

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

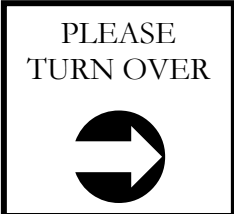
Home Phone Number: _____
Mailing Address: _____
City/County of Legal Residence: _____
Marriage Date: _____ First Marriage? Yes No Pre-Nup? Yes No
Immediate Health Concerns: _____

Your Children

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
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: _____