

INDIVIDUAL PERSONAL QUESTIONNAIRE

This confidential financial questionnaire is the first step to achieve your financial objectives and goals. Please complete the information requested, being as accurate in your answers as possible. This questionnaire is designed to help us better understand who you are and what is important to you. **This information will be held under the strictest standards of confidentiality.**

Name: _____	Home Phone: (____) ____ - _____
P.O. Box: _____	Mobile Phone: (____) ____ - _____
Street Address: _____	Years: _____
City: _____ State: _____ Zip: _____	Email: _____
Occupation: _____	Date of Birth: ____/____/____ Birth State _____
Duties: _____	Social Security: _____ - _____ - _____
Industry/Business: _____	Years: _____ or Ownership: _____%
Employer: _____	Years: _____ Hire Date ____ - ____ - ____
Address: _____	Work Phone: (____) ____ - _____
City: _____ State: _____ Zip: _____	Driver's License #: _____

Life Status: Married Single Separated Divorced Widow Domestic Partner

Spouse's Name: _____ Wedding Date ____ - ____ - ____

Occupation: _____	Date of Birth: ____/____/____ Birth State _____
Duties: --- _____	Social Security: _____ - _____ - _____
Industry/Business: _____	Years: _____ or Ownership: _____%
Employer: --- _____	Years: _____ Hire Date ____ - ____ - ____
Address: _____	Work Phone: (____) ____ - _____
City: _____ State: _____ Zip: _____	Driver's License #: _____

Children	Married	Age	Spouse's Name	State	Grandkids	Num
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

<input type="checkbox"/> Yes <input type="checkbox"/> No Is your father still alive? If Yes: Age: _____ State of Residence: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Is your spouse's father still alive? If Yes: Age: _____ State of Residence: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Is your mother still alive? If Yes: Age: _____ State of Residence: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Is your spouse's mother still alive? If Yes: Age: _____ State of Residence: _____

Personal Questions:

Do you:

- 1. have a Living Trust? Yes No
- 2. have a Will? Yes No
- 3. have financial power of attorney? Yes No
- 4. have healthcare directives? Yes No
- 5. expect to care for a:
 - a. Child Yes No
 - b. Parent Yes No
 - c. Other Yes No
- 6. expect an inheritance? Yes No
- 7. have Long Term Care protection? Yes No

Financial Future Concerns:

What most concerns you about your financial future?

Rank 1-3, with 1 as the most important.

Accumulation of Money _____

Preservation of Money _____

Distribution of Money _____

Other Concerns:

ADVISORS INFORMATION

Do you:

Who?

have a property/casualty agent? Yes No _____ Years: _____

have an investment advisor? Yes No _____ Years: _____

have an insurance consultant? Yes No _____ Years: _____

have a financial advisor? Yes No _____ Years: _____

have an attorney? Yes No _____ Years: _____

have an accountant? Yes No _____ Years: _____

have a real estate agent? Yes No _____ Years: _____

have a mortgage broker? Yes No _____ Years: _____

Does anyone else help you with your financial decisions? Yes No Years: _____

Have you ever had any problems of any kind with any advisor in the past? Yes No

If yes, please explain the situation/circumstances/outcome:

Health Questions:

Client Male Female
Height: ___ft. ___in. Weight: _____lbs.
Overall Health:
 Excellent Good Fair Poor
Ever rejected or rated for any insurance?
 No Yes Type: _____

Spouse Male Female
Height: ___ft. ___in. Weight: _____lbs.
Overall Health:
 Excellent Good Fair Poor
Ever rejected or rated for any insurance?
 No Yes Type: _____

Real Estate:

Estimated Value of Home _____
Remaining Mortgage _____
2nd Home _____
Mortgage _____
Land _____
Total Value of Real Estate _____

Sources of Monthly Retirement Income:

Social Security
You _____
Spouse _____
Pensions
You _____
Spouse _____
Other Income
You _____
Spouse _____

Collections/Collectibles: (coins, stamps, etc.)

_____ \$ _____
_____ \$ _____
_____ \$ _____
_____ \$ _____
_____ \$ _____

Bank & Credit Union Inventory:

_____ \$ _____
_____ \$ _____
_____ \$ _____
_____ \$ _____
_____ \$ _____

Certificates of Deposit:

Name of Institution	Rate	Maturity Date	Q?	Approx. Value
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____

Client Medicare Info:

Medicare Part A
Medicare Part B
Part D Company

Date Enrolled:

Spouse's Medicare Info:

Medicare Part A
Medicare Part B
Part D Company

Date Enrolled:

Annuities:

Name of Company	Maturity Date	Original Investment	Q?	Market Value
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____
_____	_____	_____	<input type="checkbox"/>	\$ _____

Life Insurance:

Insured	Name of Company	Date Established	Death Benefit	Cash Value
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

Health and Long-Term Care Insurance:

Insured	Name of Company	Date Established	Deductible	Mo. Premium
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

Disability Income Insurance:

Insured	Name of Company	Date Established	Deductible	Mo. Premium
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

Business Interests:

Nature/Name of Business Interest	% Ownership	Employees	Approx. Value
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Investments: Stocks, Bonds, Mutual Funds, Brokerage Accounts, etc.:

Name of Company	Quantity	Date Acquired	Original Investment	Q?	Market Value
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____
_____	_____	_____	\$ _____	<input type="checkbox"/>	\$ _____

Additional Coverage Owned:

- | | | | |
|---|--|----------------------|--|
| Flood Coverage: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental Coverage: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Personal Umbrella: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Coverage: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Renters Insurance: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer Insurance: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Additional Critical Illness: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Business Overhead: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prescription Coverage:
(other than Part D) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Buy/Sell Agreements: | <input type="checkbox"/> Yes <input type="checkbox"/> No |