

**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 \_\_\_\_\_

**(Wife)**

Birth Date \_\_\_\_\_

Social Security No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

U.S. Citizen? Yes  No

U.S. Citizen? Yes  No

Veteran? 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 \$115.40 Medicare Part B Deduction, if applicable)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME</b>	\$ _____	\$ _____

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 \_\_\_\_\_



**F. 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**

		<u>ASSETS</u>		<u>LIABILITIES</u>
	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]	\$ _____	\$ _____	\$ _____	\$ _____
<b>TOTALS</b>	\$ _____	\$ _____	\$ _____	\$ _____

**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, 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 Fendrick & Morgan, 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:

\_\_\_\_\_