

**** Confidential Planning Information (for Married Couple) ****

Your appointment with us is _____

These questions pertain to the persons (the married couple) for whom we are planning. Please do your best, but do not worry if you don't have all of the information. Please call us if you need help.

Date: _____

Referred by: _____

1. Personal Information

Spouse 1

Spouse 2

Name: _____

Address: _____

County: _____

Phone: _____

Email: _____

Birth date: _____

Birth place: _____

SSN: _____

SSN: _____

US citizen?: Yes No **Prior Claims?:**

Yes No **Prior Claims?:**

Veteran?: Yes No Yes No

Yes No Yes No

Dates of service: _____

Dates of service: _____

Branch of service: _____ If

Branch of service: _____

yes to Veteran, complete page 7

If yes to Veteran, complete page 7

Spouse's maiden name: _____ Date and place of marriage: _____

2. Will you be the primary contact? Yes No **If no, Who?** _____

Your primary contact person(s): Landline Cell Text Email Mail Fax Other _____

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Email: _____

Email: _____

| Place Where You Live | Spouse1:When? | Spouse2:When? |
|--|---------------|---------------|
| Single-family home or apartment | | |
| Same, but you need assistance | | |
| Name of Independent living community: | | |
| Name of Assisted-living or memory care facility: | | |
| Name of Nursing home: Facility Name: | | |
| Other: | | |

List all legal children – adopted, living, deceased, step and estranged

3. Children

| | |
|----------------|----------------|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| DOB: _____ | DOB: _____ |
| Phone: _____ | Phone: _____ |
| Email: _____ | Email: _____ |
| Spouse: _____ | Spouse: _____ |

| | |
|----------------|----------------|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| DOB: _____ | DOB: _____ |
| Phone: _____ | Phone: _____ |
| Email: _____ | Email: _____ |
| Spouse: _____ | Spouse: _____ |

| | |
|----------------|----------------|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| DOB: _____ | DOB: _____ |
| Phone: _____ | Phone: _____ |
| Email: _____ | Email: _____ |
| Spouse: _____ | Spouse: _____ |

a. Do you have any dependents (someone who depends on you, in whole or in part, for their support)?

Yes No If yes, who?: _____

b. Are any of your children or other family members receiving Supplement Security Income, Social Security Disability; or, whether or not receiving any benefits, is blind or has any major disabilities?

Yes No If yes, who?: _____

4. Information About Your Health (Spouse 1)

a. What medical or health problems do you currently have?

b. What medical problems have you had in the past?

c. When were you last in the hospital, and why?

d. Please attach a list of the drugs you are currently taking to this workbook (or list them below).

5. Important Contact Information (Spouse 1)

| Your Primary Care Physician | Your Financial Advisor/Broker |
|-----------------------------|-------------------------------|
| Name: _____ | Name: _____ |
| Specialty: _____ | Company: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone: _____ | Phone: _____ |
| Email: _____ | Email: _____ |
| _____ | _____ |

6. Information About Your Health (Spouse 2)

a. What medical or health problems do you currently have?

b. What medical problems have you had in the past?

c. When were you last in the hospital, and why?

d. Please attach a list of the drugs you are currently taking to this workbook (or list them below).

7. Important Contact Information (Spouse 2)

| Your Primary Care Physician | Your Financial Advisor/Broker |
|-----------------------------|-------------------------------|
| Name: _____ | Name: _____ |
| Specialty: _____ | Company: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone: _____ | Phone: _____ |
| Email: _____ | Email: _____ |
| _____ | _____ |

8. Resources—Failure to disclose assets could completely change the parameters of your plan, therefore it is imperative you disclose everything in writing.

a. ALL Monthly GROSS Income (SS, VA, pension, employment, and rental)

| Source | Spouse 1 | Spouse 2 |
|------------------|----------|----------|
| Social Security: | | |
| Pension: | | |
| Other: | | |
| Other: | | |
| Total: | | |

b. Real Estate (please bring your deeds with you for us to copy)

| Address | Owner(s) | Tax Value | Mortgage | Date Acquired |
|---------|----------|-----------|----------|---------------|
| | | | | |
| | | | | |

c. All Other Assets: Bank accounts, CDs, annuities, stocks, retirement plans, and the like

| Type of Asset | Company Name | How Is It Titled? | Beneficiary | Value |
|---------------|--------------|-------------------|-------------|-------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

d. Life Insurance (including any policies through your employer)

| Policy Details | Policy 1 | Policy 2 | Policy 3 |
|------------------------------|----------|----------|----------|
| Company name | | | |
| Policy owner | | | |
| Insured | | | |
| Beneficiary | | | |
| Death benefit (face value) | | | |
| Current cash value (if any) | | | |
| Loan against policy (if any) | | | |

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

| Personal Property (Item) | Value |
|--------------------------|-------|
| | |
| | |
| | |

9. Health Insurance and Long-Term Care Insurance

| a. Health Insurance | Spouse 1 | Spouse 2 |
|--|--------------------------|--------------------------|
| Traditional Medicare | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicare Supplemental Insurance | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicare Advantage Plan (e.g. Healthsprings) | <input type="checkbox"/> | <input type="checkbox"/> |
| Retiree Health Insurance | <input type="checkbox"/> | <input type="checkbox"/> |
| TRICARE for Life | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please describe) | <input type="checkbox"/> | <input type="checkbox"/> |

b. Long-Term Care Insurance Name of Company: _____
 Spouse 1: Yes No Length of Policy: _____
 Spouse 2: Yes No Benefit Amount: _____

Bring summary of coverage for all policies

10. Final Arrangements

Prepaid funeral, burial, cremation? Spouse 1: Yes No / Spouse 2: Yes No

11. Estate Planning: *If you have estate planning documents, please bring them with you to the meeting.*

| Do you have any of the following documents? | Spouse 1 | Spouse 2 |
|--|--|--|
| Durable Power of Attorney Name of your Agent: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Health Care Power of Attorney/Advance Care Plan Name of your Health Care Agent: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Will - Name of your Executor | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Revocable Living Trust – Name of your Trustee | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

12. Gifts and Transfers

Have either of you given away any money or property within the past 60 months? Yes No

If Yes, what did you give away, when, and to whom?:

13. Checklist of things to bring with you.

- Durable Power of Attorney
- Healthcare Power of Attorney/Advance Directive/Living Will
- Will/Handwritten Will
- Trust (Revocable or Irrevocable) and any amendments
- DD214 (any and all Veterans papers)
- Deed(s) to your property (all)
- Long Term Care Insurance Policy
- Other: _____

Addendum

Military Service Information:

- Branch of Service: _____
- Dates of Service (Month/Year if possible):
 - Entered active service: _____
 - Released from active service: _____
- Type of Discharge: _____
 - If discharge is not an Honorable Discharge, please describe in note field below the circumstances surrounding the discharge.
- Did you retire from military service (Y/N): _____
- Were you medically separated or discharged (Y/N): _____
- Did you serve in Vietnam or in the territorial waters (12 nautical miles) of Vietnam (Y/N): _____
- Were you ever exposed to atomic bomb testing (Y/N): _____ * (“Oath of secrecy” that atomic veterans were required to take has been rescinded by the 1996 repeal of the Nuclear Radiation Secrecy Agreement Act; veterans are free to discuss their participation in atomic testing)
- Did you serve in the Korean DMZ area (Y/N): _____

Veterans Administration Information:

- Have you previously filed a claim with the VA (Y/N): _____
- Do you have any currently pending claims with the VA (Y/N): _____
- Have you, or anyone on your behalf, filed an “intent to file” form with the VA (Y/N): _____
- Did you suffer any physical or mental injuries during your military service (Y/N): _____
 - If yes, please describe: _____
- Do you have a service connected rating with the VA (Y/N): _____
 - If yes, what is your current rating (%): _____
 - If yes, how long have you had this current rating (years): _____
 - If yes, when did you receive your initial rating (year): _____
- Do you currently have an individual appointed as your VA representative (Y/N): _____

Checklist Items:

- Copy of DD-214
- Military Medical records related to any service-connected injuries
- Official Military Personnel File (OMPF) ** (If you don't have this, you can request it, medical records and a copy of your DD-214 at this website:
<https://vetrecs.archives.gov/VeteranRequest/home.html#BasicInformation>)

Notes:
