Ronald Ryan, Certified trainer
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Gatineau, QC
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Save, close and reopen this form and fill it in or fill it out and print it in pdf format.

To erase :

CLIENT QUESTIONNAIRE 2020-2022

NAME ☐ Mr. ☐ Mrs

First name: _____

Last name: _____

NAME - SPOUSE ☐ Mr. ☐ Mrs

First name: _____

Last name: _____

IDENTIFICATION

Social Ins. Number: _____- _____- _____

Date of birth: (DD / MM / YY): ___ / ___ / ____

IDENTIFICATION - SPOUSE

Social Ins. Number: _____ -_____ -_____

Date of birth: (DD / MM / YY): ___ / ___ / ____

MARITAL STATUS

☐ Single ☐ Common-law partner ☐ Married) ☐ Separated ☐ Divorcee) ☐ Widower

If your marital status has changed during the year: Old marital status: _____

Date of the change (DD / MM / YY): ___ / ___ / _____

CONTACT DETAILS

Phone: (____) ____ - _____

Mobile Phone : (____) _____- _____

Address : _____ App. : ___

City: _____ Prov .: ___

Postal code: _____

E-mail : _____

CONTACT DETAILS - SPOUSE

Phone (____) _____-_____

Phone Mobile:(____) _____-_____ Check if the address is identical ☐

Will we process the spouse's return: ☐ YES ☐ NO

If not, give their approximate net income for the year $ _____

E-mail : _____

- Have you lived alone for all tax year? (**excluding dependents**) ☐ YES ☐ NO
- Did you move during the tax year? ☐ YES ☐ NO
- Do you own more than $ 100,000 in property abroad? ☐ YES ☐ NO
- Are you a Canadian citizen? ☐ YES ☐ NO
- Are you a non-resident of Canada for tax purposes? ☐ YES ☐ NO
- Did you buy a first home or sell your main residence? ☐ BOUGHT ☐ SOLD
- Do you want a technician to call you? ☐ NO ☐ If needed
- How would you like to receive a copy of your tax returns? ☐ ☐ E-mail ☐ In person
- Has your employer authorized you to telework due to the **COVID-19**? If so, complete the section below. ☐ YES ☐ NO

DRUG INSURANCE

Basic insurance (not complementary) covering drugs?

	month	month
Government plan (RAMQ)	From _____	at _____
My own group plan	From _____	at _____
Spouse's / parent's plan	From _____	at _____

DRUG INSURANCE - spouse

Basic insurance (not complementary) covering drugs?

	month	month
Government plan (RAMQ)	From _____	at _____
My own group plan	From _____	at _____
Spouse's / parent's plan	From _____	at _____

DEPENDENTS

☐M ☐F First name: _____ Last name: _____

Date of birth: (DD / MM / YY): ___ / ___ / ____ SIN (if assigned): _____-_____-_____

☐M ☐F Firstname name: _____

Date of birth: (DD / MM / YY): ___ / ___ / ____ SIN (if assigned): _____-_____-_____

☐M ☐F First name: _____ Last name: _____

Date of birth: (DD / MM / YY): ___ / ___ / ____ SIN (if assigned): _____-_____-_____

COVID-19 TELEWORKING

Number of days in teleworking (max 250) see example here

If you have a T2200S form, calculate the amount to which you are entitled here and enter it here