

## CONFIDENTIAL LEGAL PLANNING INFORMATION

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITY BEFORE OUR SCHEDULED MEETING. Not all questions will apply to you. Do your best, but don't worry if some of the information you need to complete this form is not available to you. This information will be held in the strictest confidence.

Date of scheduled initial meeting:

Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

### 1. Personal Information

Your Name: \_\_\_\_\_

Your Spouse: \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

\_\_\_\_\_

Place of birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of death: \_\_\_\_\_

Email: \_\_\_\_\_

Place of death: \_\_\_\_\_

County: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of birth: \_\_\_\_\_

U.S. citizen?: Yes  No

Place of birth: \_\_\_\_\_

Veteran?: Yes  No

SSN: \_\_\_\_\_

U.S. citizen?: Yes  No

Veteran?: Yes  No

### Marriage Information:

Date of marriage: \_\_\_\_\_

Place of marriage: \_\_\_\_\_

If your last marriage ended by divorce:

Date of divorce: \_\_\_\_\_

Place of divorce: \_\_\_\_\_

If not you, who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?: \_\_\_\_\_

**2. Children**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)? Yes  No  If yes, who?: \_\_\_\_\_  
\_\_\_\_\_

Are any of your **children** receiving Supplement Security Income, Social Security Disability; or, if not, has any major disabilities? Yes  No  If yes, who?: \_\_\_\_\_  
\_\_\_\_\_

Are any of your **grandchildren** receiving Supplement Security Income, Social Security Disability; or, if not, has any major disabilities? Yes  No  If yes, who?: \_\_\_\_\_  
\_\_\_\_\_

### **3. Resources**

**Monthly Income** (do not list interest or dividend income)

<b>Source</b>	<b>Amount</b>
Employment	
Social Security	
Other:	
Total:	

#### **A. Personal Residence**

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date acquired: \_\_\_\_\_ Purchase price: \_\_\_\_\_

Current value: \_\_\_\_\_ Tax-appraised value : \_\_\_\_\_

Mortgage company: \_\_\_\_\_

Mortgage balance: \_\_\_\_\_

#### **B. Other Real Estate**

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date acquired: \_\_\_\_\_ Purchase price: \_\_\_\_\_

Current value: \_\_\_\_\_ Tax-appraised value : \_\_\_\_\_

Mortgage company: \_\_\_\_\_

Mortgage balance: \_\_\_\_\_

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date acquired: \_\_\_\_\_ Purchase price: \_\_\_\_\_  
Current value: \_\_\_\_\_ Tax-appraised value : \_\_\_\_\_  
Mortgage company: \_\_\_\_\_  
Mortgage balance: \_\_\_\_\_

**Other Assets** (These are your bank accounts, CDs, annuities, stocks, retirement plans, and the like)

Type of asset: \_\_\_\_\_  
Name of company: \_\_\_\_\_  
Value: \_\_\_\_\_  
How is it titled: \_\_\_\_\_

Type of asset: \_\_\_\_\_  
Name of company: \_\_\_\_\_  
Value: \_\_\_\_\_  
How is it titled: \_\_\_\_\_

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Name of company: \_\_\_\_\_  
Value: \_\_\_\_\_  
How is it titled: \_\_\_\_\_

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Name of company: \_\_\_\_\_  
Value: \_\_\_\_\_  
How is it titled: \_\_\_\_\_

Type of asset: \_\_\_\_\_  
Name of company: \_\_\_\_\_  
Value: \_\_\_\_\_  
How is it titled: \_\_\_\_\_

Type of asset: \_\_\_\_\_  
Name of company: \_\_\_\_\_  
Value: \_\_\_\_\_  
How is it titled: \_\_\_\_\_

Type of asset: \_\_\_\_\_

Name of company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled: \_\_\_\_\_

**Total value of assets on this page:** \_\_\_\_\_

**List all life insurance**

Company name: \_\_\_\_\_

Owner: \_\_\_\_\_

Insured: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Death benefit (face value): \_\_\_\_\_

Cash surrender value: \_\_\_\_\_

Loan against policy (if any): \_\_\_\_\_

Company name: \_\_\_\_\_

Owner: \_\_\_\_\_

Insured: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Death benefit (face value): \_\_\_\_\_

Cash surrender value: \_\_\_\_\_

Loan against policy (if any): \_\_\_\_\_

Company name: \_\_\_\_\_

Owner: \_\_\_\_\_

Insured: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Death benefit (face value): \_\_\_\_\_

Cash surrender value: \_\_\_\_\_

Loan against policy (if any): \_\_\_\_\_

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.)

Personal Property (Item)	Value

Do you have a prepaid funeral or burial? Yes  No

If yes, describe the arrangements: \_\_\_\_\_

**Other Insurance** (Please complete the following health insurance information as it applies)

Medicare

Traditional Medicare Fee-for-Service? Yes  No

OR

Medicare HMO, PSO, PPO, Private Plan? Yes  No

Company: \_\_\_\_\_

Medicare Supplement (“Medigap”)

Company: \_\_\_\_\_

Type (Plan A through J): \_\_\_\_\_

Medicare Prescription Drug Plan

Company: \_\_\_\_\_

Employer Retiree Health Plan

Company: \_\_\_\_\_

Private Health Insurance

Company: \_\_\_\_\_

Long Term Care Insurance

Company: \_\_\_\_\_

Daily benefit amount: \_\_\_\_\_

Length of Coverage: \_\_\_\_\_

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: \_\_\_\_\_

Type: \_\_\_\_\_

Company: \_\_\_\_\_

Type: \_\_\_\_\_

Company: \_\_\_\_\_

Type: \_\_\_\_\_

**6. Gifts and Transfers**

Have you made any gifts or transfers, greater than \$500.00, to any individuals or to a trust within the last 60 months? Yes  No

If yes, please furnish the indicated information for each gift or transfer:

To whom: _____	To whom: _____
Date of gift: _____	Date of gift: _____
Item: _____	Item: _____
Value: _____	Value: _____
To whom: _____	To whom: _____
Date of gift: _____	Date of gift: _____
Item: _____	Item: _____
Value: _____	Value: _____

**7. Estate Planning**

Do you have any of the following documents?

- Durable Power of Attorney Yes  No
- Health Care Power of Attorney Yes  No
- Health Care Directive/Living Will Yes  No
- Will Yes  No
- Revocable Living Trust Yes  No

Please provide to our office your existing documents before our meeting.

Note: Please read all of the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.) We will discuss your choices at our meeting.

**Upon my death, I want to give...**

- Everything to my children in equal shares

Alternative #1

- Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age \_\_\_\_\_.

Alternative #2

- Everything to my children and to my deceased spouse's children in equal shares.

Alternative #3

- I want to make bequests different from those above. *Describe:*

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Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount
_____	_____
_____	_____
_____	_____

Please identify contingent beneficiaries in the event that those to whom you wish to leave your estate might predecease you.

Beneficiary	Item/Amount
_____	_____
_____	_____
_____	_____

Whom do you want to serve as your executor? Please give name and full addresses for a first choice, and for an alternate second choice.

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

If you were to need guardians for your children, please give name and full addresses for a first choice guardian, and for an alternate second choice.

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

## **8. Decision Making**

### ***Health Care***

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? (List in order of priority)

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

Springing versus Immediate Effectiveness: Do you want the authority of your attorney-in-fact for health care decisions (your health care agent) to be effective only upon proof of your disability as certified by your physician (“Springing”) or effective immediately?

Springing                       Immediate

Do you want to be an organ donor?      Yes  No

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference?    Yes  No

***Legal and Financial***

If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? (List in order of priority)

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone number: \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Springing versus Immediate Effectiveness: Do you want the authority of your attorney-in-fact for financial decisions to be effective only upon proof of your disability as certified by your physician (“Springing”) or effective immediately?      Springing   
Immediate

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?    Yes  No   
Don’t know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

- No restrictions, I trust my attorney-in-fact to make the right decision.
- My restrictions are: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Fiduciary/Other Legal***

I am the legally appointed guardian of: \_\_\_\_\_

I am serving as power of attorney for : \_\_\_\_\_

I am serving as executor or administrator of an estate      Yes  No

I am involved in a lawsuit      Yes  No

***Please bring to our office or mail copies of this completed questionnaire and the following documents to our office prior to meeting with Lynn St. Louis:***

1. Will, Codicil, Trust Agreements
2. Real Estate Deeds, Appraisals
3. Admission Agreements to hospitals and health facilities
4. Divorce decrees, Pre-nuptial Agreements, Adoption Papers
5. Guardianship documents
6. Living Will, Health Care Directive
7. Power of Attorney, Durable Powers of Attorney
8. A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries or your estate, helpers, and advisors
9. Retirement plans, including any forms designating beneficiaries
10. Life Insurance policies, including any forms designating beneficiaries