FENDRICK MORGAN

LIFE REQUIRES PLANNING WORKBOOK
MARRIED COUPLE

Please complete this Workbook to the best of your ability. Your answers to the questions asked herein will allow us to provide you with the most appropriate counsel and care. If you have a question about any of the information requested, or are unsure how to answer any question asked herein, please leave it blank and we can review it with you at your appointment.

____

A. *PERSONAL INFORMATION*

HUSBAND

Full Legal Name________________________________Nickname:___________________________________

(print name as shown on your checks and other financial accounts)

Email Address ____

Cell Number __________________________________Home Number _____________________________

Street Address ____

City ____State____________Zip______________________

Birth Date_______________________________________Social Security No. ________________________

U.S. Citizen? Yes □ No □ Veteran? Yes □ No □

WIFE

Full Legal Name__________________________________Nickname: _______________________________

(print name as shown on your checks and other financial accounts)

Email Address ____

Cell Number ____________________________________Home Number ____________________________

Street Address____

City____State__________Zip________________________

Birth Date_______________________________________ Social Security No. ________________________

U.S. Citizen? Yes □ No □ Veteran? Yes □ No □

If either of you are a Veteran, are you receiving Tri-Care? Yes □ No □

Do either of you have long-term care insurance? Yes □ No □

B. ***MEDICAL DATA***

1. HEALTH

Have either of you had any medical diagnoses of which we should be aware in our representation of you? If so, please describe your diagnosis and prognosis: ____

____

____

Have either of you been diagnosed with any chronic condition (such as dementia of any kind, Alzheimer's Disease, Parkinson's Disease, Multiple Sclerosis, etc.)? If so, please explain: ______________________

____

____

Have either of you noticed any recent change in your memory, appetite, energy levels, balance, or anything else which might affect your activities of daily life? ____

____

____

Do either of you require any assistance with activities of daily living (such as administering medications, driving, cooking, grooming, feeding, transportation, etc.)? If so, please explain:

____

____

____

2. MEDICAL INSURANCE

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior Gold? Yes □ No □

If you are a Pennsylvania resident, are you currently receiving benefits under PACE or PACE NET?
Yes □ No □

If you are a Veteran, are you currently receiving prescription benefits from the Veteran's Administration?
Yes □ No □

Do you maintain any have any medical, prescription, or dental insurance other than Medicare? Yes □ No □

If yes, please provide carrier information, who is covered and any premiums paid: ______________________

____

C. *FAMILY*

1. CHILDREN (if applicable)

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

Does the Husband have any children by a previous marriage? Yes □ No □
If so, who? ____

Does the Wife have any children by a previous marriage? Yes □ No □

If so, who? ____

Are all of your children in good health? Yes □ No □

Are any of your children blind or disabled? Yes □ No □

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

If yes, how much is the child's monthly payment? $__________________________

Child is receiving: Medicaid □ Medicare □ Veterans Disability Benefit □

Do any of your family members have any problems with:

Drug Addiction?	Yes □	No □
Alcoholism?	Yes □	No □
Spendthrift?	Yes □	No □
Marital Difficulty?	Yes □	No □
Financial Difficulty?	Yes □	No □

Do any of your children live with you in your home? Yes □ No □

If so, who and for how long? ____

2. <u>GRANDCHILDREN</u>

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?____

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Do you want to leave your grandchildren a specific bequest or percentage distribution upon the death of either of you? Yes □ No □

If so, how much do you want to leave your grandchildren? ______________

Are any of your grandchildren disabled? Yes □ No □

Are any of your grandchildren receiving SSI or other form of government entitlement? Yes □ No □

Grandchild is receiving: Medicaid □ Medicare □ Veterans Disability Benefit □

At what age do you want distributions to your grandchildren? ____
(You might decide to distribute funds to adult grandchildren immediately, or you may decide to hold the assets in trust for your grandchildren until they reach certain ages. For example, you may want your grandchildren to receive 1/3 of their share at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35, or any other age/ages that make sense to you.)

3. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than your spouse, children, grandchildren, i.e., charity or other person?

Yes □ No □

If yes, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

D. ***MONTHLY INCOME***

In completing this section, please provide only your fixed monthly income amounts. For example, if you receive periodic dividend payments or required minimum distributions from an IRA, you do not need to list that income here. We are interested in your fixed, recurring monthly income.

	Husband's Monthly Income	Wife's Monthly Income
Gross Social Security Benefits (*include $134.00 Medicare Part B Deduction, if applicable*)	$________________	$________________
Gross Monthly Pension (*Do not reduce this amount by any monies taken out for federal income taxes, health insurance, or any other reason.*)	$________________	$________________
VA Disability Benefit	$________________	$________________
Annuity Income	$________________	$________________
Rental Income	$________________	$________________
TOTAL MONTHLY INCOME	$________________	$________________

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E. ***FINANCIAL SUMMARY*** *- Please bring spreadsheet of your financial assets or fill out the information requested below and bring most recent statements, if possible.*

	ASSETS			**LIABILITIES**
	Husband	Wife	Joint	
Bank Accounts	$_________	$_________	$_________	$_________
Real Estate (residence) *[bring copy of deed, if possible]*	$_________	$_________	$_________	$_________
Real Estate (other) *[bring copies of all deeds, if possible]*	$_________	$_________	$_________	$_________
Non-Retirement Investments (*Brokerage Accounts, Stock, Mutual Fund, CDs, etc*.)	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
Non-Retirement Account Annuities	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
Retirement Account Assets *(IRAs, 401(k), 403(b), etc.)*	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
	$_________	$_________	$_________	$_________
Business Interests *[if any]*	$_________	$_________	$_________	$_________
Anticipated Inheritance *[if any]*	$_________	$_________	$_________	$_________
Life Insurance	$_________	$_________	$_________	$_________
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)

F. *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? ____

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 ____

G. 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)

H. 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?____________________

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

If yes, with whom? ____________________

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____________________

J. LIFE INSURANCE

Name of Insurance Company________________________________ Policy #_________________

Street Address ____

City________________________________ State___________________Zip ____________________

Type of Policy_______________________Owner ____

Insured______________________________Beficiary ______________________________________

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: $____________

K. MISCELLANEOUS

Do you have any other legal issues, which I should be aware of? Yes □ No □

If yes, please explain____

L. REFERRAL

By Whom Were You Referred To This Office?

Name ____

Street Address ____

City____ State__________ Zip_______

Have you visited our Website? Yes □No □

M. *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:

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