JULIAN GRAY ASSOCIATES

ELDER LAW ♦ ESTATE & DISABILITY PLANNING

AVOID MISTAKES. PROTECT ASSETS.

ESTATE PLANNING QUESTIONNAIRE

(PLEASE COMPLETE THIS PACKET IN INK)

This information packet must be returned to us at least three days prior to your meeting (this will ensure we have enough time to understand the specifics of your situation before our meeting). If you need assistance completing the information, call our Client Relations Manager, Courtney Bachik, at (412-458-6000).

DON'T WORRY ABOUT TOTAL ACCURACY – JUST DO THE BEST YOU CAN

WE LOOK FORWARD TO SEEING YOU!!!

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

Julian Gray Associates
954 Greentree Road
Pittsburgh, PA 15220
Phone: 412-458-6000
Fax: 412-458-6015

www.GrayElderLaw.com

ESTATE PLANNING QUESTIONNAIRE
(MARRIED)

PLEASE BE AWARE no attorney client relationship has been formed by completing or not completing this questionnaire. If we do not receive your completed questionnaire within **thirty (30) days** from the date of receipt, we will close your file and Julian Gray Associates will take no further action on this matter.

Today's Date _____

This form is extremely important. Your accuracy and completeness in responding will help us to assess your situation.

A. PERSONAL DATA

(Husband)

Full Name _____

Street Address _____

City _____County:_____ State _____ Zip_____

Telephone Number: _____

Email _____

(Husband)

Birth Date _____

Social Security No. _____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

Date of Discharge: _____

(Wife)

Full Name _____

Street Address _____

City _____County:_____ State _____ Zip_____

Telephone Number: _____

Email _____

(Wife)

Birth Date _____

Social Security No. _____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

Date of Discharge: _____

B. MONTHLY INCOME

Do not include interest and dividend income on this form.

	Husband's Monthly Income	Wife's Monthly Income
Salary	$_____	$_____
Personal Business Income	$_____	$_____
Rental Income	$_____	$_____
Other Income	$_____	$_____
TOTAL MONTHLY INCOME	$_____	$_____

C. LIFE INSURANCE

Name of Insurance Company ________________________________ Policy #___________________

Street Address ____

City _________________________ State _________________ Zip _______________

Type of Policy ________________ Owner _______________________________________

Insured ______________________ Beneficiary ___________________________________

Death Benefit: $____________ Face Value $___________ Cash Value $_________________

Name of Insurance Company ________________________________ Policy #___________________

Street Address ____

City _________________________ State _________________ Zip _______________

Type of Policy ________________ Owner _______________________________________

Insured ______________________ Beneficiary ___________________________________

Death Benefit: $____________ Face Value $___________ Cash Value $_________________

Name of Insurance Company ________________________________ Policy #___________________

Street Address ____

City _________________________ State _________________ Zip _______________

Type of Policy ________________ Owner _______________________________________

Insured ______________________ Beneficiary ___________________________________

Death Benefit: $____________ Face Value $___________ Cash Value $_________________

D. LONG TERM CARE INSURANCE

Name of Insurance Company ________________________________ Policy #___________________

Street Address ____

City _________________________ State _________________ Zip _______________

Type of Policy ________________ Owner _______________________________________

Insured __________________________ Is spouse also insured under the policy? Yes ☐ No ☐

Beneficiary ____

Daily Rate: $__________ Maximum Payment $_________ Duration of Policy ______________

E. **<u>CHILDREN</u>** (if applicable, including adult children)

Check this box if you have No living Children (adult or minor). ☐

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married?_____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Does the Husband have any children by a previous marriage? Yes ☐ No ☐

Does the Wife have any children by a previous marriage? Yes ☐ No ☐

Are all of your children in good health? Yes ☐ No ☐

Are any of your children blind? Yes ☐ No ☐

Are any of your children disabled? Yes ☐ No ☐

Are any of your children receiving government benefits such as Social Security disability, SSI, Medicaid or Veteran's Benefits? If so, please specify. ☐ Yes _____ No ☐

Do any of your family members have any problems with:

Drug Addiction? Yes ☐ No ☐

Alcoholism? Yes ☐ No ☐

Spendthrift? Yes ☐ No ☐

Do any of your children live with you in your home? Yes ☐ No ☐

If yes, name of children _____

Does a sibling live in your home with you? Yes ☐ No ☐

If yes, name of sibling _____

Is anyone in your immediate or extended family disabled (including any spouses of your children): Yes ☐ No ☐

If yes, name of disabled family member _____

F. PARENTS

Does the Husband have living parents? Yes ☐ No ☐

If yes, please check the applicable boxes:

Mother ☐ Father ☐

PA Resident? ☐ PA Resident? ☐

Age? _____ Age? _____

Does the Wife have living parents? Yes ☐ No ☐

If yes, please check the applicable boxes:

Mother ☐ Father ☐

PA Resident? ☐ PA Resident? ☐

Age? _____ Age? _____

G. YOUR ADVISORS: **Name** **Telephone No.**

Accountant _____ _____
Life Insurance Agent _____ _____
Investment Advisor _____ _____
Other Attorney _____ _____
Other Consultant or Advisor _____ _____

H. CURRENT ESTATE PLAN

HUSBAND – Do you have any of the following estate planning documents?

Last Will & Testament Yes ☐ No ☐
Financial/General Durable Power of Attorney Yes ☐ No ☐ if yes, Agent: _____
Healthcare Power of Attorney/Living Will Yes ☐ No ☐ if yes, Agent: _____
Trusts Yes ☐ No ☐
If yes, name of Trust: _____
I do not have any of the types of documents listed above. ☐

WIFE – Do you have any of the following estate planning documents?

Last Will & Testament Yes ☐ No ☐
Financial/General Durable Power of Attorney Yes ☐ No ☐ if yes, Agent: _____
Healthcare Power of Attorney/Living Will Yes ☐ No ☐ if yes, Agent: _____
Trusts Yes ☐ No ☐
If yes, name of Trust: _____
I do not have any of the types of documents listed above.

I. SAFE DEPOSIT BOX

Do you have a Safe Deposit Box? Yes ☐ No ☐
If yes, please provide name of bank where it is located: _____

J. MISCELLANEOUS

Do you own a firearm? Yes ☐ No ☐
Do you have a gun trust? Yes ☐ No ☐
Do you have any other legal issues which we should be aware of: Yes ☐ No ☐

If yes, please explain _____
_____

K. REFERRAL

By whom were you referred to this office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Have you visited our Website? Yes ☐ No ☐

Do you have any ideas for improving our Website? If so, please discuss.

_____

L. CERTIFICATION

The undersigned hereby represents to Julian Gray Associates and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein in inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_____

Although reasonable value approximations are acceptable, it is important to be certain of the identity of <u>all</u> assets and <u>how they are owned or titled</u>. This Questionnaire provides for identification of assets as owned solely by wife, solely by husband, or as co-owned (either with a spouse or with another).

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
Personal Effects/Household Items	$	$	$	$
Automobile	$	$	$	$
Checking Account	$	$	$	$
Savings Account	$	$	$	$
Money Market Account	$	$	$	$
Certificates of Deposit	$	$	$	$
Residence (Assessed Value) Block #_____ Lot #_____ (Obtain from Tax Bill)	$	$	$	$
Other Real Estate	$	$	$	$
Additional Automobiles	$	$	$	$
Mutual Funds	$	$	$	$
Stocks	$	$	$	$
Bonds	$	$	$	$
Annuities	$	$	$	$
Cash Value - Life Insurance	$	$	$	$
IRA/Roth	$	$	$	$
401K/403B, etc.	$	$	$	$
Other	$	$	$	$
Other	$	$	$	$
TOTALS	$	$	$	$

What did you pay for your current home including any improvements? $_____

Do you own any real property <u>other</u> than personal residence: _____

Address:_____