Risk Management Services

BUSINESS PROTECTION | EXECUTIVE COMPENSATION | GROUP INSURANCE

BUSINESS OWNER PLANNING | SUCCESSION PLANNING

Quantum Life
Powered by ORG
AN INTEGRITY COMPANY

Let us help you manage your risk

Fact Finder

thequantum.com

Key Person Insurance

Company Information

Company Name: _____

Company Structure: _____ Company Tax Bracket: _____

Employee Information

Employee Name: _____ Employee Age/DOB: _____

Gender: _____ Salary: _____ Retirement Age: _____

State of Residence:

Tobacco Use: ☐ Yes ☐ No Type of Use: _____

Employee Health Information: _____

_____

_____

_____

Employee Title: _____

Employee Job Function: _____

_____

_____

Business Disability Protections

Business Overhead Expense Plan

Business Name: _____ State: _____

Monthly Expenses

Rent, lease or mortgage: _____ Property taxes: _____

Business-related loan payments: _____ Insurance premiums: _____

Equipment leasing costs: _____ Accounting, billing, and collection fees: _____

Security and maintenance: _____ Electricity, heat and water: _____

Telephone: _____ Subscriptions and membership dues: _____

Other fixed business expenses: _____ Employee salaries: _____

Monthly Resources

Source: _____ Amount: _____

Source: _____ Amount: _____

Source: _____ Amount: _____

Business Loan Protection Plan

Loan taken for: _____ Total amount of loan: _____

Monthly loan payment: _____ Loan termination date: _____

Buy/Sell Agreement

Business Information

Business Name: _____ Business Structure: _____

Worth of Business: _____ Total Assets of Business: _____

How long is the buy/sell funding needed? _____

Is the business value expected to change? ☐ Yes ☐ No

Details: _____

_____

Conditions upon which the buy/sell agreement will become operative: _____

Death ☐ Disability ☐ Retirement ☐ Withdrawal from business ☐

Attempted sale or transfer ☐ Other ☐ Details: _____

Owner/Shareholder Information

Owner/Shareholder #1

Name: _____ Age/DOB: _____ Gender: _____

% of Business Owned: _____ Planned retirement age: _____ State of Residence: _____

Tobacco Use: ☐ Yes ☐ No Type of Use: _____

Health Information: _____

_____

_____

Buy/Sell Agreement

Owner/Shareholder #2

Name: _____ Age/DOB: _____ Gender: _____

% of Business Owned: _____ Planned retirement age: _____ State of Residence: ____

Tobacco Use: ☐ Yes ☐ No Type of Use: _____

Health Information: _____

_____

_____

Owner/Shareholder #3

Name: _____ Age/DOB: _____ Gender: _____

% of Business Owned: _____ Planned retirement age: _____ State of Residence: ____

Tobacco Use: ☐ Yes ☐ No Type of Use: _____

Health Information: _____

_____

_____

Owner/Shareholder #4

Name: _____ Age/DOB: _____ Gender: _____

% of Business Owned: _____ Planned retirement age: _____ State of Residence: ____

Tobacco Use: ☐ Yes ☐ No Type of Use: _____

Health Information: _____

_____

_____

Executive Bonus Plans

Business Information

Business Name: _____ Business tax bracket: _____

Business Structure: _____

Executive Information

Name: _____ Title/Position: _____

Age/DOB: _____ Executive tax bracket: _____ Planned retirement age: _____

State of Residence: _____ Gender: _____

Bonus amount: _____ Bonus paid until: _____

Desired death benefit amount: _____ Targeted cash flow at retirement: _____

Tobacco Use: ☐ Yes ☐ No Type of Use: _____

Health Information: _____

_____

_____

_____

Comments: _____

_____

_____

_____

_____

_____

_____

Group Benefits

Company Information

Company Name: _____ Company Structure: _____

Number of employees: _____

Benefits looking to add/review:

Health ☐ Vision ☐ Dental ☐ Life ☐

Short-term Disability ☐ Long-term Disability ☐

Current carriers: _____

_____

Please provide us with a current census of employees that includes employee:

Names _____

Social Security Numbers _____

Gender _____

Date of Hire _____

Date of Birth _____

Hours _____

Worked per Week _____

Address _____

Dependents (Name, Social Security Number, Gender, DOB and Relationship to Employee)

_____

_____

_____

We can provide a template of needed information if necessary.

Business Owner Solutions

Business Owner Information

Name: _____

Age/DOB: _____ Gender: _____

State of Residence: _____ Tobacco User? ☐ Yes ☐ No Type of use: _____

Health Information: _____

_____

_____

Supplemental Retirement Using Life Insurance

How much are you wanting to contribute? _____ Annually ☐ Monthly ☐

Contribute to age: _____ Start Income at age: _____ Number of years income: ____

How much income are you looking for? _____ Annually ☐ Monthly ☐

Fixed Indexed Annuities

Premium Amount: _____ Lump Sum? ☐ Yes ☐ No Tax Qualified? ☐ Yes ☐ No

Year to begin income: _____ Number of years income: _____

Charitable Giving

Annual contribution: _____

How much would you like to be able to give in total? _____

Business Owner Solutions

Estate Planning

Needs Assessment

Client Name: _____ Age/DOB: _____ Gender: _____

State of Residence: _____ Tobacco User? ☐ Yes ☐ No Type of use: _____

Health Information: _____

_____

_____

Current Income: _____ Outstanding personal debt: _____ Retirement Age: _____

Net Worth: _____ Existing Life Insurance Death Benefit: _____

Policy #1

Carrier: _____ Face Amount: _____ Premium: _____

Product Type: Term ☐ Year Coverage Ends: _____ Permanent ☐ Cash Value: _____

Policy #2

Carrier: _____ Face Amount: _____ Premium: _____

Product Type: Term ☐ Year Coverage Ends: _____ Permanent ☐ Cash Value: _____

Policy #3

Carrier: _____ Face Amount: _____ Premium: _____

Product Type: Term ☐ Year Coverage Ends: _____ Permanent ☐ Cash Value: _____

Number of Children: _____ Number of children expected to particpate in business: _____

Desired amount to be left for children not participating in business: _____

Business Insurance

Business Information

Company Name: _____ Tax ID #: _____

Address: _____

Year of Origin: _____ Business Type: _____

Description of Operations: _____

_____

_____

Current Coverage Information

General Liability & Property Insurance Company: _____

Expiration Date: _____ Years with current carrier: _____ Premium: _____

Automobile Insurance Company: _____

Expiration Date: _____ Years with current carrier: _____ Premium: _____

Worker's Compensation Insurance Company: _____

Expiration Date: _____ Years with current carrier: _____ Premium: _____

Please provide current declaration pages of coverage for review and comparison.

Email: quantum.org@orgcoep.com