



## FINANCIAL PLANNING SERVICES

## Financial Planning Condensed Factfinder

Please include annual amounts and provide the latest account statements.

Date											
Client/Co-Client											
Name					DOB			(	⊃ Not a U	.S. Citizen	
Name					DOB			(	O Not a U.S. Citizen		
Home Address											
Tax Filing Status:	O Single C	O Head o	of Household	O Ma	rried Filing .	lointly (	○ Marrie	d Filing Separa	ately		
Children/Dependents											
Name	Name			DOB				DOB			
Name			DOB		Name				DOB		
Income	Gross Salary		Bonus/Othe	r	Income		Gross S	alary	Bonu	s/Other	
Name	\$		\$		Name		\$		\$	\$	
	\$		\$				\$		\$	\$	
	FRA Amount (If no Receiving)/ Amou Currently Receivin	nt		Amount		COLA		Survivorship Percentage	)	Start Date	
Name		Pens	sion Income								
Name		Pens	sion Income								

Assets	Owner(s)	Purchase Price	Current Value	Property Taxes	Loan
Personal Residence					See Below
Second Residence					See Below
Rental Property					
Vehicle 1					
Vehicle 2					
Personal Assets					
Other					

Liabilities	Current Balance	Start Date	Term	Interest Rate	Payment (P & I only)	Add. Pmt.
Mortgage						
Mortgage/ HELOC						
Credit Cards						
Students Loans						
Other Loan						

Fixed Expenses	Amount	Discretionary Expenses	Amount	Discretionary Expenses	Amount
Housing (excluding mortgage)	\$ /yr	Furnishings	\$ /yr	Charity	\$ /yr
Medical	\$ /yr	Personal Care/Cash	\$ /yr	Gifts	\$ /yr
Transportation	\$ /yr	Child Care	\$ /yr	Pets	\$ /yr
Groceries	\$ /yr	Vacation	\$ /yr	Professional Services	\$ /yr
Clothing	\$ /yr	Entertainment	\$ /yr	Miscellaneous	\$ /yr
Total	\$ /yr	Total	\$ /yr	Total	\$ /yr

1	Cash Accounts	Checking	Savings/Money Markets	Money Market/CDs
	Name:	\$	\$	\$
	Name:	\$	\$	\$

Investments (e.g. 401(k), IRA, After-Tax)	Account Type	Balance	Contribution/Savings (pre-tax, post-tax, roth)	Employer Contributions (% of salary, fixed amount)
Owner:				

Group/Individual Life Insurance	Owner/Benef	Owner/Beneficiary Start Date			Type/Term		Death Benefit			Premium		C	Cash Value	
Insured:														
Insured:														
Insured:														
Group/Individual Disability Insurance	Туре		Waiting Per	riod	Bene	fit A	mount	Premium	1		Benefit	Period	C	COLA
Insured:														
Insured:														
Long Term Care		Waiti	ng Period	Benefi	t Amou	nt	Premium		Benef	fit Per	iod	Hybrid (	(If App	licable)
Insured:												Hybrid	O Li	fe O Annuity
Insured:												Hybrid	O Life O Annuity	
Property & Casualty		Тур	e			Pre	emium			Umb	rella Ins	urance		
Asset:									Coverage Amount		\$			
Asset:									Premium		\$			
Insurance/Medicare	Insured				Pre	miur	m/Contribu	tion		Ту	/pe			
Health Insurance	Name:										OMH C	O PO	S O	Medicare
T leath in sur ance	Name:									C	O PPO	O Hig	h Dedu	ıctible
Dental Insurance	Name:									C	) Basic	O Pre	mium	
Dentarinsurance	Name:	:						C	O Basic O Premium					
Healthcare Savings		Balan	ce				Contributi	ons			Wi	thdrawal	ls	
HSA														
FSA														
Estate														
Wills O Yes O	No Date Est.		Last Rev:			Po	ower Of Atto	orney: O	Yes C	O No	Date E	st.	Lá	ast Rev:
Trusts O Yes O	No Date Est.		Last Rev:			Не	ealthcare Pr	оху: О	Yes C	O No	Date E	st.	Lā	st Rev:
Do you currently have	e guardianship pro	visions	? O Yes	O No	Are you	the	guardian for	someone	else?	O Yes	o No	)		
Do you work with a CPA? O Yes O No										O Yes O No				

