

PERSONAL INFORMATION

(Please Print)

Client # 1

Date Completed _____

Full Legal Name _____

How you sign your name on legal documents _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Position _____ Business Telephone (____) _____

Business address _____ City _____ State _____ Zip _____

Married: _____ Divorced: Date _____ Widowed: Date _____ Single

U.S. Citizen Lived in the following states: CA, WA, NV, AZ, NM, TX, ID, LA or WI

Client # 2

Full Legal Name _____

How you sign your name on legal documents _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Position _____ Business Telephone (____) _____

Business address _____ City _____ State _____ Zip _____

Married: Date _____ Divorced: Date _____ Widowed: Date _____ Single

U.S. Citizen Lived in the following states: CA, WA, NV, AZ, NM, TX, ID, LA or WI

CHILDREN'S INFORMATION

Child # 1

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special
Needs _____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 2

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special
Needs _____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 3

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special
Needs _____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 4

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special
Needs _____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 5

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special
Needs _____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 6

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special
Needs _____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Do any of your children have any mental or physical disabilities?

YES NO

If so, please indicate the name of the child and describe the physical or mental disabilities:

**Do any of your children have any dependency addiction issues
(gambling, drugs, etc)?**

YES NO

If so, please summarize issues here naming child(ren) so effected.

Do you have any pets? YES NO

If yes, please list names, ages and type of animal.

OTHER DEPENDENTS

Friends or relatives who are dependents.

Dependent # 1

Dependent's Full Legal Name _____

Relationship: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email: _____ Cell Phone: _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Dependent # 2

Dependent's Full Legal Name _____

Relationship: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Email: _____ Cell Phone: _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

PROFESSIONAL ADVISORS

Name of CPA: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Financial Advisor: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Family Attorney: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Stock Broker: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Life Insurance Agent: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Personal Banker: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

IMPORTANT FAMILY QUESTIONS

Please Check “Yes” or “No” for Your Answer	YES	NO
Do you have a child with a learning disability?		
Do any of your children receive governmental support or benefits?		
Do you have any adopted children?		
Are any of your children institutionalized?		
Are you or your spouse receiving social security, disability, or other governmental benefits?		
Do you provide primary or other major financial support to adult children?		
Have either you or your spouse been divorced?		
Are you making payments pursuant to a divorce or property settlement agreement? (Please furnish a copy.)		
Have you and your spouse ever signed a pre- and/or post-marriage contract? (Please furnish a copy.)		
Have you or your spouse been widowed? (If a Federal estate tax or State death tax return was filed, please furnish a copy.)		
Have you or your spouse ever filed Federal or State gift tax returns? (Please furnish a copy.)		
Have you or your spouse completed previous Health Care Powers of Attorney or Living Wills? (Please furnish copies.)		
Have you or your spouse completed previous wills, trusts, or estate planning? (Please furnish copies.)		

IMPORTANT FAMILY QUESTIONS *Continued*

Are you concerned about who will handle your affairs should you become disabled?		
Are you concerned about your loved ones' abilities to handle any future inheritance?		
Do you have any concerns over your children's creditors or liabilities?		
Do you own or have any rental property?		
Do you own any real estate outside of New Hampshire? If yes, where is the property located?_____		
Are you or your spouse beneficiaries or trustees of any trust?		
Do you or your spouse have a power of appointment under any trust?		
Do you or your spouse anticipate receiving an inheritance? If yes, estimate the size of the inheritance_____		
Are you (Client #1) a United States citizen?		
Is your spouse (Client #2) a United States citizen?		
Client #1, if you answered "NO," are you a resident or a non-resident alien?		
If Client #2, if you answered "NO," are you a resident or a non-resident alien?		
Client #1, do you have any pets that you would like to arrange to be cared for in the event of your disability or death?		
Client #2, do you have any pets that you would like to arrange to be cared for in the event of your disability or death?		

MEDICAL PROFESSIONALS

Please indicate the name, address and telephone number of your current attending physicians. We need this information for your Docubank application to insure your directives are available when they are needed.

Client #1
Name of Doctor:
Address:
City, ST, Zip:
Telephone:
Fax:

Client #2
Name of Doctor:
Address:
City, ST, Zip:
Telephone:
Fax:

VETERAN STATUS

Please indicate your status below.	Yes	No
Are you (Client #1) a Veteran?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Spouse (Client #2) a Veteran?	<input type="checkbox"/>	<input type="checkbox"/>
Are any of your children Veterans?	<input type="checkbox"/>	<input type="checkbox"/>

PROPERTY INFORMATION

CASH ACCOUNTS

TYPE: Checking Account "CA" ♦ Savings Account "SA" ♦ Certificate of deposits "CD" ♦ Safety Deposit Box "SD". (*Indicate type below.*)

Name of Institution and Branch	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Institution and Branch	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Institution and Branch	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Institution and Branch	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Institution and Branch	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Are any funds electronically deposited or withdrawn from any of the above accounts (such as social security or mortgage)?
 Yes No

Are you named as a co-owner on any accounts owned by someone else (i.e. parents, siblings, grandchildren, etc.)?
 Yes No

Note: If Account is in your name (or your spouse's name) for the benefit of a minor, please specify and give minor's name.

INVESTMENT ACCOUNTS

• IRAs and Annuities should be listed later •

TYPE: Money market “MM” ♦ Investment “I” ♦ Cash Management “CM” ♦ Or other account that is in a street name. (*Indicate type below.*)

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		

Are any funds electronically deposited or withdrawn from any of the above accounts?
 Yes No

Are you named as a co-owner on any accounts owned by someone else (i.e. parents, siblings, grandchildren, etc.)?
 Yes No

Note: If Account is in your name (or your spouse’s name) for the benefit of a minor, please specify and give minor’s name.

STOCKS

Please indicate any **stock certificates** that are in your possession. Stock owned in family business or non-publicly-traded company should be listed under “Corporate Business and Professional Interests.” Stocks held in a **street name** or **investment account** should be listed under “Investment Accounts” (*above*).

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____ Phone: _____			

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____ Phone: _____			

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____ Phone: _____			

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____ Phone: _____			

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____		Phone: _____	

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____		Phone: _____	

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company: Name: _____			
Address: _____		Phone: _____	

Are any of the above referenced stock pledged as collateral on any loans? Yes No

Are you named as a co-owner on any stock owned by someone else (i.e. parents, siblings, grandchildren, etc.)? Yes No

BONDS

TYPE: US Savings Bonds

Corporate Bonds ♦ Municipal Bonds ♦ Treasury Bills (*Indicate type below.*)

Type	Owner	Face Value

PERSONAL EFFECTS

TYPE: Major personal effects such as motor vehicles, boats, and all other valuable non-business personal property. *(Indicate type below and give a lump sum value for miscellaneous items.)*

Year/Make/Model or Type	Owner	Value	Is there a lien against the asset?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTO INSURANCE

Name of Car Insurance Agent _____			
Policy # _____			
Company _____			
Address _____	City _____	State _____	Zip _____
Phone # _____	Fax # _____	E-Mail _____	

RETIREMENT PLANS

TYPE: Profit Sharing (PS) ♦ H.R. 10 ♦ IRA ♦ SEP ♦ 401(k) *(Indicate type below.)*

Company Name	Type of Plan	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Type of Plan	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Type of Plan	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Type of Plan	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Type of Plan	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				

PENSION PLANS

Company Name	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____
Address: _____		Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Company Name	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____
Address: _____		Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Company Name	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____
Address: _____		Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Company Name	Beneficiary Upon Your Death	Owner	Value
_____	_____	_____	_____
Address: _____		Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

LIFE INSURANCE POLICIES

TYPE: Term ♦ Whole life ♦ Variable or Universal life ♦ Split dollar ♦ Group life ♦ Second-To-Die *(Indicate type of policy below. If a corporation or company owns the policy or pays the premium on the policy, write "Corporation")*.

Company Name	Insured	Policy #	Owner	Type of Policy	Face Amount	Cash Value
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____			

Company Name	Insured	Policy #	Owner	Type of Policy	Face Amount	Cash Value
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____			

Company Name	Insured	Policy #	Owner	Type of Policy	Face Amount	Cash Value
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____			

Company Name	Insured	Policy #	Owner	Type of Policy	Face Amount	Cash Value
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____			

Are any of the above referenced insurance policies pledged as collateral on any loans? Yes No

LONG TERM CARE INSURANCE POLICIES

Company Name	Insured	Policy #	Owner	Elimination Period	Daily Benefit	Coverage Period
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____						

Company Name	Insured	Policy #	Owner	Elimination Period	Daily Benefit	Coverage Period
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____						

Company Name	Insured	Policy #	Owner	Elimination Period	Daily Benefit	Coverage Period
_____	_____	_____	_____	_____	_____	_____
Address: _____			Phone: _____		Agent: _____	
Primary Beneficiary: _____						

ANNUITIES

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$ _____	\$ _____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$ _____	\$ _____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$ _____	\$ _____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$ _____	\$ _____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		

Are you receiving any regular distributions from any annuity contracts? Yes No

If "yes," do the distributions have "survivorship" or "period certain" provisions? Yes No
 Survivorship Period Certain

MONIES OWED TO YOU

TYPE: Promissory notes payable to you ♦ Other monies owed to you
(Please provide a copy of any promissory notes.)

Name of Debtor	Date Due	Owed To	Current Balance	Promissory Note
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

PARTNERSHIP & LLC INTERESTS

TYPE: General and Limited Partnerships. Please list the percentages that you own.
(Please provide a copy of the Partnership Agreement.)

<p>Name of Partnership or LLC _____</p> <p>Owners _____ Value _____</p> <p>Who holds Partnership or LLC papers _____ Phone: _____</p> <p>Is this a "Professional" Partnership or LLC? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Entity Type: <input type="checkbox"/> General Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Limited Liability Company</p> <p>Name of General Partner or Managing Member _____</p>

<p>Name of Partnership or LLC _____</p> <p>Owners _____ Value _____</p> <p>Who holds Partnership or LLC papers _____ Phone: _____</p> <p>Is this a "Professional" Partnership or LLC? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Entity Type: <input type="checkbox"/> General Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Limited Liability Company</p> <p>Name of General Partner or Managing Member _____</p>

CORPORATE BUSINESS INTERESTS

TYPE: Privately owned (non-publicly traded) stock.

(Please provide a copy of your Corp. book and any Buy/Sell agreements, if applicable.)

Company _____	Address _____	Phone: _____
Number of Shares _____	% of Ownership _____	
Owner _____	Value _____	
Is there a Buy/Sell Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this an "S-Corporation" <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a "Professional" Corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Company _____	Address _____	Phone: _____
Number of Shares _____	% of Ownership _____	
Owner _____	Value _____	
Is there a Buy/Sell Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this an "S-Corporation" <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a "Professional" Corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Company _____	Address _____	Phone: _____
Number of Shares _____	% of Ownership _____	
Owner _____	Value _____	
Is there a Buy/Sell Agreement <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this an "S-Corporation" <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a "Professional" Corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SOLE PROPRIETORSHIP INTERESTS

TYPE: All assets owned by you in a sole proprietorship type of business.

Name of Business	Description of Business	Owner	Value
_____	_____	_____	_____
Is this a "Professional" Business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Business Insurance Agent _____ Phone _____ Policy # _____			
Address _____ City _____ State _____ Zip _____			

Name of Business	Description of Business	Owner	Value
_____	_____	_____	_____
Is this a "Professional" Business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Business Insurance Agent _____ Phone _____ Policy # _____			
Address _____ City _____ State _____ Zip _____			

OIL, GAS, AND MINERAL INTERESTS

TYPE: Lease ♦ Overriding royalty ♦ Fee mineral estate ♦ Working interest ♦ Pooling agreement, etc. *(Please provide copy of Agreement, Certificate, or Deed.)*

Company_____	Type_____	Name_____
Address_____	City_____	State_____ Zip_____
County_____	Phone #_____	
Owner_____	Value_____	

Company_____	Type_____	Name_____
Address_____	City_____	State_____ Zip_____
County_____	Phone #_____	
Owner_____	Value_____	

ANTICIPATED INHERITANCE, GIFT, OR LAWSUIT JUDGMENT

TYPE: Gifts or inheritances that you expect to receive at some time in the future; or monies that you anticipate receiving through a judgment in a lawsuit.

Description	Value
_____	_____
_____	_____

REAL PROPERTY

TYPE: Land ♦ Buildings ♦ Homes ♦ Time shares. TYPE OF OWNERSHIP: Joint Tenants with survivorship rights (JTWROS) ♦ Tenants in common (TC) ♦ Tenancy by the entireties (TBE) *(Please provide a copy of the Deed or Agreement relating to each property.)*

PROPERTY 1.

	Owner	Mortgage Amount	Fair Market Value
Address _____			
City _____ State _____ Zip _____	_____	_____	_____
County _____			
Property Tax Map/Lot Numbers (please provide tax bill) Map _____ Lot _____			
Do you have a mortgage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lender _____	Loan # _____		
Address _____			
Home Insurance Agent _____	Phone _____		
Company _____	Policy # _____		
Address _____	City _____	State _____	Zip _____
What year did you buy this property? _____	How much did you pay? _____		
Please provide a copy of your Title Insurance Policy			

PROPERTY 2.

Address _____	Owner	Mortgage Amount	Fair Market Value
City _____ State _____ Zip _____	_____	_____	_____
County _____			
Property Tax Map/Lot Numbers (please provide tax bill) Map _____ Lot _____			
Do you have a mortgage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lender _____	Loan # _____		
Address _____			
Home Insurance Agent _____	Phone _____		
Company _____	Policy # _____		
Address _____	City _____	State _____	Zip _____
What year did you buy this property? _____ How much did you pay? _____			
Please provide a copy of your Title Insurance Policy			

PROPERTY 3.

Address _____	Owner	Mortgage Amount	Fair Market Value
City _____ State _____ Zip _____	_____	_____	_____
County _____			
Property Tax Map Lot Numbers (please provide tax bill) Map _____ Lot _____			
Do you have a mortgage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lender _____	Loan # _____		
Address _____			
Home Insurance Agent _____	Phone _____		
Company _____	Policy # _____		
Address _____	City _____	State _____	Zip _____
What year did you buy this property? _____ How much did you pay? _____			
Please provide a copy of your Title Insurance Policy			

PROPERTY 4.

Address _____	Owner _____	Mortgage Amount _____	Fair Market Value _____
City _____ State _____ Zip _____	_____	_____	_____
County _____			
Property Tax Map Lot Numbers (please provide tax bill) Map _____ Lot _____			
Do you have a mortgage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lender _____	Loan # _____		
Address _____			
Home Insurance Agent _____	Phone _____		
Company _____	Policy # _____		
Address _____	City _____	State _____	Zip _____
What year did you buy this property? _____ How much did you pay? _____			
Please provide a copy of your Title Insurance Policy			

PROPERTY 5.

Address _____	Owner _____	Mortgage Amount _____	Fair Market Value _____
City _____ State _____ Zip _____	_____	_____	_____
County _____			
Property Tax Map Lot Numbers (please provide tax bill) Map _____ Lot _____			
Do you have a mortgage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Lender _____	Loan # _____		
Address _____			
Home Insurance Agent _____	Phone _____		
Company _____	Policy # _____		
Address _____	City _____	State _____	Zip _____
What year did you buy this property? _____ How much did you pay? _____			
Please provide a copy of your Title Insurance Policy			

OTHER ASSETS

TYPE: Any property you own that does not fit into any other listed category.

Description	Owner	Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CEMETERY LOTS

Description	City State	Owner	Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DESIGN INFORMATION

DISPOSITION OF ESTATE

What are your general desires as to the disposition of your estate?

Who would you like to be the beneficiaries of your estate?

Is there anyone in your family that you specifically do NOT want to receive anything from your estate? YES NO

If not, whom?

Have you thought about distributions to the beneficiaries? YES NO
If so, how would you like to make distributions to the beneficiaries?

(If any grandchildren) Have you considered leaving anything to grandchildren? (If yes) Please describe how you want to leave assets to your grandchildren:

CHARITABLE GIVING

Have you at any time made any donations to any charitable organizations?

YES NO

If so, please indicate the nature and amount of the contributions and whether you would consider making such contributions in the future.

SPECIFIC GIFTS: Do you wish to make any specific gifts of specific property either at this time or at the time of your death? If so, please indicate your wishes here.

Description of Gift	Name of Recipient	Relationship to you	Address	Value of Gift

PREVIOUS GIFTS: Have you made any gifts to anyone in the past year?

YES NO

Description of Gift	Name of Recipient	Value of Gift	Was a Gift Tax Return (Form 709) filed?	
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO

ESTATE PLANNING MATTERS

In this section, please indicate the name, address & telephone number of your “helpers.” These “helpers” have different names; personal representatives, trustees, guardians, or agents. These are the people who may be called upon to assist with the operation of your estate plan at different times. Generally it is preferred if you have at least three (3) different alternatives, and the same helpers may serve different roles.

DISABILITY TRUSTEES: These persons assume complete financial control of your trust assets if your definition of mental disability is met. They serve subject to the instructions and priorities you have provided in your trust. No medical decision-making authority is delegated to the persons serving in this role. There is no residency requirement for naming a Trustee, and we strongly recommend you name Cotrustees. Your trust can contain great flexibility in how the Cotrustees will work together. Who would you like to serve as a Trustee of your trust if you should become disabled?

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

MAY WE DISCLOSE ANY INFORMATION ABOUT YOUR PLANNING TO THE TRUSTEES YOU HAVE NAMED HERE? YES NO

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

MAY WE DISCLOSE ANY INFORMATION ABOUT YOUR PLANNING TO THE TRUSTEES YOU HAVE NAMED HERE? YES NO

Customizing may be appropriate for you - for example, if you want two children to serve as disability trustees at same time, then please indicate.

DEATH TRUSTEES: These persons assume complete financial control of trust assets after your death. They serve subject to the instructions and priorities you have provided in your trust. They may be the same persons as those named as Disability Trustees, but may be different if you so choose. You may select a corporate trustee to serve with a family member if you wish. Who would you like to serve as a Trustee after your death (for married couples this is usually a surviving spouse)?

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

MAY WE DISCLOSE ANY INFORMATION ABOUT YOUR PLANNING TO THE TRUSTEES YOU HAVE NAMED HERE? YES NO

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

MAY WE DISCLOSE ANY INFORMATION ABOUT YOUR PLANNING TO THE TRUSTEES YOU HAVE NAMED HERE? YES NO

Customizing may be appropriate for you - for example, if you want two children or a spouse to serve as disability trustees at same time, then please indicate.

PERSONAL REPRESENTATIVES: These persons assume responsibility for assets controlled by your Pour-over Will. Their major function is to transfer assets from your Pour-over Will into your trust. As you know, only assets left in individual name will require use of the probate process. We strongly recommend you name the same persons you named to serve as Death Trustees. Naming the same persons for both roles assures coordinated tax planning, catastrophic illness planning and a host of other benefits, including protection from legal challenge if your Pour-over Will ends up being used. Who would you like to serve as the Personal Representative of the Estate?

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

FINANCIAL AGENTS: Who would you like to serve as your Financial Agent under the Durable Financial Power of Attorney if you were to become mentally disabled? These persons are appointed under Financial Powers of Attorney. The Power of Attorney describes the powers you delegate to your agent. All powers of attorney are "durable" (meaning the agent's power continues during the maker's disability). Complete financial control is delegated, either immediately or after a 'weak' definition of disability is satisfied. We recommend these Powers of Attorney be held in escrow, by us, and only released upon your (or your doctor's) direction).

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

HEALTH CARE AGENTS: Who would you like to serve as your agent to make medical decisions for you if you are unable to do so? These persons are appointed under your Health Care Power of Attorney. A Health Care Representative makes medical decisions for you when you are unable to communicate yourself. These decisions are not limited to "extraordinary care" issues. They include all medical decisions. You can and should leave detailed instructions for your Health Care Representative regarding your health care goals, likes and dislikes. There is no financial authority delegated to the person serving in this role. We recommend you name one individual to serve at a time as opposed to joint Health Care Representatives in order to increase the likelihood of cooperation from medical personnel.

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

GUARDIANS: A Guardian is appointed by the Probate Court. There are guardians over the person and guardians over the estate, and the length and scope of the Guardian's responsibility is determined by the court. These persons take care of your minor children or your adult children who are unable to take care of themselves. They make decisions with regard to health care, education, religious training, discipline, and all other decisions a loving parent would make for the child. Only one person or a couple living in the same home should serve in this position at a time, to avoid disputes over custody, decision-making, etc. If you name another married couple as guardians, we recommend that you clarify which spouse should serve if the couple separates or divorces while serving. Name these persons or couple in the order in which they should serve. A guardian may have financial authority, medical decision-making authority, or both. You may nominate the persons of your choice in your Power of Attorney documents. If there is an individual you do **NOT** want to serve as your guardian, it is important to name them too.

GUARDIAN OVER THE PERSON: Who would you like to serve as guardian over the person of your minor children should you become unable to care for them?

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

GUARDIANS OVER THE ESTATE: Who would you like to serve as guardian over the estate of your minor children (to make all the financial decisions) should you become unable to care for them? (The same person may be both, but sometimes the best care-givers are not the best financial decision makers.)

For Client #1	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

For Client #2	Name	Address	Phone
1 st Choice			
2 nd Choice			
3 rd Choice			

*Thank you for taking the time to complete this comprehensive form. All this information will be needed to properly plan your affairs in the event of mental disability, and to arrange for orderly transfer of your assets to your loved ones or to charity upon your death.
We look forward to working with you.*