



# Business

solutions that meet your objectives

## Confidential Information

<input type="text"/>	Business Name	
<input type="text"/>	Client Name	
<input type="text"/>	Address	
<input type="text"/>	City	
<input type="text"/>	Province	Postal Code
<input type="text"/>	Business Phone (    )	
<input type="text"/>	eMail Address	

# General Business Data

Date 

d	d	m	m	y	y	y	y

Revised 

d	d	m	m	y	y	y	y

## 1. Form of Business

- Proprietorship
- Partnership
- Corporation  if so,
  - Private
  - Holding Company
  - Public Company
  - Operating Company
  - Other

Are there any other companies?

YES  NO

Name: \_\_\_\_\_

## 2. Does your company qualify for the small business deduction?

YES  NO

If yes, are you bonusing down to the \$200,000 level?

YES  NO

## 3. How long do you plan on keeping your business? \_\_\_\_\_ years

## 4. Are you currently doing any business/succession planning?

YES  NO

If YES, please specify in notes section

NOTES:

---

---

---

**5. Ownership**

Owner(s) Name	Percentage (%) ownership	Title

**6. Are there any family members involved with the business who are not shareholders?**

Name	Relationship	Position

**7. Does the corporation own any life insurance policies?**

Insured	Sum Insured	Annual Cost	Purpose	Date Purchased

**8. Do you offer employee benefits? Check all that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> Pension Plan                        | <input type="checkbox"/> Shared Ownership            |
| <input type="checkbox"/> Critical Illness Insurance          | <input type="checkbox"/> Life, Health, Dental        |
| <input type="checkbox"/> Retirement Compensation Arrangement | <input type="checkbox"/> Short / Longterm Disability |
| <input type="checkbox"/> Executive Compensation              |  |

**9. Are financial statements available?**

YES       NO

NOTES:

---



---



---

# Business Information

**1. What do you foresee happening to your business if an owner retires, dies, becomes disabled, suffers a critical illness, or you encounter an unresolvable disagreement?**

GIFT: YES  NO

If gift, to  
Spouse  Children  Other

SELL: YES  NO

If sell, sell to  
Partners/Shareholders  Children  Other

**If you die or become disabled prior to gifting or selling your business, who do you want to sell your interest to...?**

In the event of disability or critical illness, sell to  
Partners/Shareholders  Children  Other

In the event of death, sell to  
Partners/Shareholders  Children  Other

**2. Are these intentions expressed in a formal agreement?**

YES  NO

If yes,

Buy Sell Agreement  Partnership Agreement   
Will  Other

**3. Has the agreement been formalized and reviewed by your professional advisors?**

YES  NO

Date put in place

Date last reviewed

Date agreement signed

**4. If no, would you like to have the agreement reviewed?**

YES  NO

**5. How is your Buy Sell agreement funded?**

Cash  Bank Loan  Asset Sale  Life Insurance

Other (please specify): \_\_\_\_\_  
\_\_\_\_\_

**6. Method of Buy Sell**

Redemption  Promissory Note   
Criss-Cross  Hybrid

**7. Have you done an estate freeze?**

YES  NO

NOTES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Key Employees

1. How many employees do you have? \_\_\_\_\_

Do any of these employees stand out as being key to the success of the business?

2. If YES, please list these below

Name	Title & duties	% ownership

If you lost any of these employees, for any reason, would you try to replace them?

YES  NO

If YES, would there be a cost to replace? (i.e. recruiting and training cost)

YES  NO

If YES, please explain

---



---



---

3. Would the loss of this key employee impact any of the following?

Morale <input type="checkbox"/>	Sales & Productivity <input type="checkbox"/>
Day to day business activities <input type="checkbox"/>	Supplier Relationships <input type="checkbox"/>
Ability to attract new employees <input type="checkbox"/>	Creditor Relationships <input type="checkbox"/>
Other <input type="checkbox"/> _____	

4. Would you like an estimate of how the loss of a key person could impact your corporation?

YES  NO

# Capital Gains

1. What is the fair market value (FMV) of your business? \$ \_\_\_\_\_

2. What was the value of your business when you acquired it? \$ \_\_\_\_\_

3. Have you used any or all of the \$500,000 capital gains exemption?

YES  NO

If YES, please specify when, how much, and on what business:

---

---

4. Is the value of your business growing?

YES  by \_\_\_\_% NO

If you died prior to selling your business, where would the funds come from to pay income tax on the taxable capital gains?

Cash (savings)  Bank Loan  Asset Sale   
Life Insurance  Other

If Other, please explain:

---

---

5. Is it important to you to take advantage of the most cost-effective method of paying this tax?

YES  NO

NOTES:

---

---

---

---

---

# Other

Who are your other advisors?

Name	Profession	Address	Phone Number

## Personal Data

Date of Birth 

d	d	m	m	y	y	y	y

Smoking Status Smoker  Non-smoker

Children Name \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_

Citizenship \_\_\_\_\_

Marital Status Single  Married  Separated  Divorced

## Spousal Data

Spouse's name \_\_\_\_\_

Date of Birth 

d	d	m	m	y	y	y	y

Smoking Status Smoker  Non-smoker

If separated or divorced please provide details that impact on your business plans:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Important Information

\_\_\_\_\_  
\_\_\_\_\_

Client Signature \_\_\_\_\_

Date 

d	d	m	m	y	y	y	y

Broker Signature \_\_\_\_\_

Date 

d	d	m	m	y	y	y	y