

## GOALS

What are your three most important financial goals?

**Client:**

**Spouse:**

**A.**

**A.**

**B.**

**B.**

**C.**

**C.**

What are your three most important personal goals?

**Client:**

**Spouse:**

**A.**

**A.**

**B.**

**B.**

**C.**

**C.**

What would you like for Clement Financial Services, Inc. to help you accomplish?

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**FAMILY**

Name	Birthday	Age	Social Security Number
<b>Client :</b>			
<b>Spouse:</b>			

Children/Dependents	Live at home?	Birthday	Age	Social Security Number

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Client Cell Phone \_\_\_\_\_ Spouse Cell Phone \_\_\_\_\_

(Circle one)    Single    Married    Divorced    Widow    Anniversary Date: \_\_\_\_\_

Client Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Email \_\_\_\_\_

Employer Address \_\_\_\_\_

How long have you been with current employer? \_\_\_\_\_

Previous Occupations \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Email \_\_\_\_\_

Employer Address \_\_\_\_\_

How long have you been with current employer? \_\_\_\_\_

Previous Occupations \_\_\_\_\_

Do you have a Will/Trust? \_\_\_\_\_ When was it last reviewed? \_\_\_\_\_

Where do you attend Church? \_\_\_\_\_ How Long? \_\_\_\_\_

## INSURANCE

✓ PD if premiums are payroll deducted

### Medical Insurance

Insured	Insurance Company	Deductible Co-Pay	Type	Premium		PD
				Amount	Frequency	

### Life Insurance

Insured	Insurance Company	Face Amount / Cash Value	Type	Premium		PD
				Amount	Frequency	

What do you want your life insurance to cover? (Circle all that apply)

Survivor Income    Final Expense    Pay off mortgage    Pay off consumer debt    Fund College

### Disability Insurance

Insured	Insurance Company	Mo.Benefits/ Waiting Period	Short Term or Long Term	Premium		PD
				Amount	Frequency	

### Long Term Care Insurance / Dental / Cancer / Critical Illness

Insured	Insurance Company	Benefit/ Deductible	Type	Premium		PD
				Amount	Frequency	

### Liability Insurance

What is the liability limits on your auto policy? \_\_\_\_\_ (Example: 50,000/100,000/50,000)

What is the liability limit on you home policy? \_\_\_\_\_

Do you have a umbrella liability policy? \_\_\_\_\_ What is the limit? \_\_\_\_\_



Estimated Social Security Benefit

Client:  
 At age 62 \_\_\_\_\_  
 At age \_\_ \_\_\_\_\_

Spouse:  
 At age 62 \_\_\_\_\_  
 At age \_\_ \_\_\_\_\_

Estimated Pension Benefit

Client:  
 At age \_\_ \_\_\_\_\_  
 Cost of living adjustment \_\_\_\_\_  
 Survivor Benefit \_\_\_\_\_

Spouse:  
 At age \_\_ \_\_\_\_\_  
 Cost of living adjustment \_\_\_\_\_  
 Survivor Benefit \_\_\_\_\_

Do you plan to pay for or assist with children's college cost? Yes or No Where? \_\_\_\_\_

Please describe plan: \_\_\_\_\_  
 \_\_\_\_\_

Are you expecting an inheritance? \_\_\_\_\_ Please describe it:  
 \_\_\_\_\_  
 \_\_\_\_\_

**ASSETS**

Real Estate

Description	Creditor	% Interest	Current Value	Outstanding Loan	Minimum Payment	Pmt. You're Making

How long to you expect to live at current residence? \_\_\_\_\_ Interest Rate Fixed or Variable  
 Do you have credit life on your home mortgage? \_\_\_\_\_ Number of Years Financed \_\_\_\_\_  
 Number of Years Remaining on Mortgage \_\_\_\_\_

Vehicles


Other Assets (i.e. Boat, RV, Motorcycle, Jet ski, Livestock, etc.)


## INCOME

The following information should be taken from your payroll stub. (please bring pay stub)  
 If you are Self-Employed (skip this page) Enter income and tax information on Page 6

1 <sup>st</sup> Earner	How often do you get paid?		2 <sup>nd</sup> Earner	How often do you get paid?
	Weekly <input type="checkbox"/>			Weekly <input type="checkbox"/>
	Bi-Weekly <input type="checkbox"/>			Bi-Weekly <input type="checkbox"/>
	Semi-Monthly <input type="checkbox"/>			Semi-Monthly <input type="checkbox"/>
	Monthly <input type="checkbox"/>			Monthly <input type="checkbox"/>
	<b>Gross per Paycheck</b>	_____		<b>Gross per Paycheck</b>
D	Federal	_____	D	Federal
E	State	_____	E	State
D	Soc.Sec./FICA/OASDI	_____	D	Soc.Sec./FICA/OASDI
U	Medicare	_____	U	Medicare
C	Medical Reimbursement	_____	C	Medical Reimbursement
T	Health Ins.	_____	T	Health Ins.
I	Dental Ins.	_____	I	Dental Ins.
O	Cancer Ins.	_____	O	Cancer Ins.
N	Vision Ins.	_____	N	Vision Ins.
S	Life Ins.	_____	S	Life Ins.
	Dependent Life	_____		Dependent Life
	AD&D	_____		AD&D
	Disability ST	_____		Disability ST
	Disability LT	_____		Disability LT
	Other Ins.	_____		Other Ins.
	Retirement/401k	_____		Retirement/401k
	Savings	_____		Savings
	Stock Purchase	_____		Stock Purchase
	Loan Payment	_____		Loan Payment
	Garnishment	_____		Garnishment
	Charities	_____		Charities
	Christmas Club	_____		Christmas Club
	Fitness Center	_____		Fitness Center
	Child Support	_____		Child Support
	Child Care Reimbursement	_____		Child Care Reimbursement
	Other	_____		Other
	<b>Take Home per Paycheck</b>	_____		<b>Take Home per Paycheck</b>

### OTHER INCOME

Bonus \_\_\_\_\_  
 Child Support \_\_\_\_\_  
 Commission \_\_\_\_\_  
 Other \_\_\_\_\_

Bonus \_\_\_\_\_  
 Child Support \_\_\_\_\_  
 Commission \_\_\_\_\_  
 Other \_\_\_\_\_

# MONTHLY EXPENSES

## GIVING

Tithe/Contribution \_\_\_\_\_  
 Extra Giving \_\_\_\_\_

## CHILDCARE

Childcare \_\_\_\_\_  
 Child Support \_\_\_\_\_

## HOUSING

House Payment/Rent \_\_\_\_\_  
 Cable/Internet \_\_\_\_\_  
 Water/Trash \_\_\_\_\_  
 Electric \_\_\_\_\_  
 Gas \_\_\_\_\_  
 Propane/Wood \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Home Insurance/Taxes \_\_\_\_\_  
 Home Maintenance \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Housekeeper \_\_\_\_\_  
 Alarm System \_\_\_\_\_  
 Misc. Housing \_\_\_\_\_

## FOOD

Groceries/Sundries \_\_\_\_\_  
 Meals Out \_\_\_\_\_

## AUTO

Auto Payment 1 \_\_\_\_\_  
 Auto Payment 2 \_\_\_\_\_  
 Auto Insurance \_\_\_\_\_  
 Gasoline \_\_\_\_\_  
 Auto Maintenance \_\_\_\_\_  
 Tags/Personal Property Taxes \_\_\_\_\_  
 Car Fund \_\_\_\_\_

## MEDICAL Monthly

Doctor \_\_\_\_\_  
 Dentist \_\_\_\_\_  
 Optometry \_\_\_\_\_  
 Medicine \_\_\_\_\_

## MEDICAL Non-Monthly

Doctor \_\_\_\_\_  
 Dentist \_\_\_\_\_  
 Optometry \_\_\_\_\_  
 Medicine \_\_\_\_\_

## INSURANCE

Health \_\_\_\_\_  
 Life \_\_\_\_\_  
 Disability \_\_\_\_\_  
 Long Term Care \_\_\_\_\_  
 Misc. Insurance \_\_\_\_\_

## ENTERTAINMENT

Vacation/Trips \_\_\_\_\_  
 Camps \_\_\_\_\_  
 Spending/Entertainment \_\_\_\_\_  
 Sports/Activities \_\_\_\_\_  
 Fitness Center \_\_\_\_\_  
 Misc. Entertainment \_\_\_\_\_

## MISCELLANEOUS

Hair Care/Nails \_\_\_\_\_  
 Pets \_\_\_\_\_  
 School Lunch \_\_\_\_\_  
 Dry Cleaning \_\_\_\_\_  
 Bank Fees \_\_\_\_\_  
 Misc. \_\_\_\_\_  
 Misc. \_\_\_\_\_  
 Misc. \_\_\_\_\_

## SAVINGS

Retirement \_\_\_\_\_  
 College Savings \_\_\_\_\_  
 Misc. Savings \_\_\_\_\_  
 Uncommitted \_\_\_\_\_

## CLOTHING

Clothing \_\_\_\_\_

## GIFTS

Christmas \_\_\_\_\_  
 Gifts \_\_\_\_\_

## SCHOOLING

Tuition/Exp. (Monthly) \_\_\_\_\_  
 Tuition/Exp. (Non-Monthly) \_\_\_\_\_  
 Lessons \_\_\_\_\_

**Instructions:**

Figure each category and enter the amount into the blank.

This is a monthly spending plan therefore you need to convert all numbers to monthly amounts.

Example:

You spend \$100 a week on Groceries  
 $100 \times 52\text{wks} \div 12\text{mo} = \$433 \text{ mo.}$

You spend \$1,200 a yr. on Christmas  
 $1,200 \div 12\text{mo} = \$100 \text{ month}$

You pay \$500 a Car Insurance every 6 months  
 $500 \div 6 = \$83.33 \text{ mo.}$

