Name: DOB: SSN: Phone:

Spouse (or N/A): DOB: SSN: Phone:

Address: City/State: Zip:

**Veteran status:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Veteran? | Service dates (MM/YY To MM/YY) | War/Operation | Honorable discharge? |
| You | Yes 🞏 No 🞏 |  |  | Yes 🞏 No 🞏 |
| Spouse | Yes 🞏 No 🞏 |  |  | Yes 🞏 No 🞏 |

**Family living status:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Do you have children? | How many? | Living with you? | Disabled? | Or temporary? |
| You | Yes 🞏 No 🞏 |  | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 |
| Spouse | Yes 🞏 No 🞏 |  | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 |

**Health status:**

|  |  |  |
| --- | --- | --- |
|  | Current health | Concerns (If Fair or Poor) |
| You | Excellent 🞏 Good 🞏 Fair 🞏 Poor 🞏 |  |
| Spouse | Excellent 🞏 Good 🞏 Fair 🞏 Poor 🞏 |  |

**Current information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you….? | You | Spouse | Details | | | |
| Live in a care facility? | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 | Cost per month: | $ | Unpaid bal: |  |
| Have long term care insurance? | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 | Benefit per day: | $ | Term (Yrs): |  |
| Have an Estate plan/Will/Trust? | Yes 🞏 No 🞏 | Yes 🞏 No 🞏 | Revocable 🞏 | Irrevocable 🞏 | Date: |  |
| Have you given away any assets in the last 60 months? | | Yes 🞏 No 🞏 | Date gifted: |  | Amount: | $ |

**Financial status:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MONTHLY INCOME** | | YOU | SPOUSE | TOTAL |
| Pension, SS, etc. | | $ | $ | $ |
| **ASSETS** (CURRENT VALUE) | | YOU OR JOINT | SPOUSES NAME | TOTAL |
| Cash, Checking/Savings, CDs, Money Market, etc. | | $ | $ | $ |
| Brokerage accounts, Stocks, etc. | | $ | $ | $ |
| Life Insurance: | Cash surrender value: | $ | $ | $ |
| Death benefit: | $ | $ | $ |
| Annuities | | $ | $ | $ |
| Home | | $ | $ | $ |
| Other Assets | | $ | $ | $ |
| **LIABILITIES/DEBTS** | | YOU OR JOINT | SPOUSES NAME | TOTAL |
| Total mortgage(s), Other debts & Liabilities | | $ | $ | $ |
| **MONTHLY LIVING EXPENSES** | | YOU OR JOINT | SPOUSES NAME | TOTAL |
| How much do you spend to live? | | $ | $ | $ |
| How much to you spend on medical needs? | | $ | $ | $ |
| Amount of Medicare part A and B deducted? | | $ | $ | $ |
| Amount for Medicare supplemental insurance? | | $ | $ | $ |