

LIFEPLAN NEBRASKA

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PERSONAL INFORMATION

(Please Print)

Client # 1 Male Female Date Completed _____

Full Legal Name _____

How you sign your name on legal documents (please print) _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email Address: _____

Employer _____

Position _____ Business Telephone _____

Business address _____ City _____ State _____ Zip _____

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

U.S. Citizen Lived in any of the following states:

California Washington Nevada Arizona New Mexico

Texas Idaho Louisiana Wisconsin

Veteran: _____ No _____ Yes (Branch: _____)

Primary Care Physician name: _____

Address: _____

Telephone number: _____ Fax number: _____

Medical information for **DocuBank** Enrollment:

Allergies: *(Optional)*

- Penicillin Bee Stings Shellfish Sulfa Latex Nuts

Other – Please specify

- _____ _____ _____

Permanent Medical Conditions: *(Optional)* Do not list medications you're taking.

- Alzheimer's Cancer survivor Low vision Arthritis
- Diabetes Lung disease Asthma Hearing loss
- Stroke history High blood pressure Heart disease
- Cancer (type) _____ _____
- _____ _____

First Emergency Contact: *(Optional)*

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

Second Emergency Contact: *(Optional)*

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

Third Emergency Contact: *(Optional)*

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

How soon would you like to complete planning? Is there a specific deadline, such as an upcoming trip, surgery, etc? _____

Client # 2 **Male** **Female**

Full Legal Name _____

How you sign your name on legal documents (please print) _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Email Address: _____

Employer _____

Position _____ Business Telephone _____

Business address _____ City _____ State _____ Zip _____

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

U.S. Citizen Lived in any of the following states:

California Washington Nevada Arizona New Mexico

Texas Idaho Louisiana Wisconsin

Veteran: _____ No _____ Yes (Branch: _____)

Primary Care Physician name: _____

Address: _____

Telephone number: _____ Fax number: _____

Medical information for **DocuBank** Enrollment:

Allergies: (Optional)

- Penicillin Bee Stings Shellfish Sulfa Latex Nuts

Other – Please specify

- _____ _____ _____

Permanent Medical Conditions: (Optional) Do not list medications you're taking.

- Alzheimer's Cancer survivor Low vision Arthritis
- Diabetes Lung disease Asthma Hearing loss
- Stroke history High blood pressure Heart disease
- Cancer (type) _____ _____
- _____ _____

First Emergency Contact: (Optional)

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

Second Emergency Contact: (Optional)

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

Third Emergency Contact: (Optional)

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

How soon would you like to complete planning? Is there a specific deadline, such as an upcoming trip, surgery, etc? _____

INFORMATION FOR CHILDREN

Child # 1 **Male** **Female**

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Parent: Husband Wife Joint

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

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

Child # 2 **Male** **Female**

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Parent: Husband Wife Joint

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

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

Child # 3 **Male** **Female**

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Parent: Husband Wife Joint

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

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

Child # 4 **Male** **Female**

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Parent: Husband Wife Joint

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

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

Child # 5 **Male** **Female**

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Parent: Husband Wife Joint

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

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

Child # 6 **Male** **Female**

Child's Full Legal Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Parent: Husband Wife Joint

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

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

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 _____
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 _____
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: _____

PROVISIONS FOR YOUR PETS

DO YOU OWN ANY PETS? _____ HOW MANY? _____

NAME and BREED?

HOW WOULD YOU LIKE YOUR PETS TO BE CARED FOR?

WHO WOULD YOU LIKE TO APPOINT TO TAKE CARE OF YOUR PETS?

NAME: _____

ADDRESS: _____

TELEPHONE: _____

WHO WOULD YOU LIKE TO APPOINT AS AN ALTERNATE IF THE PERSON NAMED ABOVE SHOULD DECLINE, OR BECOME UNABLE TO CARE FOR YOUR PETS?

NAME: _____

ADDRESS: _____

TELEPHONE: _____

OTHER 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	Client #1		Client #2	
	YES	NO	YES	NO
Do you have children not of spouse?				
Do any of your children receive governmental support or benefits?				
Do you have any adopted children?				
Do any of your children have special education/learning disability, medical, or physical needs?				
Are any of your children institutionalized?				
Are you or your spouse receiving social security, disability, or other governmental benefits?				
Do you or your spouse own a long-term care (nursing home) insurance policy?				
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.)				
Do you hold everything jointly with your partner?				
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.)				
Are you and your spouse United States citizens?				
If you answered “NO,” are either you or your spouse a resident or a non-resident alien?				
Do you or your spouse have any property that was inherited by one or gifted to one, that that spouse would consider his or her sole and separate property?				

Gift Tax Returns

Have gift tax returns ever been filed to report gifts made? No Yes ***If YES, please bring copies of the returns to your appointment.

Appointments

1. Personal Representative. The will should name a personal representative to probate the estate. (Personal representative is also sometimes referred to as executor or administrator.)

Personal Representative: _____

Address: _____

Telephone Number: _____

Alternate Name: _____

Address: _____

Telephone Number: _____

Second Alternate Name: _____

Address: _____

Telephone Number: _____

2. Successor Trustee. If you choose to avoid probate of your estate by executing a living trust during lifetime, a successor trustee should be named. The successor trustee would be responsible for managing assets if you were unable to do so. The successor trustee would manage assets in the event of your incapacity and would distribute assets to beneficiaries after death.

Successor Trustee: _____

Address: _____

Telephone Number: _____

Alternate Name: _____

Address: _____

Telephone Number: _____

Second Alternate: _____

Address: _____

Telephone Number: _____

3. Financial Agent. Who should be named to make financial decisions on your behalf? It is not necessary to appoint the same person who is your successor trustee, health care agent or personal representative as your financial agent.

You would like your Financial Power of Attorney document(s) to be effective:

- Immediately
- Upon Incapacity
- Mixed

Financial Agent: _____

Address: _____

Telephone Number: _____

Alternate Name: _____

Address: _____

Telephone Number: _____

Second Alternate Name: _____

Address: _____

Telephone Number: _____

4. Health Care Agent. Who should be named to make medical decisions on your behalf including decisions regarding medical consents, life support issues, and nursing home admission if you were unable to make these decisions yourself? It is not necessary to appoint the same person who is your successor trustee, personal representative or your financial agent, as your health care agent.

You would like your Health Care Power of Attorney document(s) to be effective:

- Immediately
- Upon Incapacity
- Mixed

Health Care Agent: _____

Address: _____

Telephone Number: _____

Alternate Name: _____

Address: _____

Telephone Number: _____

Second Alternate Name: _____

Address: _____

Telephone Number: _____

Plan of Distribution

1. Specific Gifts. Do you want to make charitable gifts, such as to a house of worship or other institution? Do you wish to make a special gift to a particular person, such as a piece of jewelry to a particular child?

2. Briefly describe the plan of distribution for assets remaining after any specific gifts described above are made. (Don't worry about tax planning or other considerations in answering this question. We'll consider those details later if needed.)

- All to spouse; then among children, and if a child didn't survive, the deceased child's share to the deceased child's children.
- All to spouse, then equally among surviving children.
- All to spouse, then _____
- As follows: _____

3. Ultimate Distribution. You might want to provide for the distribution of your property if neither you, your spouse, nor your children/other beneficiaries named above survive.

Please complete this section *only* if you have minor beneficiaries or beneficiaries with disabilities.

1. Guardian. If you have minor child(ren), beneficiary(ies), or child(ren)/beneficiary(ies) with special needs, you may need to appoint a guardian. The guardian is responsible for the day-to-day care of the child. It is a good idea to name an alternate guardian to act if your first choice cannot serve.

Guardian: _____

Address: _____

Telephone Number: _____

Alternate Name: _____

Address: _____

Telephone Number: _____

2. Testamentary Trustee. You may need a trustee to manage assets for beneficiaries until they reach an age when you believe they should be capable of managing assets on their own. A trustee can keep the beneficiary's money invested wisely and use it for their education, support, etc., until they reach the age specified for outright distribution of assets to them. The trustee can be a relative, friend, trust company, or other person or institution you trust to manage and distribute assets according to your wishes. The testamentary trustee can be the same person named as the guardian, or could be a different person or institution.

Testamentary Trustee: _____

Address: _____

Telephone Number: _____

Alternate Name: _____

Address: _____

Telephone Number: _____

3. Age of Distribution. If you do establish a trust to allow a third party to manage assets for beneficiaries, then it is necessary for you to decide when the beneficiaries will be mature enough to manage assets on their own. You may want to give each beneficiary his or her share at the time the beneficiary reaches a particular age. You may consider splitting the distribution, such as 2 at age 25 and the balance at age 30, or 1/3 at 21, 1/3 at 25, and 1/3 at 35. You may use any age or combination of ages that you choose.

CASH ACCOUNTS

TYPE: Checking Account "CA" ♦ Savings Account "SA" ♦ Certificate of Deposits "CD" ♦ Safety Deposit Box "SD". *(Indicate type below for all bank and credit union accounts.)* If you are named as a co-owner on any accounts owned by someone else (i.e. parents, siblings, children, grandchildren, etc.) please indicate the name of the co-owner. (Please bring your statements.)

Name of Institution and Branch Where Account was Opened	Type	Account #	Owner	Balance
_____	_____	_____	_____	\$ _____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Institution and Branch Where Account was Opened	Type	Account #	Owner	Balance
_____	_____	_____	_____	\$ _____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Institution and Branch Where Account was Opened	Type	Account #	Owner	Balance
_____	_____	_____	_____	\$ _____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Institution and Branch Where Account was Opened	Type	Account #	Owner	Balance
_____	_____	_____	_____	\$ _____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Institution and Branch Where Account was Opened	Type	Account #	Owner	Balance
_____	_____	_____	_____	\$ _____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				

INVESTMENT ACCOUNTS

• IRAs and Annuities should be listed later •

TYPE: Money Market “MM” ♦ Investment Account “IA” ♦ Cash Management “CM” ♦ or Other Account “OA”. (*Indicate type below for all investment and street accounts.*) If you hold individual stock certificates, please indicate those under “Stocks” on the following page. If you are named as a co-owner on any accounts owned by someone else (i.e. parents, siblings, children, grandchildren, etc.) please indicate the name of the co-owner. (Please bring your statements.)

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this account pledged as collateral on any loans? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this account pledged as collateral on any loans? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this account pledged as collateral on any loans? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name of Brokerage Firm	Type	Account #	Owner	Amount
_____	_____	_____	_____	_____
Address: _____		Phone: _____		
Are funds electronically deposited or withdrawn from this account? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this account pledged as collateral on any loans? <input type="checkbox"/> Yes <input type="checkbox"/> No				

STOCKS

Please indicate any **stock certificates** that are in your possession. Stock owned in a family business or non-publicly-traded company should be listed under “Corporate and Professional Business Interests.” Stocks held in a **Street Account** or **Investment Account** should be listed under “Investment Accounts”. If you are named as a co-owner on any stocks owned by someone else (i.e. parents, siblings, children, grandchildren, etc.) please indicate the name of the co-owner.

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans? <input type="checkbox"/> Yes		<input type="checkbox"/> No	

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans? <input type="checkbox"/> Yes		<input type="checkbox"/> No	

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans? <input type="checkbox"/> Yes		<input type="checkbox"/> No	

Name of Stock	Number of Shares	Owner	Fair Market Value
_____	_____	_____	_____
Please provide name and address of Transfer Company:			
Address: _____		Name: _____	
_____		Phone: _____	
Is this stock pledged as collateral on any loans? <input type="checkbox"/> Yes		<input type="checkbox"/> No	

PERSONAL EFFECTS

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

Type	Owner	Value	Indicate Primary Driver for Automobiles	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

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.*) Please provide a copy of your Retirement Plan Summary Agreement. (Please bring your statements.)

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

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

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

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

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

PENSION PLANS

Please bring your statements.

Company Name	Account #	Owner	Beneficiary Upon Your Death	Value
_____	_____	_____	_____	_____
Address: _____			Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do your benefits continue to be paid out to a beneficiary after your death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, do your benefits continue to be paid out after the death of your beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Account #	Owner	Beneficiary Upon Your Death	Value
_____	_____	_____	_____	_____
Address: _____			Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do your benefits continue to be paid out to a beneficiary after your death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, do your benefits continue to be paid out after the death of your beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Account #	Owner	Beneficiary Upon Your Death	Value
_____	_____	_____	_____	_____
Address: _____			Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do your benefits continue to be paid out to a beneficiary after your death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, do your benefits continue to be paid out after the death of your beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Company Name	Account #	Owner	Beneficiary Upon Your Death	Value
_____	_____	_____	_____	_____
Address: _____			Phone: _____	
Are you currently receiving benefits from this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do your benefits continue to be paid out to a beneficiary after your death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, do your benefits continue to be paid out after the death of your beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No				

INSURANCE POLICIES

TYPE: Term ♦ Whole life ♦ Variable or Universal life ♦ Split dollar ♦ Group life ♦ Second-To-Die ♦ Disability ♦ Long Term Care *(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
_____	_____	_____	_____	_____
Address: _____		Phone: _____		Agent: _____
Face Amount _____	Death Benefit _____	Cash Value _____		
Primary Beneficiary: _____		Secondary Beneficiary: _____		

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

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

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

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

ANNUITIES

Please provide a copy of each annuity contract.

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$_____	\$_____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		
Are you receiving any regular distributions from this annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", do the distributions have "survivorship" or "period certain" provisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Survivorship <input type="checkbox"/> Period Certain					

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$_____	\$_____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		
Are you receiving any regular distributions from this annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", do the distributions have "survivorship" or "period certain" provisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Survivorship <input type="checkbox"/> Period Certain					

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$_____	\$_____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		
Are you receiving any regular distributions from this annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", do the distributions have "survivorship" or "period certain" provisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Survivorship <input type="checkbox"/> Period Certain					

Company Name	Annuitant	Account #	Owner	Face Amount	Cash Value
_____	_____	_____	_____	\$_____	\$_____
Address: _____		Phone: _____		Agent: _____	
Primary Beneficiary: _____			Secondary Beneficiary: _____		
Are you receiving any regular distributions from this annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", do the distributions have "survivorship" or "period certain" provisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Survivorship <input type="checkbox"/> Period Certain					

PARTNERSHIP & LLC INTERESTS

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

Name of Partnership or LLC _____

Owners _____ Value _____

Who holds Partnership or LLC papers _____ Phone: _____

Is this a “Professional” Partnership or LLC? Yes No

Entity Type: General Partnership Limited Partnership Limited Liability Company

Name of General Partner or Managing Member _____

Name of Partnership or LLC _____

Owners _____ Value _____

Who holds Partnership or LLC papers _____ Phone: _____

Is this a “Professional” Partnership or LLC? Yes No

Entity Type: General Partnership Limited Partnership Limited Liability Company

Name of General Partner or Managing Member _____

Do any of your children work in a business with you?

CORPORATE BUSINESS INTERESTS

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

(Please provide a copy of your Corporate 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 _____			

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
_____	_____
_____	_____

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 _____	

OTHER ASSETS

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

Description	Owner	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)

Owner	Mortgage Amount	Fair Market Value
_____	_____	_____
Address _____	City _____	State _____ Zip _____
County _____		
Legal Description _____		
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		

Owner	Mortgage Amount	Fair Market Value
_____	_____	_____
Address _____	City _____	State _____ Zip _____
County _____		
Legal Description _____		
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		

Owner	Mortgage Amount	Fair Market Value
_____	_____	_____
Address _____	City _____	State _____ Zip _____
County _____		
Legal Description _____		
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		

Owner	Mortgage Amount	Fair Market Value
_____	_____	_____
Address _____	City _____	State _____ Zip _____
County _____		
Legal Description _____		
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		

Owner	Mortgage Amount	Fair Market Value
_____	_____	_____
Address _____	City _____	State _____ Zip _____
County _____		
Legal Description _____		
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		

Owner	Mortgage Amount	Fair Market Value
_____	_____	_____
Address _____	City _____	State _____ Zip _____
County _____		
Legal Description _____		
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		

