



**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**

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**Julian Gray Associates**  
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Phone: 412-458-6000  
Fax: 412-458-6015

[www. GrayElderLaw.com](http://www.GrayElderLaw.com)

**ESTATE 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.**

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**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. MONTHLY INCOME (Do not include interest and dividend income on this form.)**

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 \_\_\_\_\_ Beneficiary \_\_\_\_\_

Daily Rate: \$ \_\_\_\_\_ Maximum Payment \$ \_\_\_\_\_ Duration of Policy \_\_\_\_\_

**E. 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(ren) \_\_\_\_\_

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 \_\_\_\_\_

**F. PARENTS**

Do you have living parents? Yes  No

If yes, please check the applicable boxes:

Mother	<input type="checkbox"/>	Father	<input type="checkbox"/>
PA Resident?	<input type="checkbox"/>	PA Resident?	<input type="checkbox"/>
Age?	_____	Age?	_____

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

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

**H. 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.

**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 I should be aware of? Yes  No

If yes, please explain.

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**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.

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**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 is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

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**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/Roth	\$	\$	\$
401K/403B, etc.	\$	\$	\$
Other	\$	\$	\$
Other	\$	\$	\$
<b>TOTALS</b>	\$	\$	\$

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

Do you own any real property other than personal residence? \_\_\_\_\_

Address: \_\_\_\_\_