

**INFORMATION SHEET**

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#1

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

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#2

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

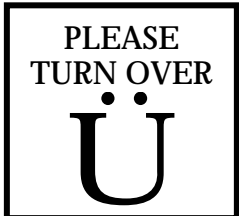
**Home Phone Number:** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_  
**City/County of Residence:** \_\_\_\_\_  
**Marriage Date:** \_\_\_\_\_ **First Marriage?**  Yes  No **Pre-Nup?**  Yes  No  
**Immediate Health Concerns:** \_\_\_\_\_

**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!

<b>ASSET INFORMATION</b>			
<b><u>REAL PROPERTY</u></b>	<b>ADDRESS</b>	<b>OWNERS</b>	<b>VALUE</b>
<b><u>LIFE INSURANCE</u></b>	<b>OWNER/INSURED</b>	<b>BENEFICIARY</b>	<b>DEATH BENEFIT</b>
<b><u>RETIREMENT ACCOUNTS</u></b>  IRAs, 401ks, Annuities, ROTHs, TSPs	<b>OWNER</b>	<b>BENEFICIARY</b>	<b>VALUE</b>
<b><u>OTHER ASSETS</u></b>  Bank Accounts/CDs, stock & mutual funds, bonds, business interests, notes held, vehicles, personal items, etc	<b>TYPE</b>	<b>OWNER</b>	<b>VALUE</b>
	Do you own any firearms? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b><u>LIABILITIES</u></b> Mortgage, Credit Card, etc.			
<b>TOTAL GROSS ESTATE VALUE</b>			<b>\$</b>

**ESTATE PLANNING QUESTIONNAIRE**

**What do you want to accomplish with your estate plan?**

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**What are your fears regarding your estate plan?**

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**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:** \_\_\_\_\_