

INFORMATION SHEET

N
A
M
E
#1

Legal Name: _____ /Signature Name: _____
 Mr. / Mrs. / Ms. / Other: _____ DOB: _____
 Occupation: _____ U.S. Citizen? Yes No
 Cell Phone: _____ E-mail: _____
 Military Service? Yes No

N
A
M
E
#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 Legal Residence: _____

Marriage Date: _____ First Marriage? Yes No Pre-Nup? Yes No

Immediate Health Concerns: _____

Your Children - Please list all legal children regardless of status

Full Legal Name	DOB	Gender	State of Residence	Married or Single	# of Children	Parent

Financial/Insurance Advisor: _____ Phone/Email _____

Permission to share information with them Yes No _____

Accountant: _____ Phone/Email _____

Permission to share information with them Yes No _____

Long Term Care Insurance Yes No Umbrella Policy Yes No Will Yes No

Trust Yes No Who referred you to JGB? _____



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

ASSET INFORMATION			
<u>REAL PROPERTY</u>	ADDRESS	OWNERS	VALUE
<u>LIFE INSURANCE</u>	OWNER/INSURED	BENEFICIARY	DEATH BENEFIT
<u>RETIREMENT ACCOUNTS</u> IRAs, 401ks, Annuities, ROTHs, TSPs	OWNER	BENEFICIARY	VALUE
<u>OTHER ASSETS</u> Bank Accounts/CDs, stock & mutual funds, bonds, business interests, notes held, vehicles, personal items, etc.	TYPE	OWNER	VALUE
	Do you own any firearms? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>LIABILITIES</u> 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: _____