GRECO & O'NEAL WEALTH STRATEGIES
1393 Veterans Memorial Highway, Ste. 307S
Hauppauge, NY 11788
Phone: 631.390.4300 x700
Fax: 631.812.1406

A. Client Information

Name First _____ Middle _____ Last _____

Date of Birth _____/_____/_____ | SSN _____ | Height _____ | Weight _____ | Gender _____

Driver License Number _____ State _____ | Citizenship _____ | Birthplace _____

Issue Date _____ Expiration Date _____ | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

B. Spouse Information

Name First _____ Middle _____ Last _____

Date of Birth _____/_____/_____ | SSN _____ | Height _____ | Weight _____ | Gender _____

Citizenship _____ | Birthplace _____

Driver License Number _____ State _____ | Issue Date _____ | Expiration Date _____

C. Contact Information

Home Phone _____ | Cell Phone _____ | Business Phone _____ | Spouse Cell Phone _____

Email Address _____ | Spouse Email Address _____

Primary Residence _____ _____ ZIP _____ | Secondary Residence _____ _____ ZIP _____

Business Address _____ ZIP _____

D. Employment Information

Employment Status _____ | If Employed, Name of Employer _____ | Date of Hire _____

Primary Occupation _____ | Occupation Annual Income _____ | Referred By _____

Other Income _____ | Source of Other Income _____ | Net Worth _____

Attorney Name _____ Phone Number _____ Email _____

Address _____ ZIP _____

Accountant Name _____ Phone Number _____ Email _____

Address _____ ZIP _____

Do you have a trust in place? ☐ Yes ☐ No | If yes, what kind of trust? _____

E. Children/Grandchildren Information				
Children Name	Age	Date of Birth	Gender	SSN or Tax ID #
_____	_____	____ / ____ / _____	_____	_____
_____	_____	____ / ____ / _____	_____	_____
_____	_____	____ / ____ / _____	_____	_____
_____	_____	____ / ____ / _____	_____	_____

F. Existing Retirement Plan		
Type of Plan (check all that apply): ☐ IRA ☐ Roth IRA ☐ SEP IRA ☐ 401k ☐ 403b		Current Account Value _____
Does your employer make contributions to your plan on your behalf? ☐ Yes ☐ No	If yes, how much do they contribute? _____	Are you maxing out yearly contributions? ☐ Yes ☐ No

G. Spouse Existing Retirement Plan		
Type of Plan (check all that apply): ☐ IRA ☐ Roth IRA ☐ SEP IRA ☐ 401k ☐ 403b		Current Account Value _____
Does their employer make contributions to their plan on their behalf? ☐ Yes ☐ No	If yes, how much do they contribute? _____	Are they maxing out yearly contributions? ☐ Yes ☐ No

H. Account Profile		
Individual Annual Income _____	Spouse Annual Income _____	Estimated Net Worth _____
Investable Assets _____	Annual Expenses _____	Tax Status ☐ W-2 ☐ 1099
Value of Primary Residence $ _____	Value of Secondary Residence $ _____	

Ia. Investable IRA (Provide the Value of Each)			
Total Value of Investable Assets $ _____	Stocks $ _____	Checking/Savings Accounts $ _____	Bonds $ _____
Mutual Funds $ _____	Investment Real Estate $ _____	Alternative Investments (NFTs, Cryptocurrencies, Art, etc) $ _____	
Fixed Annuities _____			Issue Date _____
Variable Contracts _____			Issue Date _____

Ib. Investable non-IRA assets (Provide the Value of Each)			
Total Value of Investable Assets $ _____	Stocks $ _____	Checking/Savings Accounts $ _____	Bonds $ _____
Mutual Funds $ _____	Investment Real Estate $ _____	Alternative Investments (NFTs, Cryptocurrencies, Art, etc) $ _____	
Fixed Annuities _____			Issue Date _____
Variable Contracts _____			Issue Date _____

J. Beneficiary Information

1. Name First _____ Middle _____ Last _____ | Relationship to Policy Holder _____

Address _____ _____ ZIP _____ | Beneficiary Designation ☐ Primary ☐ Contingent

Date of Birth ____ / ____ / _____ | SSN (if known) _____ | Phone Number _____ | Percentage _____

2. Name First _____ Middle _____ Last _____ | Relationship to Policy Holder _____

Address _____ _____ ZIP _____ | Beneficiary Designation ☐ Primary ☐ Contingent

Date of Birth ____ / ____ / _____ | SSN (if known) _____ | Phone Number _____ | Percentage _____

3. Name First _____ Middle _____ Last _____ | Relationship to Policy Holder _____

Address _____ _____ ZIP _____ | Beneficiary Designation ☐ Primary ☐ Contingent

Date of Birth ____ / ____ / _____ | SSN (if known) _____ | Phone Number _____ | Percentage _____

4. Name First _____ Middle _____ Last _____ | Relationship to Policy Holder _____

Address _____ _____ ZIP _____ | Beneficiary Designation ☐ Primary ☐ Contingent

Date of Birth ____ / ____ / _____ | SSN (if known) _____ | Phone Number _____ | Percentage _____

5. Name First _____ Middle _____ Last _____ | Relationship to Policy Holder _____

Address _____ _____ ZIP _____ | Beneficiary Designation ☐ Primary ☐ Contingent

Date of Birth ____ / ____ / _____ | SSN (if known) _____ | Phone Number _____ | Percentage _____

K. Trusted Contact

Would you like to add a trusted contact to your account? ☐ Yes ☐ No If yes, provide the following information below:

Name First _____ | Middle _____ | Last _____ | Date of Birth _____/_____/_____

Address _____ _____ ZIP _____ Email _____ | Phone Number _____ | Relationship to Policy Holder _____

L. Existing Life Insurance (If applicable, fill out more than one)			
1. ☐ Term	☐ UL	☐ IUL	☐ Whole Life
Policy Owner _____		Issue Date _____	Current Annual Premium _____
Insured _____		Death Benefit _____	Cash Value _____
2. ☐ Term	☐ UL	☐ IUL	☐ Whole Life
Policy Owner _____		Issue Date _____	Current Annual Premium _____
Insured _____		Death Benefit _____	Cash Value _____
3. ☐ Term	☐ UL	☐ IUL	☐ Whole Life
Policy Owner _____		Issue Date _____	Current Annual Premium _____
Insured _____		Death Benefit _____	Cash Value _____

M. Primary Care Physician and Any Specialists You Haven Seen Within the Past 5 Years: *(For example: Cardiologists, Gynecologists, Gastroenterologists, Neurologists etc.)*

Physician Name	Phone Number	Address
1 _____	_____	_____ _____ ZIP _____
2 _____	_____	_____ _____ ZIP _____
3 _____	_____	_____ _____ ZIP _____
4 _____	_____	_____ _____ ZIP _____