Personal Information Form

*** All information contained in this form is confidential and protected by attorney-client privilege. ***

Returning the completed form prior to your appointment will enable us to spend more time during the meeting to answer your questions and help you identify solutions to your concerns.

Name: ______________________________ DOB: _______________ ☐ US citizen ☐ Naturalized citizen ☐ resident alien

Occupation:____________________ ☐ retired ☐ employed Veteran ☐ Yes ☐ No Service Dates ____________________

Marital status: ☐ single ☐ widow(er) ☐ married (date _______________) ☐ first ☐ second ☐ other _____

Spouse (if applicable):________________________________ DOB:______________ DOD (if applicable)______________

☐ US citizen ☐ Naturalized citizen ☐ resident alien Occupation:____________________________ ☐ retired ☐ employed

☐ first marriage ☐ second marriage ☐ other _______ Veteran ☐ Yes ☐ No Service Dates ___________________

Address:____ City:______________________ State:________

County ___________ Zip _________ Home # ______________ Cell (you) # _______________ Cell (spouse) # ______________

Email (you) _______________________ Email (spouse) ______________________ Email (other)_______________________

Info for Primary Contact Person if not you: ____

What is the best way to contact you? ____ What is the best time?__________

Referred to us by: Name:__________________________________ Firm:__________________________________

Contacts: Financial Advisor: ___________________ Firm:___________________ Phone:___________________

Accountant: ______________________ Firm:___________________ Phone:___________________

Existing Estate Planning:	**You**		**Spouse** ☐ NA		**Date Document Executed**
Will	☐ Yes	☐ No	☐ Yes	☐ No	Date:___________________
Revocable Living Trust	☐ Yes	☐ No	☐ Yes	☐ No	Date:___________________
Power of Attorney	☐ Yes	☐ No	☐ Yes	☐ No	Date:___________________
Health Care Proxy	☐ Yes	☐ No	☐ Yes	☐ No	Date:___________________
Living Will	☐ Yes	☐ No	☐ Yes	☐ No	Date:___________________
Long-Term Care Insurance	☐ Yes	☐ No	☐ Yes	☐ No	Daily benefit:$_______Term_______

Have you transferred or given assets away in the last 60 months? Amount $________________ Date:__________

Your health status plays an important role in the designing of an estate plan best suited for you and your loved ones.

You - current health status: ☐ Good ☐ Concern ☐ Problem

Specific concern/problem:____________________________

____

Spouse - current health status: ☐ Good ☐ Concern ☐ Problem

Specific concern/problem:____________________________

____

What would completing your estate planning accomplish for you?______________________________________

____

What do you see as your biggest risk if you don't complete your estate plan?______________________________

____

Rate the level of importance to you of the following issues (1 = Low 10 = High)

_____Avoid probate

_____Keep estate matters private

_____Minimize/eliminate taxes

_____Remain independent and in control of my care and/or assets

_____Protect assets from government/lawsuits/nursing homes

_____Protect assets for family from predators after my death (i.e. my spouse's disability or remarriage, my children's/beneficiary's lawsuits, divorce or bankruptcy)

_____Keep it simple for my family when something happens to me (disability/death)

_____Provide detailed instructions and authority to people I trust to have the care I desire provided for me if I become disabled

PERSONAL/FAMILY INFORMATION

CHILDREN or BENEFICIARIES (who you want to get your "Stuff") Total # Children: ____ You ____ Spouse ____ Joint

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Child of: ☐ joint ☐ you ☐ spouse ☐ adopted ☐ Other relation __________

☐ Single ☐ Married: ☐ first ☐ second ☐ other - how long? _______ Spouse's name: __________

☐ Student ☐ Employed - Occupation:__________ Spouse's Occupation: __________

Children: ☐ none How many? _____ Names and Ages: __________

Special needs/considerations: __________

Potential problems/hardships/issues: __________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Child of: ☐ joint ☐ you ☐ spouse ☐ adopted ☐ Other relation __________

☐ Single ☐ Married: ☐ first ☐ second ☐ other - how long? _______ Spouse's name: __________

☐ Student ☐ Employed - Occupation:__________ Spouse's Occupation: __________

Children: ☐ none How many? _____ Names and Ages: __________

Special needs/considerations: __________

Potential problems/hardships/issues:__________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Child of: ☐ joint ☐ you ☐ spouse ☐ adopted ☐ Other relation __________

☐ Single ☐ Married: ☐ first ☐ second ☐ other - how long? _______ Spouse's name: __________

☐ Student ☐ Employed - Occupation:__________ Spouse's Occupation: __________

Children: ☐ none How many? _____ Names and Ages: __________

Special needs/considerations: __________

Potential problems/hardships/issues: __________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Child of: ☐ joint ☐ you ☐ spouse ☐ adopted ☐ Other relation __________

☐ Single ☐ Married: ☐ first ☐ second ☐ other - how long? _______ Spouse's name: __________

☐ Student ☐ Employed - Occupation:__________ Spouse's Occupation: __________

Children: ☐ none How many? _____ Names and Ages: __________

Special needs/considerations: __________

Potential problems/hardships/issues:__________

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Any other person or entity named in your plan (siblings, entities like churches, charities, executors, trustees or any other named person):

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Other relation: ______________________________

☐ Beneficiary ☐ Financial Agent #__ ☐ Health Agent #__ ☐ Executor #__ ☐ Trustee #__ ☐ Child's Guardian #__

Special needs/considerations: ______________________________

Potential problems/hardships/issues:______________________________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Other relation: ______________________________

☐ Beneficiary ☐ Financial Agent #__ ☐ Health Agent #__ ☐ Executor #__ ☐ Trustee #__ ☐ Child's Guardian #__

Special needs/considerations: ______________________________

Potential problems/hardships/issues:______________________________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Other relation: ______________________________

☐ Beneficiary ☐ Financial Agent #__ ☐ Health Agent #__ ☐ Executor #__ ☐ Trustee #__ ☐ Child's Guardian #__

Special needs/considerations: ______________________________

Potential problems/hardships/issues:______________________________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Other relation: ______________________________

☐ Beneficiary ☐ Financial Agent #__ ☐ Health Agent #__ ☐ Executor #__ ☐ Trustee #__ ☐ Child's Guardian #__

Special needs/considerations: ______________________________

Potential problems/hardships/issues:______________________________

Name: ______________________________ ☐ Male ☐ Female Date of Birth:__________

Address: ______________________________ Phone: __________

Other relation: ______________________________

☐ Beneficiary ☐ Financial Agent #__ ☐ Health Agent #__ ☐ Executor #__ ☐ Trustee #__ ☐ Child's Guardian #__

Special needs/considerations: ______________________________

Potential problems/hardships/issues:______________________________

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Personal Financial Information as of _______________

*** It is very important you indicate in each category <u>ownership</u> and <u>dollar amount</u> separately, as well as total value.***

TYPE OF ASSET	YOU	SPOUSE	JOINT	TOTAL
Cash, Checking, Savings, CD's, Money Market & Cash Management Accounts	$	$	$	$
Investment/Broker-held Accounts (not including cash) and Mutual Fund Accounts	$	$	$	$
Retirement Accounts: IRA, 401K, 403B, SEP, etc.	$	$	$	$
Life Insurance: death benefit and cash value	D.B. $ C.V. $	D.B. $ C.V. $	D.B. $ C.V. $	D.B. $ C.V. $
Stocks: you hold (not in brokerage accounts)	$	$	$	$
Bonds: bonds you hold (not in brokerage accounts)	$	$	$	$
Annuities: $ = original amount date=month/year purchased CV=current value	$ ______ date ____ CV ______________	$ ______ date ____ CV ______________	$ ______ date ____ CV ______________	$ ______ date ____ CV ______________
Real estate: residence (per tax bill) Is it over 2 acres? ☐ Yes ☐ No	$	$	$	$
Real estate: other	$	$	$	$
Vehicles: automobile, motorcycle, boats, snowmobiles, etc.	$	$	$	$
Other Asset:	$	$	$	$
Other Asset:	$	$	$	$
Other Asset:	$	$	$	$
Total Assets	$	$	$	$

BUSINESS INTEREST:

TYPE	YOU	SPOUSE	JOINT	TOTAL
Farm	$	$	$	$
Partnership or LLC Interest	$	$	$	$
Corporation ☐ S-Corp?	$	$	$	$
Other:	$	$	$	$
Total Value	$	$	$	$

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LIABILITIES:

TYPE	YOU	SPOUSE	JOINT	TOTAL
Mortgage	$	$	$	$
Loans Payable	$	$	$	$
Other	$	$	$	$
Total Value	$	$	$	$

MONTHLY INCOME: Use Gross Values (i.e. before taxes, etc. are deducted)

SOURCE	YOU	SPOUSE	JOINT	TOTAL
Wages	$	$		$
Pension	$	$		$
Social Security	$	$		$
Social Security Disability	$	$		$
VA Disability ______% rating	$	$		$
IRA Distribution	$	$		$
Annuity Distribution	$	$	$	$
Investment Income	$	$	$	$
Rental Property Income	$	$	$	$
Crops/Farmland Income	$	$	$	$
Business Income	$	$	$	$
Dividends	$	$	$	$
Other Income:	$	$	$	$
Other Income:	$	$	$	$
Total Income	$	$	$	$

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MONTHLY LIVING EXPENSES:

TYPE	YOU	SPOUSE	JOINT	TOTAL
Housing	$	$	$	$
Room and Board at Assisted Living	$	$	$	$
Care Costs	$	$	$	$
Health Insurance (☐ Medicare Part A ☐ Part B ☐ Supplement)	$	$	$	$
Other Medical Costs	$	$	$	$
Other	$	$	$	$
Total Expenses	$	$	$	$

Care Issues (if applicable)**:**
Where does the person receive care?

☐ Assisted Living ☐ Adult Family Home ☐ Nursing Home ☐ At Home

Facility Name: ______________________________ Date Admitted: ______________

Address: ____

Select the activities of daily living for which the person needs assistance:

☐ Bathing ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring ☐ Ambulating in home

☐ Supervision because unsafe if left alone due to mental disorder or disease

☐ Shopping ☐ Food Prep ☐ Housekeeping ☐ Laundry ☐ Finances ☐ Telephone ☐ Handling Medications ☐ Non-medical Transport

Other things you think we should know:

____

____

____

____

____

____

____

WALL GROUP LAW

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