



Confidential Personal Planning
Questionnaire for Financial & Insurance

Prepared for: _____

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This fact finder serves to help identify your financial needs and priorities and may be used in developing proposed solutions consistent with your needs and objectives. In completing this fact finder, you are entrusting our organization with certain personal and confidential financial data. We recognize that our relationship with you is based on trust and we hold ourselves to the highest standards in the safekeeping and use of your confidential information. Pls send this sheet back at your earliest convenience .

Provided by:

Personal Information

	Client	Spouse
Name:	_____	_____
Date of Birth:	____/____/____	____/____/____
E-Mail Address:	_____	_____
Height/Weight:	____ft____inches/____lbs.	____ft____inches/____lbs.
Tobacco Use?:	☐ Yes ☐ No _____	☐ Yes ☐ No _____
Hazardous	☐ Yes ☐ No _____	☐ Yes ☐ No _____
Occupation?:	_____	_____

Children

	Child 1	Child 2	Child 3	Child 4
Name:	_____	_____	_____	_____
Date of Birth:	____/____/____	____/____/____	____/____/____	____/____/____

Residence information

Street Address:	_____
City, State, Zip:	_____
Home Phone No:	_____ Cell Phone No: _____
☐ Own?	Mortgage Payment: _____ Mortgage Balance: _____
☐ Rent?	Monthly Rent: _____

Professional Advisor Information

Client's Will:	Date _____	Type _____
Spouse's Will:	Date _____	Type _____
Attorney's Name:	_____	Phone No.: _____
Accountant's Name:	_____	Phone No.: _____

Employment/Income Information

	Client	Spouse
Occupation:	_____	_____
Employer:	_____	_____
Business Street Address:	_____	_____
City, State, Zip:	_____	_____
Phone Number:	_____	_____
Fax Number:	_____	_____
E-Mail Address:	_____	_____
Annual Income:	_____	_____
Other Income:	_____	_____

Financial Information

Assets

Savings _____
 Investments _____
 IRA(s) _____
 Real Estate _____
 Business Interests _____
 Personal Property _____
 Other _____
 Total Assets _____ 0
 Current Monthly Systematic Savings: _____

Liabilities

Installment Loans _____
 Mortgage(s) _____
 Charge Accounts _____
 Credit Cards _____
 Personal Notes _____
 Business Debt _____
 Other _____
 Total Liabilities _____ 0

Insurance Information

Life Insurance

Insured	Company	Policy Number	Policy Date	Face Amount	Annual Premium	Beneficiary
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Long-Term Care Insurance

Insured	Company	Policy Number	Policy Date	Daily Benefit	Benefit Period	Annual Premium
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Other Insurance

Monthly Disability Benefit: Client _____ Spouse _____
 Critical Illness Insurance Benefit: Client _____ Spouse _____
 Health Insurance: Client _____ Spouse _____
 P&C Expiration Dates: Auto _____ Homeowners _____ Other _____

Planning Priorities

	High	Medium	Low	None
Protecting Family's Lifestyle	☐	☐	☐	☐
Protecting Income	☐	☐	☐	☐
Providing Education Funds	☐	☐	☐	☐
Implementing Savings Plan	☐	☐	☐	☐
Planning for Retirement	☐	☐	☐	☐
Minimizing Estate Shrinkage	☐	☐	☐	☐
Planning for Business Continuation	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

How much do you feel comfortable setting aside on a monthly basis?: _____

Parents Information: Name & Birthdays(optional) _____



Pre-interview Worksheet if considering a Life or LTC plan

(Fill up one form per Applicant)

Doctors you have visited in the last five years, including primary care physician

Name		Specialization	
Address			
Date of visit		Reason for visit	
Treatment or test received			
Name		Specialization	
Address			
Date of visit		Reason for visit	
Treatment or test received			

Prescription and over-the-counter medications

Name	Dosage	Reason for taking	Length taken	Date last taken

Medical history

All diagnoses including but not limited to coronary conditions, cancers, diabetes, heart disease, retinopathy, hypertension, neuropathy, kidney disease, insulin reaction, urine protein/microalbumin, cerebrovascular/peripheral vascular disease.

Condition	Date of onset	Last date of treatment	Exam or test results	MD treating condition

Additional Comments or Information _____
