PLANNING QUESTIONNAIRE (Married)

Please complete the following questionnaire to the best of your ability. This information is most helpful to me so that I may properly plan for you and it will be held in the strictest confidence. We will review this information at our meeting. The client is the person for whom planning is being implemented

	Business/Cellular Telephone:
E-Mail Address:	Fax Number:
Your Preferred Method of C	ommunication: E-mailTelephone (Check one.)
PA	RT A: PERSONAL INFORMATION
CONTACT PERSON: [the	e person who will accompany client(s) to meeting, if any]
Name:	
Address:	
Relationship to Client:	
Telephone Number:	
Email Address:	
HUSBAND:	
	any legal documents prepared by our office)
Full Name: (To be used on a	
Full Name: (To be used on a	
Full Name: (To be used on a Address: Social Security No.: Birth Date:	U. S .Citizen?
Full Name: (To be used on a Address: Social Security No.: Birth Date:	U. S .Citizen? no
Full Name: (To be used on a Address: Social Security No.: Birth Date: What do you want to accom	U. S .Citizen? yes no Age: Veteran? yes no plish through planning?
Full Name: (To be used on a Address: Social Security No.: Birth Date: What do you want to accom	U. S .Citizen?
Full Name: (To be used on a Address: Social Security No.: Birth Date: What do you want to accom	U. S .Citizen? yes no Age: Veteran? yes no plish through planning?
Full Name: (To be used on a Address:	U. S .Citizen? yesno Age:Veteran? yesno plish through planning?

Nur	sing Home/Assisted Living Facility/Hospital:	
	Name	
	Date of Admission:	
	Monthly Cost:	
	Monthly Prescription Cost:	
The	Nursing Home is paid through:	(month/year)
Hea	lth Issues:	
	Physical Health:	
	Mental Health:	
Any	problems:walkingdressingeatingbath memoryaggression	ning continence
1.	Do you expect to receive an inheritance or large gift? In explain	f yes, please
2.	Have you ever filed a federal gift tax return?	yesno
3.	Have you made any gifts over \$5,000 in the last 5 years?	yesno
4.	Have you had any prior marriages?	esno
5.	If so, how many?	
6.	If previously married, please list date(s) of divorce or date(s)	of death:
7.	Was there a written property settlement agreement?	s no

WIFE:

Addı	ress:					
Socia	al Security No.:	U.	. S. Citizen?		yes	no
Birth	ndate:	_ Age:	_ Veteran?	yes	no_	
Оссі	upation: (past or present) _					
Curr	ently Living:at home	assisted livi	ng facilitynu	rsing ho	me	hospital
Nurs	ing Home/Assisted Living	Facility/Hospita	1:			
	Name					
	Date of Admission:			_		
	Monthly Cost:					
	Monthly Prescription C	ost:		<u> </u>		
The	Nursing Home is paid throu	ıgh:				(month/year)
Heal	th Issues:					
	Physical Health:					
Any	Mental Health: problems: walking	dressing				
Any	Mental Health: problems: walking					
	Mental Health: problems: walking	dressing aggression e an inheritance	eating or large gift? _	_ bathin	g co	ontinence
1.	Mental Health: problems: walking memory Do you expect to receiv	dressingaggression e an inheritance	eating or large gift? _	bathin	g co	e
1.	Mental Health: problems: walking memory Do you expect to receive explain	dressing aggression e an inheritance	eating or large gift? Return?	bathin	g co	e
Any 1. 2. 3. 4.	Mental Health: problems: walking memory Do you expect to receive explain Have you ever filed a Fo	dressingaggression e an inheritance ederal Gift Tax lass over \$5,000 in	or large gift?Return?	bathin	g co	e
1. 2. 3.	Mental Health: memory Do you expect to receive explain Have you ever filed a Fellow Have you made any gift	dressing aggression e an inheritance ederal Gift Tax lass over \$5,000 in marriages?	or large gift?	If you	es, pleasno yes	e no

PART B: CHILDREN

CHILDREN'S NAMES	ADDRESS & TELEPHONE #	DATE OF BIRTH	# OF CHILDREN	# OF CHILDREN UNDER 18	MARRIED? DIVORCED? SEPARATED
Do any of	your children/grandchildren have	special need	s? yes_	no	_
Are any of	se describe: your children/grandchildren recent entitlement?	iving SSI or	other form of	yes1	no
If so, whic	h entitlement are they receiving?				
Do you ha If so, pleas	ve any predeceased children? yese indicate whether they had survi	es no_ ving children	1?		
Do any of no	your children/grandchildren have	problems wi	th drug or alo	cohol addiction	n? yes
Are any of	your children financially irrespor	nsible? yes	no		
Do any of	your children have an estate of mo	ore than \$1m	illion?		
Do any of	your children/grandchildren live v	vith you?			

PART C: HEALTH INFORMATION

HEALTH INSURANCE HUSBAND WIFE MEDICARE A: yes ____ no ___ yes ____ no ____ **MEDICARE B:** yes ____ no ____ yes ____ no ____ **MEDICARE HMO:** yes ____ no ____ yes ____ no ___ MEDICARE PART D: yes___ no ___ yes ____ no ____ Plan Name **MEDIGAP:** yes ____ no ____ yes ____ no ___ Name of Insurance Company PRIVATE INSURANCE: yes ___ no ___ yes ____ no ____ Name of Insurance Company LONG TERM CARE INSURANCE: yes ___ no ___ yes ___ no ___ Name of Insurance Company PHARMACEUTICAL PLANS: yes ____ no ____ yes ____ no ____ Name: _____ PHYSICIAN: Husband: Wife: Are you currently receiving benefits under EPIC? Husband: ves Wife: yes____ no no If you're a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? yes____ Husband: no____ Wife: yes____ no Do you wish to be an organ donor? no____ Husband: Wife: yes____ no__ yes____ Do you want a living will prepared telling your physician not to prolong your life by artificial means? Husband: Wife: yes____ yes____ no____ no____

PART D: FINANCIAL INFORMATION

Accountant: Name and Telephone Numb	er:
Average Monthly Expenses: (Estimate	ate)
Rent or Mortgage:	Real Estate Taxes:
Homeowner's Insurance:	Food:
Caretaker Expense:	Car Expenses:
Medical Expenses Including Premiums:	
Utililities:	Entertainment:
Other:	
PART E: MO	NTHLY INCOME
HUSBAND	WIFE
Net Salary or Wages	
Social Security Benefits	
Retirement Benefits	
Interest	
Dividends	
VA/Disability Benefits	
Rental Income	
Annuity Income	
Other	
there is a pension, please list the gross monthly pension overnmental entity paying the pension.	on amount and the name of the company
Gross Amount: \$Name of Company or Governmental Agency:	

PART F: PERSONAL PROPERTY/ASSETS

PLEASE PROVIDE

- DESCRIPTION OF ASSET
- NAME OF INSTITUTION
- VALUE FOR EACH ITEM
- TITLE ON ACCOUNT
- BENEFICIARY (IF APPLICABLE):

ASSETS			
	HUSBAND	WIFE	JOINT
AUTOMOBILES:			
BUSINESS INTERESTS:			
CHECKING ACCOUNTS:			
SAVINGS ACCOUNTS: and/or			
CERTIFICATES OF DEPOSIT:			

PRIMARY RESIDENCE:			
Purchase Date:			
Amount Paid:			
Current Value of Home:			
Value of Improvements:			
Balance on Mortgage:			
Intend to sell? (y/n)			
Veteran's Exemptions: (y/n)			
Senior Citizen's Exemptions: (y/n)			
STAR/Enhanced STAR Exemptions: (y/n)			
INVESTMENT ACCOUNTS:			
BONDS/BOND FUNDS STOCKS MUTUAL FUNDS:			
MUTUAL FUNDS:			
	I .	l .	

RETIREMENT ACCOUNTS:			
IRA; 401(K); 403(B);			
KEOGH; SEP			
ANNUITIES:			
OTHER REAL ESTATE:			
LIFE INSURANCE:			
OTHER:			
(i.e. copyrights, patents, mineral rights, mortgages owned by you,			
jewelry, artwork, collections, memberships)			
Do you have a safe deposit box	x? yes no	-	
If so, where is it located?			
Under whose name(s)?	?		

ADDRESS OF ANY REAL PROPERTY OTHER THAN PRIMARY RESIDENCE:

Street Address:				
City:				
State, Zip Code:				
Street Address:				
City:				
State, Zip Code:				
BURIAL				
Is it your wish to be buried or		buried	cremated	
Do you wish to include a dire	ective in your			
legal documents?		•	no	
Do you own a burial plot? Burial Plot: Location:			no	
Do you have an Irrevocable F			no	
(If so, please provide		yes	no	
Do you have a burial account		yes	no	
•		·		
	PART G: LIABIL	<u>ITIES</u>		
(Debts owed by you or your spouse, etc.)	contractual and leaseh	old obligati	ions, pending law	vsuits and claims,
Description	Name of Debt	tor	Amount	When Due
Home Mortgage				
Other Mortgage (s)				
Secured Real Property Loans				
D	N CD 1		•	W D
Description	Name of Debt	tor	Amount	When Due
Notes and accts. payable by you				
Loans on Insurance Policies				
Unsecured Promissory Notes				
General Obligations				
Other (Property Tax, Insurance, Bills)				
	TOTAL:			

PART H: GIFTS YOU HAVE MADE

	<u>Donee</u>	Date Give	<u>en</u>	Return filed?	<u>Value</u>
	_				
			<u> </u>		
			<u> </u>		-
		PART I: O	<u> </u>		
le here any or	ther information th	at you think is im	portant to you	ur legal planning	g.
	<u>P</u>	PART J: MISCE	LLANEOUS	<u>S</u>	
you have any o				_	VIFE:
ng Will?	f the following doo	cuments? H	USBAND: sno		
ng Will? Location Ith Care Proxy?	f the following dod	ye	USBAND: sno		esno
Ing Will? Location Ith Care Proxy?	f the following doo	ye ye	USBAND: sno		esno esno
Ing Will? Location Ith Care Proxy? Location ver of Attorney?	f the following dod	ye ye	USBAND: sno sno sno		esno esno
Ing Will? Location Ith Care Proxy? Location ver of Attorney?	f the following doo	ye ye	USBAND: sno sno sno		esno esno esno
Ing Will? Location Ith Care Proxy? Location ver of Attorney? Location t Will & Testame	f the following doo	ye yesn	USBAND: sno sno sno		esno esno esno
ng Will? Location Ith Care Proxy? Location er of Attorney? Location Will & Testame Date sts?	f the following dod	ye ye yesn_Location	USBAND: sno sno sno sno no		esno esno esno
Ing Will? Location Ith Care Proxy? Location ver of Attorney? Location t Will & Testame Date Sts? Location:	f the following doc	ye ye ye yesn Location	USBAND: sno sno sno sno no		VIFE: es no es no es no es no
Ing Will? Location Ith Care Proxy? Location Ver of Attorney? Location t Will & Testame Date Sts?	ent?	ye ye ye yesn Location	USBAND: sno sno sno sno		es no es no es no

PART K: IMPORTANT POINTS TO THINK ABOUT

(There are important decisions to make and to think about before your appointment. Who do you want to serve as your representative to handle the following matters? Please provide complete addresses and telephone numbers if not provided elsewhere in this questionnaire?)

Executor: (The person who carries out the terms of your will) You may have more than one person serving at a time. Name and Address: ____ Alternate #1: Alternate # 2: **Agent for Health Care Proxy:** (The person whom you would like to appoint to make health care decisions for you if you are unable to do so due to incapacity.) You may only name one person to act a time. You may also name alternates. Name, Address & Telephone: Alternate # 2: Agent for Durable Power of Attorney: (The person whom you would like to appoint to make financial and legal decisions for you in the event of your incapacity?) You may name more than one person to act at a time. You must decide whether they will act together or whether each may act separately. Name and Address: Alternate #1: Alternate # 2: Have you done any long term care planning? yes ____ no ____ Would you like to discuss ways to protect your assets from the cost of long term care? yes _____ no ____

yes _____ no ____

Would you like to discuss Long Term Care Insurance?

PART L: REFERRAL

Who referred you to this office?		
Name:		
THE ABOVE INFORMATIO KNOWLEDGE AND BELIE	N IS TRUE AND CORRECT TO THE BEST OF MY	
HUSBAND	WIFE	
DATE.	DATE.	