

*Your*

# FINANCIAL

*Profile*



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*In addition to this form information, please provide any or all of these types of documents to give us further insight into your finances:*

- Copies of all wills and trusts
- Previous year's tax return(s)
- Copies of recent statements from:
  - Bank Accounts
  - Investment Accounts
  - Insurance Policies
  - Annuities
- Copy of recent pay stub(s)
- Business financial statements
- Copies of employer benefit programs
  - Group Life
  - Health Insurance
  - Disability
  - Pension/Retirement Plans

# THE FACTS

This section provides us with a snapshot of your current situation, telling us where you are financially right now.

PERSONAL INFORMATION					
<b>Your Name</b>					
Birthdate		Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Residential Address					
Phone		Email			
Mailing Address (if different)					
Social Security Number					
Drivers License #		State of Issue		Expiration	
Do you have a will?		Dated			
Do you have a trust?		Dated			
<b>Your Spouse's Name</b>					
Birthdate		Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Phone		Email			
Social Security Number					
Drivers License #		State of Issue		Expiration	
Does your spouse have a will?		Dated			
Does your spouse have a trust?		Dated			

DEPENDENTS				
RELATION	NAME	BIRTHDATE	SEX	ADDRESS IF NOT AT HOME

EMPLOYMENT			
<b>Your Employer</b>			
Title		Address	
Work Phone		Work Email	
<b>Spouse's Employer</b>			
Title		Address	
Work Phone		Work Email	

INCOME					
	<i>ANNUAL AMOUNT</i>	<i>YOU/SPOUSE?</i>	<i>GUARANTEED</i>	<i>STARTS</i>	<i>ENDS</i>
Salary/Bonus			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Salary/Bonus			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Security			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Security			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pension			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pension			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other			<input type="checkbox"/> Yes <input type="checkbox"/> No		

MONTHLY LIVING EXPENSES			
Mortgage/Rent		Home Furnishings	
Property Taxes		Dental Ins. & Medical Co-Pays	
Utilities		Prescriptions	
Housing Maintenance		Life/Med/DI Insurance	
Property Insurance		Education/Self-Improvement	
Child Care/Tuition		Entertainment	
Car Payments		Vacations	
Gas/Maintenance		Charitable Contributions	
Car Insurance		Alimony/Child Support	
Food		Gifts	
Clothing		Ongoing Support Payments	
Personal Care/Cash		Miscellaneous	
Installment Payments		<b>Total Monthly Expenses:</b>	

**PROPERTY**

This section includes both real estate (primary residence, rental property, etc.) and personal property (boats, cars, valuable collections, etc.)

<i>REAL ESTATE/ PERSONAL</i>	<i>CURRENT VALUE</i>	<i>TAX BASIS</i>	<i>OWNER</i>	<i>DESCRIPTION</i>

**INVESTMENTS & SAVINGS**

Please list all investment (IRA, 401(k), brokerage, etc.) and bank (checking, savings, CDs, etc.) accounts, or simply provide your most recent account statements.

<i>ACCOUNT TYPE</i>	<i>YOU/SPOUSE/ BOTH?</i>	<i>COST BASIS</i>	<i>CURRENT VALUE</i>	<i>MONTHLY CONTRIBUTION</i>

**LIABILITIES**

<i>MORTGAGES/LOANS/ CREDIT CARD BALANCES</i>	<i>OWNER</i>	<i>INTEREST RATE</i>	<i>CURRENT BALANCE</i>	<i>MONTHLY PAYMENT</i>

**BUSINESS OWNERSHIP**

Please list all businesses owned by you and/or your spouse,  
including the structure (i.e. LLC, C or S Corp, etc.)

<i>BUSINESS NAME</i>	<i>BASE VALUE</i>	<i>TAX-BASIS</i>	<i>OWNER</i>	<i>% OWNERSHIP</i>

**INSURANCE**

Please list all insurance policies you and your spouse have,  
including life, disability, long-term care and umbrella.

<i>TYPE OF INSURANCE</i>	<i>COMPANY</i>	<i>YOU/ SPOUSE</i>	<i>FACE AMOUNT</i>	<i>ANNUAL PREMIUM</i>	<i>CASH VALUE</i>	<i>LOANS</i>

## EMPLOYEE BENEFITS

<i>YOU</i>					
Medical Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No			Monthly Cost	
Group Life Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount		Monthly Cost	
Disability Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount		Monthly Cost	
Long Term Care Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount		Monthly Cost	
Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly/Lump Sum at Age:			
Profit Sharing/401(k) (% , dollars per month, etc.)			Employer Matching %		
Other					
<i>SPOUSE</i>					
Medical Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No			Monthly Cost	
Group Life Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount		Monthly Cost	
Disability Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount		Monthly Cost	
Long Term Care Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount		Monthly Cost	
Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly/Lump Sum at Age:			
Profit Sharing/401(k) (% , dollars per month, etc.)			Employer Matching %		
Other					

## ADVISORS

Do you have durable power of attorney (health and/or financial decisions)?						
Attorney Name		Email		Phone		
Address						
Accountant Name		Email		Phone		
Address						
Does anyone else advise you on financial matters ( <i>financial advisor, a relative, friend or colleague</i> )?						

# THE FUTURE

*In this section, please tell us where you want to go:  
what are your dreams, your financial goals, and what are you hoping we can help you achieve?*

In what areas do you feel we can help you?

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## RETIREMENT

<i>YOU</i>			
At what age would you like to retire?		Are you eligible for retirement social security?	
Do you plan on working part-time or full-time in retirement?			
If yes, how much do you anticipate earning?		To age?	
<i>SPOUSE</i>			
At what age would you like to retire?		Are you eligible for retirement social security?	
Do you plan on working part-time or full-time in retirement?			
If yes, how much do you anticipate earning?		To age?	
<i>COMBINED</i>			
In today's dollars, from all sources, how much monthly income will you need to retire?			

## FAMILY

Is it important to provide your children with the opportunity to go to college?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, in today's dollars, how much do you anticipate college will cost?			
What type of college are you considering?	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Both		
Do you have a specific family member whom you/your spouse can confide in and who could assist in the event of critical financial and/or medical matters?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has a family member (or other) health care advocate been named who can speak on you/your spouse's behalf?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you/your spouse anticipate a substantial inheritance at some point?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, from whom?		Approximate Amount?	

**INVESTMENTS**

For planning purposes, what is a reasonable, long-term rate of return on your investments?										
Before retirement	%	After retirement	%							
What is a reasonable long-term inflation rate assumption?			%							
<i>PLEASE CIRCLE THE LEVEL OF IMPORTANCE OF THE FOLLOWING TO YOU IN REGARDS TO YOUR INVESTMENTS:</i>										
	<i>NOT IMPORTANT</i>				<i>VERY IMPORTANT</i>					
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
Capital preservation?	1	2	3	4	5	6	7	8	9	10
Growth?	1	2	3	4	5	6	7	8	9	10
Low volatility?	1	2	3	4	5	6	7	8	9	10
Inflation protection?	1	2	3	4	5	6	7	8	9	10
Income/Cash flow?	1	2	3	4	5	6	7	8	9	10
How much risk are you willing to take to pursue a higher return?	<i>LOW RISK</i>				<i>HIGH RISK</i>					
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>

**DISCUSSION TOPICS**

Some information requires more than simply filling out a form. Please check the box next to any of the topics below that you would like to discuss as a part of your work with me.

<input type="checkbox"/>	Proper handling of diminished mental capacity (ie. What are your expectations of your loved ones and/or advisors should that occur?)
<input type="checkbox"/>	Your financial legacy (ie. Is it your intention to spend your assets, pass on some or all to your heirs, or some other plan?)
<input type="checkbox"/>	Values or principles that you would like to see continued throughout your family’s generations

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