ASSET PROTECTION PLANNING QUESTIONNAIRE
(MARRIED)

Date________________________________ File No. ________________________

Home Phone No.______________________ Business Phone No. ______________________

E-mail Address________________________ Fax No.___________________________

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to our initial appointment.

A. PERSONAL DATA

(Husband)
Full Name____________________________________
(print full legal name)

(Wife)
Full Name ______________________________________
(print full legal name)

Street Address ____

City____ State___________ Zip ________________

(Husband)
Birth Date____________________________________

Social Security No._____________________________

U.S. Citizen? Yes ____ No ____

Veteran? Yes ____ No ____

(Wife)
Birth Date ______________________________________

Social Security No. _________________________________

U.S. Citizen? Yes ___ No ___

Veteran? Yes ___ No ___

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse ____

Diagnosis ____

Prognosis____

Name of Well Spouse ____

Where Well Spouse Currently Resides ____

Health of Well Spouse ____

2. PHYSICIAN

Full Name of Husband's Primary Physician ____

Street Address ____

City____ State__________ Zip ________

Full Name of Wife's Primary Physician ____

Street Address ____

City____ State__________ Zip __________

3. STATE PHARMACEUTICAL PLAN

Are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or any other state pharmaceutical plan?
Yes ___ No ____

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include $96.40 Medicare Part B Deduction, if applicable)	$______________	$______________
Retirement Benefits (Gross)	$______________	$______________
VA Disability Benefit	$______________	$______________
Annuity Income	$______________	$______________
Rental 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 _____

Do not include interest and dividend income on this form.

D. ***LAST WILL AND TESTAMENT***

DISPOSITIVE INTENTIONS - **SPOUSE AND CHILDREN**

Do you wish to provide primarily for your spouse and secondarily for your children? ___ Yes ___ No

Do you wish to treat all of your children equally? ___ Yes ___ No

If not, why? ____

After your spouse's death, at what age do you want distribution to your children? ______________________________
(e.g. typical plans provide for immediate distributions or for 1/3 at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35)

CHILDREN (if applicable)

Name of Child ____

Street Address ____

City______________________________ State________________ Zip ______________

Phone Number_______________________ E-mail Address ______________________________
Date of Birth________________________ Social Security Number ________________________

Name of Child ____

Street Address ____

City______________________________ State________________ Zip _____________

Phone Number_______________________ E-mail Address _________________________
Date of Birth________________________ Social Security Number ____________________

Name of Child ____

Street Address ____

City______________________________ State________________ Zip ______________

Phone Number_______________________ E-mail Address ______________________________
Date of Birth________________________ Social Security Number _________________________

Name of Child ____

Street Address ____

City________________________________ State_________________ Zip _____________

Phone Number______________________ E-mail Address _________________________________
Date of Birth________________________ Social Security Number ____________________________

Name of Child ____

Street Address ____

City________________________________ State_________________ Zip ______________

Phone Number______________________ E-mail Address _____________________________
Date of Birth________________________ Social Security Number ______________________

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 disabled? Yes ___ No _____

Are any of your children receiving SSI or other form of government entitlement? Yes ____ No ______

Do any of your family members have any problems with:

Creditors? Yes ___ No ___
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 ____

GRANDCHILDREN

Do you want to leave a specific amount of money or a percentage of your estate to your grandchildren?
___ Yes ___ No

Grandchild's Name	Address (including zip code)	Date of Birth

Do you wish to treat all of your grandchildren equally? ___ Yes ___ No

If not, why? ____

How much do you want to leave your grandchildren? ______________________________

At what age do you want distribution to your grandchildren? ___________________________
(e.g. typical plans provide for immediate distributions or for 1/3 at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35)

EXECUTOR

Whom do you want to serve as your Executor? ____

(Husband)
First Choice: ___ Spouse ___ Other

Second Choice ____

Third Choice ____

(Wife)
First Choice: ___ Spouse ___ Other

Second Choice ____

Third Choice ____

TRUSTEE

If a Trust is established whom do you want to serve as your Trustee?

(Husband)
First Choice ____

Second Choice ____

(Wife)
First Choice ____

Second Choice ____

E. ***POWER OF ATTORNEY***

Do either of you currently have a Power of Attorney? _____ Yes _____ No

(Husband)

First Choice ____
(Name) (Address)

Second Choice____
(Name) (Address)

(Wife)

First Choice ____
(Name) (Address)

Second Choice____
(Name) (Address)

E. ***LIVING WILL***

(Husband)
Do you want a Living Will? ___ Yes___ No

Do you want your Living Will to provide for withdrawal of artificial food and fluid? ___ Yes___ No

Do you want to donate your eyes or organs? ___ Yes ___ No

Whom do you want to make your medical decisions?

First Choice ____
(Name) (Address)

Second Choice____
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?
___ Yes ___ No

If yes, with whom? ____

(Wife)

Do you want a Living Will? ___ Yes___ No

Do you want your Living Will to provide for withdrawal of artificial food and fluid? ___ Yes___ No

Do you want to donate your eyes or organs? ___ Yes ___ No

Whom do you want to make your medical decisions?

First Choice ____
(Name) (Address)

Second Choice____
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?
___ Yes ___ No

If yes, with whom? ____

G. ***FINANCIAL SUMMARY***

	ASSETS			LIABILITIES
	Husband	Wife	Joint	
Bank Accounts [attach copies of statements]	$_________	$_________	$_________	$_________
Real Estate (residence) [attach copy of deed]	$_________	$_________	$_________	$_________
Real Estate (other) [attach copies of all deeds]	$_________	$_________	$_________	$_________
Savings Certificates (CDS) [attach copies of statements]	$_________	$_________	$_________	$_________
Stocks - (Not Held by Broker) [attach copies of all certificates]	$_________	$_________	$_________	$_________
Stocks - (Held by Broker) [attach copies of brokerage statements]	$_________	$_________	$_________	$_________
Bonds - (Not Held by Broker) [attach copies of all bonds]	$_________	$_________	$_________	$_________
Bonds - (Held by Broker) [attach copies of brokerage statements]	$_________	$_________	$_________	$_________
Mutual Funds [attach copies of statements]	$_________	$_________	$_________	$_________
Note and Mortgages Receivables [attach copies of Notes & Mortgages]	$_________	$_________	$_________	$_________
Business Interests [attach copies of stock certificates, partnership agreement and/or other documentation]	$_________	$_________	$_________	$_________
Inheritance, etc.	$_________	$_________	$_________	$_________
Automobiles	$_________	$_________	$_________	$_________
Jewelry & Collections	$_________	$_________	$_________	$_________
IRAs [attach copies of statements]	$_________	$_________	$_________	$_________
Non-IRA Tax Qualified Retirement Plans [attach copies of statements]	$_________	$_________	$_________	$_________
Life Insurance [attach copies of all policies]	$_________	$_________	$_________	$_________
Annuities [attach copies of all policies]	$_________	$_________	$_________	$_________
Other Assets [attach copies of documentation pertaining to such assets]	$_________	$_________	$_________	$_________
TOTALS	$_________	$_________	$_________	$_________

Personal Residence:

Tax Block #____________________, Lot #__________________ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1)Street_________________________________City________________State__________Zip

Tax Block #____________________, Lot #__________________ (Can be obtained from Tax Bill)

(2)Street_________________________________City________________State__________Zip

Tax Block #____________________, Lot #__________________ (Can be obtained from Tax Bill)

H. GIFTS

Have you made gifts in excess of $5,000 in any one month, to an individual or group of individuals, 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

Have you ever filed a Federal Gift Tax Return? Yes ___ No ___

If so, please state details ____

I. 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: $ ______________________

Name of Insurance Company______________________________ Policy # ________________________

Street Address ____

City______________________________ State_________________ Zip ____________

Type of Policy____________________ Owner ______________________________________

Insured__________________________ Beneficiary __________________________________

Death Benefit: $__________ Face Value: $__________ Cash Value: $ ____________________

J. MISCELLANEOUS

Do you have any other legal issues which I 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 ___

L. *CERTIFICATION*

The undersigned hereby represents to the Law Offices of Douglas A. Fendrick, LLC., that the information contained in this intake form is accurate and complete. The undersigned is aware that the law firm will rely on this information and further understands that 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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