Revised 05/17
EP - Single

Date:_____

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ESTATE PLANNING QUESTIONNAIRE

(Please Print Legibly)

CLIENT NAME: _____
First MI Last

_____
Also Known As (if any)

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

HOME ADDRESS: _____

_____

HOME TELEPHONE: _____ CELL:_____

EMAIL: _____

OCCUPATION: _____

EMPLOYER NAME: _____

ADDRESS: _____

WORK TELEPHONE: _____

CHILDREN (if any):

CHILD #1

Name

Address

Age DOB Marital Status

Born of this Marriage or prior Marriage?

CHILD #2

Name

Address

Age DOB Marital Status

Born of this Marriage or prior Marriage?

CHILD #3

Name

Address

Age DOB Marital Status

Born of this Marriage or prior Marriage?

CHILD #4

Name

Address

Age DOB Marital Status

Born of this Marriage or prior Marriage?

CHILD #5

Name

Address

Age DOB Marital Status

Born of this Marriage or prior Marriage?

GRANDCHILDREN (if any):

GRANDCHILD #1

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #2

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #3

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #4

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #5

Name

Address

Age DOB Marital Status

Name of Parent

ARE ALL YOUR CHILDREN AND GRANDCHILDREN IN GOOD HEALTH? Yes___No___

ARE ANY OF YOUR CHILDREN OR GRANDCHILDREN RECEIVING SSI OR OTHER FORM OF GOVERNMENT ASSISTANCE? Yes_____ No_____

HAVE YOU EVER BEEN MARRIED? Yes_____ No_____
If yes, please list any applicable date(s) and method of termination (death, divorce, annulment) of prior marriages, including names of former spouse(s): _____

IF DIVORCED, indicate whether you entered any property settlement agreements with a former spouse.

_____

ARE YOU A UNITED STATES CITIZEN? Yes_____ No_____
If no, please indicate country of citizenship: _____

ARE YOU IN GOOD HEALTH? Yes_____ No_____
If no, please indicate the diagnosis of your ailment(s): _____
_____

DO YOU HAVE LONG TERM CARE INSURANCE? Yes _____ No _____
If so, please indicate from which company, what the monthly or daily benefit is and the terms:

_____

_____

ARE YOU A VETERAN OF THE UNITED STATES ARMED FORCES? Yes____ No____

IF YOU ARE A VETERAN, ARE YOU RECEIVING TRI-CARE? Yes____No____

HOW WERE YOU REFERRED TO OUR FIRM? _____

PLEASE LIST NAME, ADDRESS AND TELEPHONE NUMBER OF THE FOLLOWING:

Family/Corporate Attorney _____

Accountant _____

Financial Planner/Broker _____

Banker _____

Insurance Agent _____
Homeowners

_____
Auto

_____
Life

Assets: Name:_____

Date: _____

NON-RETIREMENT ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	✓ if None	In Your Name Only	In Your Name - With Beneficiary listed or (POD) or ITF (In Trust For)	Joint with Someone Else	Loans/Mortgages against - liabilities
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD					
CD					
CD					
Residence					
Other Real Estate					
(State: _____)					
(State: _____)					
Time Shares					
Businesses					
(Name: _____)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS		$0	$0	$0	$0

Assets: Name:_____

Date: _____

RETIREMENT (TAX-QUALIFIED) ASSETS (Fill in Amounts/Values)					
	✓ if None	OWNER	INSURED / ANNUITANT	BENEFICIARY	VALUE/DEATH BENEFIT
IRA'S (including rollovers)					
401(K)					
403(b)					
TIAA/CREF					
Savings Plans					
Qualified Annuities					
NON-QUALIFIED ANNUITIES					
TOTALS					$0

DO YOU HAVE A POWER OF APPOINTMENT IN A TRUST CREATED BY ANOTHER PERSON OR IN ANOTHER PERSON'S ESTATE? _____Yes _____No

Assets:

Name:_____

Date: _____

LIFE INSURANCE

INSURED	COMPANY	POLICY #	WHOLE LIFE OR TERM?	FACE VALUE	CASH SURRENDER VALUE	DEATH BENEFIT