Other
Who has been granted the PoA and what are their contact details?		
Additional details:		

Professional advisers

	Solicitor	Accountant	Other
Company name			
Contact name			
Address			
Telephone/Fax			
Email			
Authority to contact	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client declaration

I hereby declare and acknowledge the following:

Financial Services Guide

- I have received, read and understood a copy of the Financial Services Guide.

The information you provide

- I declare that the information provided in this Client Data Form is complete and accurate to the best of my knowledge, except where I have indicated that I have chosen not to provide the information.
- I understand and acknowledge that by not fully or accurately completing the Client Data Form any financial services provided may not be appropriate to my needs.



Your privacy and confidentiality

- I give permission for the information provided in this Client Data Form and related documents to be disclosed to and used by those who will be involved in providing or implementing financial advice to us, including:
 - Prime Time Advisory (the Licensee),
 - Financial product providers that my financial adviser recommends to us,
 - Service providers (including offshore providers) engaged to provide financial planning-related services including but not limited to paraplanning, compliance, administration, estate planning and financial services software, and
 - Companies involved in communicating the information in this Client Data Form to any of the above parties, such as by electronic mail services, cloud storage services and/or document creation services.
 - My permission extends to electronic communication of the information provided in this Client Data Form and for record keeping purposes.
- ☐ I give permission to receive marketing and advertising materials on products, services, events, promotions and offers from my adviser and their related parties.
- ☐ I give permission for the information provided in this Client Data Form and related documents to also be disclosed to the following people/parties (e.g. name of my spouse/solicitor/accountant/offshore provider including country)

Tax file numbers

- I give permission for my tax file number (TFN) to be collected and retained by my adviser and the Licensee in order to provide us with financial services and/or for social security reasons.
- I understand that:
 - my TFN may need to be provided to authorised recipients of TFNs under the Superannuation Industry (Supervision) Act 1993, the Retirement Savings Accounts Act 1997 and/or under taxation legislation or social security laws, and
 - while it is not an offence to refuse to disclose my TFN, non-disclosure can delay the provision of those financial services and/or may result in taxation implications.

Client authorisation

Client 1 signature			
Signature			 Sign Here
Full name		Date	
Client 2 signature			
Signature			 Sign Here
Full name		Date	
Notes			

Advice planning scope - confirmation

Areas of advice			
Aged care	<input type="checkbox"/>	Cash flow management	<input type="checkbox"/>
Debt management	<input type="checkbox"/>	Estate planning	<input type="checkbox"/>
Investment	<input type="checkbox"/>	Insurance	<input type="checkbox"/>
Retirement income	<input type="checkbox"/>	Social security	<input type="checkbox"/>
Superannuation	<input type="checkbox"/>		

In addition to above, are there any specific areas that you would like **excluded** from our advice?

Are there any specific **products** you would like **excluded** from our advice?

Are there any specific **Goals or Needs** you would like **excluded** from our advice?

Are there any areas in which you have **not** provided **full and accurate information**?

Adviser declaration

Documentation checklist

The information recorded in this Client Data Form was provided during a discussion held on	
The FSG was provided to the above mentioned client(s) on	
The version number of the FSG provided was	
The client's risk profile questionnaire was completed on	

Financial Adviser signature			
Signature			 Sign Here
Full name		Date	
Authorised Representative Number (if applicable)	[AR#]		

Office use only – AML/CTF checklist

Has the required identification from the client and/or beneficial owners been collected and maintained on file? (beneficial ownership is ownership of 25% or more)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the source of wealth and/or funds to be invested been identified? (e.g. inheritance, sale of property)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the risk assessment form been completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Notes

Authorisation to collect information or transfer servicing rights of financial products

Client:	
Provider Name:	
Provider Address:	
Product:	
Account/Policy No:	

To whom it may concern,

- ☐ I authorise you to provide representatives of the business named below with any information and documentation they require regarding my insurance, superannuation and investments.
- ☐ I authorise the adviser named below to become my servicing authorised representative for my financial products. I understand that the responsibility of servicing my financial products will be allocated to my new authorised representative.

Adviser Name:		Authorised Representative No. (if applicable):	
Advisory Team:			
Telephone:		Fax:	
Email:			
Business Name:			
Business Address:			
Licensee:			
AFS Number:		ABN:	

Please accept this scanned copy/photocopy as authority, as the original will stay on file at the address shown above.

Yours faithfully,

Signature		Date	
Name:		Date of Birth:	
Address:			

Authorisation to collect information or transfer servicing rights of financial products

Client:	
Provider Name:	
Provider Address:	
Product:	
Account/Policy No:	

To whom it may concern,

- ☐ I authorise you to provide representatives of the business named below with any information and documentation they require regarding my insurance, superannuation and investments.
- ☐ I authorise the adviser named below to become my servicing authorised representative for my financial products. I understand that the responsibility of servicing my financial products will be allocated to my new authorised representative.

Adviser Name:		Authorised Representative No. (if applicable):	
Advisory Team:			
Telephone:		Fax:	
Email:			
Business Name:			
Business Address:			
Licensee:			
AFS Number:		ABN:	

Please accept this scanned copy/photocopy as authority, as the original will stay on file at the address shown above.

Yours faithfully,

Signature		Date	
Name:		Date of Birth:	
Address:			

Authorisation to collect information or transfer servicing rights of financial products

Client:	
Provider Name:	
Provider Address:	
Product:	
Account/Policy No:	

To whom it may concern,

- ☐ I authorise you to provide representatives of the business named below with any information and documentation they require regarding my insurance, superannuation and investments.
- ☐ I authorise the adviser named below to become my servicing authorised representative for my financial products. I understand that the responsibility of servicing my financial products will be allocated to my new authorised representative.

Adviser Name:		Authorised Representative No. (if applicable):	
Advisory Team:			
Telephone:		Fax:	
Email:			
Business Name:			
Business Address:			
Licensee:			
AFS Number:		ABN:	

Please accept this scanned copy/photocopy as authority, as the original will stay on file at the address shown above.

Yours faithfully,

Signature		Date	
Name:		Date of Birth:	
Address:			

Authorisation to collect information

Professional Adviser Type:	
Professional Adviser:	
Business Name:	
Email:	
Phone:	

To whom it may concern,

Client Name	
Associated Entities	

- ☐ I authorise you to provide representatives of the business named below with any information and documentation they require regarding my personal situation including any related entities.

Adviser Name:		Authorised Representative No. (if applicable):	
Advisory Team:			
Telephone:		Fax:	
Email:			
Business Name:			
Business Address:			
Licensee:			
AFS Number:		ABN:	

Please accept this scanned copy/photocopy as authority, as the original will stay on file at the address shown above.

Yours faithfully,

Signature		Date	
Name:		Date of Birth:	
Address:			