



please send back to jrosner@lifeandhealthsolutions.net
all info is confidential

Confidential Personal Planning Questionnaire

Prepared for:

Provided by:

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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		Liabilities	
Savings	_____	Installment Loans	_____
Investments	_____	Mortgage(s)	_____
IRA(s)	_____	Charge Accounts	_____
Real Estate	_____	Credit Cards	_____
Business Interests	_____	Personal Notes	_____
Personal Property	_____	Business Debt	_____
Other	_____	Other	_____
Total Assets	_____	Total Liabilities	_____
Current Monthly Systematic Savings:	_____		

Insurance Information

Life Insurance						
Insured	Company	Policy Number	Policy Date	Face Amount	Annual Premium	Bene- ficiary
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
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?:	_____			

Important Information

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.

The information, general principles and conclusions presented in this report are subject to local, state and federal laws and regulations, court cases and any revisions of same. While every care has been taken in the preparation of this report, neither VSA, L.P. nor The National Underwriter Company is engaged in providing legal, accounting, financial or other professional services. This report should not be used as a substitute for the professional advice of an attorney, accountant, or other qualified professional.

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