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INFORMATION SHEET

NAME #1

Legal Name: ______________________________ /Signature Name: ____________________

Mr. / Mrs. / Ms. / Other: ____________________ DOB: __________________

Occupation: ________________________________ U.S. Citizen? □ Yes □ No

Cell Phone: ________________________________ E-mail: ______________________

Military Service? □ Yes □ No

NAME #2

Legal Name: ______________________________ /Signature Name: ____________________

Mr. / Mrs. / Ms. / Other: ____________________ DOB: __________________

Occupation: ________________________________ U.S. Citizen? □ Yes □ No

Cell Phone: ________________________________ E-mail: ______________________

Military Service? □ Yes □ No

Home Phone Number: ____________________________

Mailing Address: ____

City/County of Residence: _________________________

Marriage Date: ___________ First Marriage? □ Yes □ No Pre-Nup? □ Yes □No

Immediate Health Concerns: ____

Your Children

Full Legal Name	Birthdate	Male/ Female	State of Residence	Married or Single	Children

DO YOU CURRENTLY HAVE:

Financial/Insurance Advisor: ______________________________

Permission to Contact them □ No □ Yes- Phone/Email__________________

Accountant: __________________________

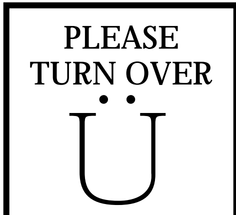
Permission to Contact them □ No □ Yes- Phone/Email__________________

Long Term Care Insurance □ YES □ NO

Umbrella Policy □ YES □ NO

Will □ YES □ NO

Trust □ YES □ NO



PLEASE DO YOUR BEST TO FILL OUT. EXACT VALUES ARE NOT NECESSARY!

ASSET INFORMATION

REAL PROPERTY	ADDRESS	OWNERS	VALUE

LIFE INSURANCE	OWNER/INSURED	BENEFICIARY	DEATH BENEFIT

RETIREMENT ACCOUNTS IRAs, 401ks, Annuities, ROTHs, TSPs	OWNER	BENEFICIARY	VALUE

OTHER ASSETS Bank Accounts/CDs, stock & mutual funds, bonds, business interests, notes held, vehicles, personal items, etc	TYPE	OWNER	VALUE
	Do you own any firearms? □ YES □ NO		

LIABILITIES Mortgage, Credit Card, etc.	

TOTAL GROSS ESTATE VALUE	$

ESTATE PLANNING QUESTIONNAIRE

What do you want to accomplish with your estate plan?

____

____

What are your fears regarding your estate plan?

____

____

Who would you want to make health care decisions for you upon your incapacity?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Who would you want to make financial decisions for you upon your incapacity/death?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Who do you want to be your beneficiary (people/charities)?

1. ____ Percentage:________
2. ____ Percentage:________
3. ____ Percentage:________
4. ____ Percentage:________
5. ____ Percentage:________

Is any beneficiary a recipient of SSI, Medicaid or Needs Based Gov't Benefits
□ YES □ NO
If Yes, please name:____