

CLIENT INFORMATION FORM

Name of	Contact -	Person filling	out form: _				Date:		
Contact E	mail:			CI	ient Email	:			
County:	Bristol	Plymouth	Norfolk	Middlesex	Suffolk	Barnstable	Other:		
Client's N	lame:			DOI	B:/_	/			
Address:					ŀ	Home Phone:			
						Cell Phone:			
US Citize	en: Yes	No If No, C	Citizen of: _						
Employe	r:			Retireme	ent Date: _	//	Veteran:	Yes	No
Spouse's	Name:			DO	B:/_	/			
If spouse	is deceas	ed, date of de	ath:/		_ Cell P	hone:			
Date of N	/larriage: _	//_	U:	S Citizen: Ye	es No I	f No, Citizen c	of:		
Employe	r:			Retireme	ent Date: _		Veteran:	Yes	No
Family									
•		nis section as t	horoughly	as possible, ir	ncluding zi	p codes & pho	one #'s		
First N	Name		MI			Last Name			Age
Addre	ess (includ	e street, towr	n, state & zi	ip code)		Teleph	none		
Snous	e's Name		Names (in	cluding last na	ame if diff	erent from vo	urs) & Δσρς	of chile	—— dren

(2)									
Fii	rst Name	N	11		Last Na	me		Age	
Address (include street, town, state & zip code)				e)	Telephone				
Sp	ouse's Name	Name	s (includin	g last name	e if different fro	om yours) & A	ges of chi	ldren	
(3) _									
Fii	rst Name	N	11		Last Nai	me		Age	
Ac	ddress (include	street, town, state	& zip cod	e)	Т	elephone			
Sp	ouse's Name	Name	s (includin	g last name	e if different fro	om yours) & A	ges of chi	ldren	
(Pleas	se use the end	of this form to list a	additional	children or	agent informa	tion)			
Have	you or your sp	ouse been married	before?				Yes	No	
If Yes	do you or you	spouse have any o	hildren fr	om this pre	vious marriage		Yes	No	
Do yo	ou or your spou	se have children w	ho have d	ied leaving	children?		Yes	No	
	•	om you may be leav on in managing mo	• .	•	•		Yes	No	
Do yo	ou and your spo	ouse have a pre-nu	otial or po	st-nuptial a	greement?		Yes	No	
Med	dical/Disab	ility							
ls any	one in your far	mily disabled?	Yes No	If Yes,	Please explain	:			
Is any	one at risk for	becoming seriously	ı ill or disa	bled becaus	se of a medical	condition or	family his	tory?	
Yes	No	If Yes please expl	ain:						

Has anyone in your family r	ecently entered a ho	spital or skilled	nursing facility?	Yes No			
Name of facility:		Date					
Date of discharge:		Diag					
Health Insurance	You (number)		Spouse (number	Spouse (number)			
Medicare			_				
Insurance from Employer							
Medicare Supplement							
Long-Term Care Insurance			_				
Other							
Financial							
Income Producing Assets: E	Bank accounts, Broke	rage Accounts,	Stocks, Corporate o	r U.S. Bonds, other			
Type of Account/Asset	Own	ner(s)	Va	alue (numbers only)			
TOTAL:							
Have you or your spouse m	ade any transfers or a	gifts of \$1,000 (or more during the p	past five years?			
Yes No							
Real Estate		,	Fatiment ad				
Description of Property	Purchase Date Purc	Cu	Estimated Irrent Value Imbers only) Owners	(c)			
	Fulcilase Date Fulc		Owners				
Are any of the above prope	rties not connected t	o a sewer line?	Yes	No			
Do you or your spouse have			Yes	No			

	(please enter numbers only)						
Monthly Income	You	Your Spous	e Joint				
Social Security							
Employment:							
Pension from:							
IRAs, Annuities, etc.:							
Rents:							
Business Interest:		_					
Other:		_					
Totals:							
Which sources of income have a benefit for a	a surviving spou						
Life Insurance	((please enter n	umbers only)				
Owner Whose Life? Company Name	Whole/Term? Fa	ace Value	Cash Value	Beneficiary			
Other Property with Designated Bene Annuities, or Other Assets that would pass o	n your death to	=	esignated ben	eficiary?			
Description Value	e Owner		Designate	d Beneficiary			
Do you or your spouse expect an inheritance	?	Yes	No				
Are you or your spouse the beneficiary of an	y trust?	Yes	No				

Description	Baland	ce Due	Month	ly Payment	Maturity Date	
	 					
Location of important papers:						
Monthly Expenses						
Health insurance premium:		Medica	al Expen	ses:		
Real estate taxes:		Homeo	wner's	insurance p	oremium:	
Condominium Fee:		Rent:				
Do you pay for heat and utilities? Yes	No					
Legal						
	Date N	Made		Location of	f Original	
Document	Date N	Made		Location of	f Original	
Document Last Will and Testament					f Original	
Document Last Will and Testament Durable Power of Attorney						
Document Last Will and Testament Durable Power of Attorney Living Will/Health Care Proxy						
Document Last Will and Testament Durable Power of Attorney Living Will/Health Care Proxy Living Trust						
Legal Document Last Will and Testament Durable Power of Attorney Living Will/Health Care Proxy Living Trust I am the legally appointed guardian of: I am serving as a power of attorney for:						
Document Last Will and Testament Durable Power of Attorney Living Will/Health Care Proxy Living Trust I am the legally appointed guardian of:						

I have lived in a commu	nity pro	perty state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico,
Texas, Washington):	Yes	No
Other legal concerns:		

Please provide copies of the following documents PRIOR to your meeting with the attorney:

- 1. Will, codicil, trust agreements
- 2. Real estate deeds, appraisals
- 3. Admission agreements to hospitals and health facilities
- 4. Divorce decrees, prenuptial agreements, adoption papers
- 5. Guardianship documents
- 6. Living Will, Health Care Declaration or Power of Attorney, Durable Powers of Attorney
- 7. A list of full names, addresses and telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries of your estate, helpers and advisors.
- 8. Retirement plans, including any forms designating beneficiaries.

Additional Children or Agent Information (from page 2)