JULIAN GRAY ASSOCIATES

ELDER LAW ♦ ESTATE & DISABILITY PLANNING

AVOID MISTAKES. PROTECT ASSETS.

RETIREMENT 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

RETIREMENT PLANNING QUESTIONNAIRE
(SINGLE)

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

Full Name ____

Street Address ____

City ______________ County:________________ State ______ Zip________

Telephone Number: ____________________ Email ________________________

Birth Date ________________________ Social Security No. ______________

U.S. Citizen? Yes No

Veteran? Yes No
Date of Discharge: ____________

If widowed, please list name of spouse and date of death:

____________________________ ____________________________
(Name of deceased spouse) (Date of death)

Was your former spouse a Veteran? Yes No

If so, Date of Discharge from service: ______________________

B. MEDICAL DATA

1. PHYSICIAN

Full Name of Primary Physician ______________________________________

Street Address ____

City __________________________________ State __________ Zip ________

FOR FIRM USE ONLY:

LE			AF		
CLR	CAV	FMV	OFFICE		
CLR	CAV	FMW	CASE TYPE		

2. STATE PHARMACEUTICAL PLAN

Are you currently on PACE or any other state pharmaceutical plan? Yes No

C. MONTHLY INCOME

Do not include interest and dividend income on this form.

Social Security Benefits (include Medicare Part B Deduction, if applicable) $____________________

Retirement Benefits (Gross) $____________________

Veterans Disability Income $____________________

Annuity Income $____________________

Rental Income $____________________

Other Income $____________________

TOTAL MONTHLY INCOME $____________________

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future? Yes No

D. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage $____________________

Real Estate Taxes $____________________

Homeowner's insurance premium $____________________

Condominium /Homeowner Assoc. fees $____________________

Total Monthly Housing Expenses $____________________

E. MONTHLY NON-SHELTER LIVING EXPENSES

Please list any significant monthly non-shelter living expenses not disclosed in E above:

____

____

F. GIFTS

Have you made gifts in excess of $500 in any one month, to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months? Yes No

If yes, list below:

Recipient ____________________________ Date _____________ Amount __________

Recipient ____________________________ Date _____________ Amount __________

Recipient ____________________________ Date _____________ Amount __________

Recipient ____________________________ Date _____________ Amount __________

Recipient ___________________________ Date _____________ Amount __________

Have you ever filed a Federal Gift Tax Return? Yes No
If so, for what calendar year(s)? ______________________________________

G. 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 $__________

H. LONG TERM CARE INSURANCE

Name of Insurance Company _____________________________ Policy #_______________

Street Address ____

City _________________________ State _________________ Zip ______________

Type of Policy ________________ Owner ____________________________________

Insured __________________________ Beneficiary ________________________________

Daily Rate: $____________ Maximum Payment $________ Duration of Policy ______________

I. CHILDREN (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? ___________

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 child ____

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 and relationship of disabled family member_______________________________________

J. PARENTS

Do you have living parents? Yes No

If yes, please check the applicable boxes:

Mother		Father	
PA Resident?		PA Resident?	
Age?	_____	Age?	_____

K. YOUR ADVISORS:

	Name	Telephone No.
Accountant	___________________________	___________________________
Life Insurance Agent	___________________________	___________________________
Investment Advisor	___________________________	___________________________
Other Attorney	___________________________	___________________________
Other Consultant or Advisor	___________________________	___________________________

L. CURRENT ESTATE PLAN

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.

M. SAFE DEPOSIT BOX

Do you have a Safe Deposit Box? Yes No

If yes, please provide name of bank where it is located: ____

N. MISCELLANEOUS

Do you own an irrevocable burial account?	Yes	No
Do you own a cemetery plot or crypt?	Yes	No
Do you own a firearm?	Yes	No
Do you have a gun trust?	Yes	No
Do you have a Medigap (supplemental health insurance) policy?	Yes	No

If yes, please list the name of the provider and monthly premium ________________________________

Do you have any other legal issues which we should be aware of? Yes No

If yes, please explain.

____

____

O. <u>REFERRAL</u>

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.

____

____

P. <u>CERTIFICATION</u>

The undersigned hereby represents to Gray Elder Law, LLC, 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 is 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 all assets and how they are owned or titled. 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	SELF	JOINTLY HELD FUNDS	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	$	$	$
Nursing Home Deposit	$	$	$
Other	$	$	$
Other	$	$	$
TOTALS	$	$	$

What did you pay for your current home including any improvements? $_________________
Do you own any real property other than personal residence? _____________________________
Address: ____