



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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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): <input type="checkbox"/> IRA <input type="checkbox"/> Roth IRA <input type="checkbox"/> SEP IRA <input type="checkbox"/> 401k <input type="checkbox"/> 403b	Current Account Value	
Does your employer make contributions to your plan on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much do they contribute?	Are you maxing out yearly contributions? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

H. Account Profile		
Individual Annual Income	Spouse Annual Income	Estimated Net Worth
Investable Assets	Annual Expenses	Tax Status <input type="checkbox"/> W-2 <input type="checkbox"/> 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 _____			Beneficiary Designation <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
_____ ZIP _____			
Date of Birth ___/___/___	SSN (if known)	Phone Number	Percentage _____
2. Name First Middle Last			Relationship to Policy Holder
Address _____			Beneficiary Designation <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
_____ ZIP _____			
Date of Birth ___/___/___	SSN (if known)	Phone Number	Percentage _____
3. Name First Middle Last			Relationship to Policy Holder
Address _____			Beneficiary Designation <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
_____ ZIP _____			
Date of Birth ___/___/___	SSN (if known)	Phone Number	Percentage _____
4. Name First Middle Last			Relationship to Policy Holder
Address _____			Beneficiary Designation <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
_____ ZIP _____			
Date of Birth ___/___/___	SSN (if known)	Phone Number	Percentage _____
5. Name First Middle Last			Relationship to Policy Holder
Address _____			Beneficiary Designation <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
_____ ZIP _____			
Date of Birth ___/___/___	SSN (if known)	Phone Number	Percentage _____

K. Trusted Contact			
Would you like to add a trusted contact to your account? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information below:			
Name First	Middle	Last	Date of Birth ___/___/___
Address _____		Phone Number	
_____ ZIP _____		Relationship to Policy Holder	
Email			

L. Existing Life Insurance (If applicable, fill out more than one)		
1. <input type="checkbox"/> Term	<input type="checkbox"/> UL	<input type="checkbox"/> IUL <input type="checkbox"/> Whole Life
Policy Owner	Issue Date	Current Annual Premium
Insured	Death Benefit	Cash Value
2. <input type="checkbox"/> Term	<input type="checkbox"/> UL	<input type="checkbox"/> IUL <input type="checkbox"/> Whole Life
Policy Owner	Issue Date	Current Annual Premium
Insured	Death Benefit	Cash Value
3. <input type="checkbox"/> Term	<input type="checkbox"/> UL	<input type="checkbox"/> IUL <input type="checkbox"/> Whole Life
Policy Owner	Issue Date	Current Annual Premium
Insured	Death Benefit	Cash Value

M. Primary Care Physician and Any Specialists You Have Seen Within the Past 5 Years: <i>(For example: Cardiologists, Gynecologists, Gastroenterologists, Neurologists etc.)</i>		
Physician Name	Phone Number	Address
1 _____	_____	_____ _____ _____ ZIP _____
2 _____	_____	_____ _____ _____ ZIP _____
3 _____	_____	_____ _____ _____ ZIP _____
4 _____	_____	_____ _____ _____ ZIP _____