

INSURANCE PRODUCER FEE DISCLOSURE

Date: _____

Consumer: _____
 Name
 Street Address
 City, State, Zip

Retail Producer: _____
 Name
 Insurance Agency
 Street Address
 City, State Zip
 (Area Code) Telephone Number
 License No.
 Firm No.

Services To Be Provided: Financial Planning and research and recommendation on health care, disability, long-term care and life insurance coverage. Completion of forms for medical savings account.

Date Work Is To Be Completed By: _____

Fee Schedule:	Financial Plan	\$ _____
	Research and Recommend Coverage	\$ _____
	Total	\$ _____

Fee(s) Negotiated:	Yes	No	
Type of Other Fee(s) Received (Optional):		Life Commissions	\$ _____
		Disability Commissions	\$ _____
		Long-Term Care Commissions	\$ _____

Qualifications - Occupational/ Educational Background (Optional):
 Twenty-five years as a licensed agent in all lines of insurance. Securities licensed in 1986. Designated as Certified Financial Planner 1990. Twelve years' experience in financial planning, college education in accounting and economics. Other designations include CLU and FLMI.

CLIENT ATTESTATION:
 By signing below, I acknowledge that I have reviewed the information provided in this disclosure and have received a copy of this form.

Client Signature _____ Date _____

I attest that I have disclosed all relevant facts concerning services to be provided and the fees, charges or commissions that will be charged or received for providing the services described.

Producer's Signature _____ Date _____