

**INCOME & INSURANCE INFORMATION**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

Please provide a copy of your income tax returns for the previous three years and a copy of recent pay stubs covering a full month.

**From Employment:** If paid weekly, multiply weekly income by 4.3 to arrive at a monthly gross income. If paid every two weeks, multiply two weeks' income by 2.15.

Gross Monthly Income	_____
Gross Monthly Tips/Commissions/Bonuses	_____
<b>SUBTOTAL</b>	_____

**From Self-Employment**

Gross Receipts	_____
Expenses Reimbursements	_____
Less Ordinary and Necessary Business Expenses	_____
Plus Monthly Portion of Accelerated Components of any Depreciation	_____
Allowance or Investment Tax Credits	_____
<b>SUBTOTAL</b>	_____

**Other Sources of Income:** Please attach verification of Income

Dividends	_____
Interest Income	_____
Trust Income	_____
Rental income less expenses	_____
Royalty Income	_____
Contract Payments less underlying debt	_____
Annuity Income	_____
Retirement Income - Pension, IRA, Keogh	_____
Social Security Income	_____
Workers' Compensation Benefits	_____
Unemployment Benefits	_____
Disability Income	_____
Gifts or Prizes	_____
Expense Reimbursement and/or Per Diem	_____
Allowances (not listed above)	_____
Capital Gains	_____
Spousal support/maintenance or alimony	_____
Child Support	_____
Other (please specify)	_____
<b>SUBTOTAL</b>	_____

**YOUR TOTAL MONTHLY GROSS INCOME** \_\_\_\_\_

**MONTHLY DEDUCTIONS FROM GROSS INCOME**

No of Exemptions claimed by you: \_\_\_\_\_

Federal Income Tax	_____
State Income Tax	_____
Social Security (FICA)	_____
Workers' Compensation Insurance Premium	_____
Wage withholding, wage assignment or garnishment	_____
(Paid to: _____)	_____
Medical Insurance	_____
Retirement/Profit sharing	_____
Savings Plan	_____
Credit Union	_____
Other (please specify)	_____
Cafeteria Plan	_____
<b>SUBTOTAL</b>	_____
<b>MONTHLY NET INCOME</b>	_____

**INFORMATION REGARDING MEDICAL INSURANCE**

Name of Insurance Company	_____
Plan or Group Name	_____
Plan/Group Number	_____
Individual I.D. Number	_____
Gross Monthly Premium, CURRENT	_____
Gross Monthly Premium, if only you were covered	_____
Gross Monthly Premium, you with children as Dependents	_____

**INFORMATION REGARDING DENTAL INSURANCE**

Name of Insurance Company	_____
Plan or Group Name	_____
Plan/Group Number	_____
Individual I.D. Number	_____
Gross Monthly Premium, CURRENT	_____
Gross Monthly Premium, if only you were covered	_____
Gross Monthly Premium, you with children as Dependents	_____

**INFORMATION REGARDING LIFE INSURANCE**

Name of Insurance Company	_____
Policy Number	_____
Individual I.D. Number	_____
Type of Policy: Whole/Universal/Term	_____
Death Benefit:	_____
Premium: (monthly, quarterly, or yearly?)	_____
Beneficiary/Beneficiaries	_____