LIFE POINT LAW

Trusted Attorneys

Client Information Form

Federal Way Office

31919 6th Ave. South

Federal Way, WA 98003

253.838.3454

Edmonds Office

100 2nd Ave. S, Suite #290

Edmonds, WA 98020

360.318.7323

Bellevue Office

11711 Southeast 8th Street

Bellevue, WA 98005

425.429.3581

Bellingham Office

2211 Rimland Drive, Suite #405

Bellingham, WA 98226

360.318.7323

Client Information Form

NON-CRISIS *LifePlanning*

Dear Client,

This is a very thorough and extensive form that may take some time to finish. Please be sure to fill in as much of the information as possible, to the best of your abilities. It is NOT a requirement that you complete every box or line—do the best that you can. The information that you provide informs our recommendations. Thus, the more information you can provide, the greater the possibility that all of your needs will be met.

Gratefully,

Your Legal Team at

LIFE POINT LAW

Trusted Attorneys

Please bring the following items to your appointment:

- ☐ This completed packet
- ☐ Copies of your **Health Insurance Cards**
- ☐ Latest **Tax Return**
- ☐ **Long-Term Care Policy** (i.e., a complete copy of your policy, if you have one)
- ☐ **Life Insurance Policy** (i.e., a complete copy of your policy and latest statement with current values, if you have one)
- ☐ Latest **Financial Statement(s)**: (e.g., Bank, Investment, Retirement accounts)
- ☐ **Deed(s)** to real property
- ☐ Copies of all **Existing Legal Estate Planning and Trust Documents**

May we send correspondence and ***drafts*** of documents via email? ☐Yes ☐No

Where did you learn about our office?

☐AM 770 ☐FM 97.3 ☐Seminar Referred by: _____

Have you attended our *LifePlanning* Seminar? ☐Yes ☐No

Have you listened to our radio show? ☐Yes ☐No

What are your planning objectives? _____

Type Answer Here

Personal Information

Relationship Status: ☐Married ☐Never married ☐Widowed ☐Divorced

Client #1:

Full Name: _____

Previous Name(s): _____ Date of Birth: _____

Occupation(s): _____ Place of Birth: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

County (e.g., Pierce, King): _____ Email: _____

U.S. Citizen: ☐Yes ☐No

Are you a U.S. Veteran? ☐Yes ☐No Honorably discharged? ☐Yes ☐No

If yes, what was your date of entry? _____ Date of Discharge: _____

If yes, which did you serve in? ☐WWII ☐Korean Conflict ☐Vietnam ☐Gulf War

If married or widowed, please provide the following additional information.

Client #2:

Full Name of Spouse (or Deceased Spouse): _____

Previous Name(s): _____ Date of Birth: _____

Occupation(s): _____ Place of Birth: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

County (e.g., Pierce, King): _____ Email: _____

U.S. Citizen: ☐Yes ☐No

Are you a U.S. Veteran? ☐Yes ☐No Honorably discharged? ☐Yes ☐No

If yes, what was your date of entry? _____ Date of Discharge: _____

If yes, which did you serve in? ☐WWII ☐Korean Conflict ☐Vietnam ☐Gulf War

Marriage

Date of present marriage, if applicable: _____

City, County, State of Marriage: _____

Have your or your spouse been married previously? ☐Yes ☐No

Do you and your spouse have a prenuptial or postnuptial agreement? ☐Yes ☐No

If yes, what date was the agreement signed? _____

Children and Immediate Family Members

Please provide the following information for each of your children, including those from previous marriages. If you do not have children, please provide the information of your closest family members, particularly if you intend them to be beneficiaries or fiduciaries.

1st Child's Full Name: _____

☐Ours ☐His ☐Hers ☐Deceased ☐Special Needs

Does this child require help or protection in managing money or property? ☐Yes ☐No

Occupation(s): _____

Address: _____

City _____ State: _____ Zip Code: _____

Email: _____

Main Phone: _____ Alternate Phone: _____

Date of Birth: _____ Current Age: _____

Spouse's Full Name: _____

Spouse's DOB: _____ Current Age: _____

First name(s) & ages of grandchildren: Type Answer Here

2nd Child's Full Name: _____

☐Ours ☐His ☐Hers ☐Deceased ☐Special Needs

Does this child require help or protection in managing money or property? ☐Yes ☐No

Occupation(s): _____

Address: _____

City _____ State: _____ Zip Code: _____

Email: _____

Main Phone: _____ Alternate Phone: _____

Date of Birth: _____ Current Age: _____

Spouse's Full Name: _____

Spouse's DOB: _____ Current Age: _____

First name(s) & ages of grandchildren: Type Answer Here

3rd Child's Full Name: _____

☐Ours ☑His ☐Hers ☐Deceased ☐Special Needs

Does this child require help or protection in managing money or property? ☐Yes ☐No

Occupation(s): _____

Address: _____

City _____ State: _____ Zip Code: _____

Email: _____

Main Phone: _____ Alternate Phone: _____

Date of Birth: _____ Current Age: _____

Spouse's Full Name: _____

Spouse's DOB: _____ Current Age: _____

First name(s) & ages of grandchildren: Type Answer Here

4th Child's Full Name: _____

☐Ours ☐His ☐Hers ☐Deceased ☐Special Needs

Does this child require help or protection in managing money or property? ☐Yes ☐No

Occupation(s): _____

Address: _____

City _____ State: _____ Zip Code: _____

Email: _____

Main Phone: _____ Alternate Phone: _____

Date of Birth: _____ Current Age: _____

Spouse's Full Name: _____

Spouse's DOB: _____ Current Age: _____

First name(s) & ages of grandchildren: Type Answer Here

If you have more than four children, please provide their information on an additional sheet of paper.
Feel free to call our office if you prefer an additional form.

Health Information

Please provide information for each of your healthcare providers. This information supplies a frame of reference when creating a coordinated *LifePlan* with regards to Health Issues in retirement.

Primary Care Physician

Client #1:

Physician's Name: _____

How many years have you seen this physician? _____ Are you happy with his/her care? ☐Yes ☐No

Is this physician a **geriatrician?** ☐Yes ☐No If a geriatrician, board certified? ☐Yes ☐No

Clinic or Medical Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Client #2:

Physician's Name: _____

How many years have you seen this physician? _____ Are you happy with his/her care? ☐Yes ☐No

Is this physician a **geriatrician?** ☐Yes ☐No If a geriatrician, board certified? ☐Yes ☐No

Clinic or Medical Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Additional Physicians

Please provide the names and specialties of any additional healthcare providers. Use additional paper as necessary.

Provider's Name: _____ Specialty: _____

Provider's Name: _____ Specialty: _____

Provider's Name: _____ Specialty: _____

Health Insurance Plan

Please remember to bring a copy of your insurance cards and coverage paperwork.

Client #1

Health Insurance Company: _____

Name of Plan: _____

☐Medigap ☐Med Advantage

Premium Amount: _____

Client #2 (if different)

Health Insurance Company: _____

Name of Plan: _____

☐Medigap ☐Med Advantage

Premium Amount: _____

Family Medical History

	Client #1		Client #2	
	Father	Mother	Father	Mother
Age, if living:				
Age at passing:				
Reason for passing:				
Number of siblings:	____ Living	____ Deceased	____ Living	____ Deceased

	Client #1			Client #2		
	Father	Mother	Siblings	Father	Mother	Siblings
Dementia/Alzheimer's	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Blood Pressure Issues	☐	☐	☐	☐	☐	☐
Elevated Cholesterol	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐

Personal Medical History

	Client #1	Client #2
Dementia/Alzheimer's	☐	☐
Parkinson's	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Blood Pressure Issues	☐	☐
Elevated Cholesterol	☐	☐
Glaucoma	☐	☐
Grew up in a smoking household	☐	☐
Conditions that limit physical ability	☐	☐
Difficulty with gait, balance, or ambulation	☐	☐
Other, please describe:	_____	_____

Current Lifestyle

	Client #1		Client #2	
Are you at a healthy weight?	☐Yes	☐No	☐Yes	☐No
How often do you exercise?	_____		_____	
Do you get regular checkups?	☐Yes	☐No	☐Yes	☐No
Do you have good eating habits?	☐Yes	☐No	☐Yes	☐No
Do you worry about your health?	☐Yes	☐No	☐Yes	☐No
Do you have daily social interaction?	☐Yes	☐No	☐Yes	☐No
Do you have a history of drug use?	☐Yes	☐No	☑Yes	☐No
# of alcoholic drinks/week?	_____		_____	
Do you smoke?	☐Yes	☐No	☐Yes	☐No
If you quit smoking, when?	_____		_____	

Housing Information

Please tell us about your housing situation. You may need to take a few measurements, move around to review, or refer to a map. However, most of all, spend a few moments viewing your home objectively and honestly – through the lens of an older you.

Is it likely that your current home will be the last home you live in? ☐Yes ☐No

On a scale of 0 to 5, how likely is it that you will remain in your current home?

☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5

Plan to move — Will never move

If you answered **no**, please skip to **Retirement Housing Options**.

Current Residence Characteristics

What year was your home built? _____

What is your home's square footage? _____

How many stories does it have? ☐1 ☐2 ☐3 ☐More

Is it split level? ☐Yes ☐No

Is there a bedroom on the main floor (reachable without stairs)? _____

What level are the laundry facilities on? _____

What is the (maintained) yard size? _____

How many stairs must you climb to enter the front door? _____

How many stairs to exit to the back yard? _____

How many stairs to enter the garage? _____

What are the door widths? _____

What is the hallway width? _____

Is your home suitable for a live-in caregiver? ☐Yes ☐No

Are you comfortable having a caregiver in your home? ☐Yes ☐No

What is the distance to the closest relative (who is available to help)? _____

Your Feelings About Retirement Housing Options

Where would you like to retire (city and state)? _____

What is the distance to the closest relative (who is available to help)? _____

Would you consider living with a child/family member? ☐Yes ☐No

Would you consider moving to a condominium? ☐Yes ☐No

Would you consider moving to a lifestyle community? ☐Yes ☐No

Would you consider moving to a retirement community? ☐Yes ☐No

Financial Information

Please remember to bring the following information with you to your appointment.

- ☐ Latest **Tax Return**
- ☐ **Long-Term Care Policy** (i.e., a complete copy of your policy, if you have one)
- ☐ **Life Insurance Policy** (i.e., a complete copy of your policy and latest statement with current values, if you have one)
- ☐ Latest **Financial Statement(s)**: (e.g., Bank, Investment, Retirement accounts)
- ☐ **Deed(s)** to real property

Financial Advisor

Advisor's Full Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (s): _____

Email: _____

How long have you used this advisor? _____

Are you happy with this financial advisor? ☐Yes ☐No

Are you comfortable with your current financial plan? ☐Yes ☐No

Do you worry about the adequacy of your assets? ☐Yes ☐No

Do you consider your financial planner to be anything more than an investment advisor? ☐Yes ☐No

Will there be a continuity of services if this advisor retires, becomes disabled, or dies? ☐Yes ☐No

Are you open to a second opinion? ☐Yes ☐No

Do you understand the cost of investment? ☐Yes ☐No

What services does your financial advisor provide to you besides investment advice?

Type Answer Here

Accountant

Accountant's Full Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (s): _____

Email: _____

How long have you used this accountant? Are you happy with this accountant? ☐Yes ☐No

Will there be a continuity of services if this accountant retires, becomes disabled, or dies? ☐Yes ☐No

Please provide the following financial information. This information allows us to better determine which legal devices will best meet your retirement planning needs.

Assets:

Non-Qualified Financial Assets (Bank Accounts, CDs, Money Market Funds, Stocks, Bonds, Etc.):

Description of Property/ Type of Account	*Institution Where Property is Held*	*Value*	*Owner*	*Beneficiary*
	TOTAL:	**$**		

Qualified Assets (IRAs, 401(k)s, 403(b)s, etc.):

Description of Property/ Type of Account	*Institution Where Property is Held*	*Value*	*Owner*	*Beneficiary*
	TOTAL:	**$**		

Real Property:

Description of Property	*Purchase Date*	*Purchase Price*	*Today's Value*	*Owner*
	TOTAL:	**$**	**$**	

Life Insurance:

	Client #1	*Client #2*
Insurance Company		
Type of Policy?	☐Term	☐Term
	☐Universal	☐Universal
	☐Whole	☐Whole
	☐Other	☐Other
When was the policy started?		
What is the premium?		
If term insurance, when will it expire?		
Death Benefits:		
Cash Value:		
Beneficiary:		

Business Interests:

Name of Business	*Description of Business*	*Date Funded*	*Type of Business* (Sole Prop. LLC, Corp., Partnership, etc.)	*Estimated Market Value*	*Owner(s) and/or Co-owner(s)*
			TOTAL:	**$**	

Long-Term Care Insurance Policies:

	Client #1	*Client #2*
Date Policy Started:		
Insurance Company:		
Daily Benefit Amount - Nursing Home:		
Daily Benefit Amount - Personal Residence:		
Elimination Period:		
Number of Years Benefits Will Continue/Maximum Life Benefits:		
Does the plan have an inflation rider? If so, how much?		
Premium(s):		
When was the last premium increase?		

Liabilities:

Mortgages, Notes to Banks, Notes to Others, Loans on Insurance, Other:

Description	*Name of Lender*	*Payoff Date*	*Outstanding Balance*	*Monthly Payment Amount*
		TOTAL:	**$**	**$**

Current Expenses:

Please summarize your current **monthly** expenses, including expenses you may incur only once a year, or occasionally (e.g., property taxes, prescription drug costs, etc.). Feel free to use additional paper as necessary.

	Monthly
Housing:	
Utilities:	
Insurance:	
Medications:	
Food:	
Auto:	
Taxes:	
Clothes:	
Travel:	
Gym:	
Charity:	
Entertainment:	
Savings:	
Retirement Savings:	
Miscellaneous:	
TOTAL:	**$**

Non-Monthly Expenses	
Example: Property Taxes, etc.	
Description	*Amount*

Monthly Income:

			Complete if not yet retired	
	Client #1 Current	*Client #2 Current*	*Client #1 Projected Retirement*	*Client #2 Projected Retirement*
Social Security (gross):				
Employment (gross):				
Pension (gross):				
IRAs, annuities, etc. (gross):				
Income from investments:				
Rental income (net, before taxes):				
Business Interests (net, EBITDA):				
TOTAL:	**$**	**$**	**$**	**$**

How much do you contribute, monthly, to your retirement? _____

Which sources of income have a benefit for a surviving spouse?

Type Answer Here

Do you anticipate any changes to your income?

Type Answer Here

Is your monthly income less than, equal to, or greater than your monthly expenses? _____

Tax Information:

Adjusted Gross Income (AGI):	
Taxable Income:	
Total Taxes:	
Marginal Tax Rate:	
Effective Tax Rate:	

Future Expectations:

Do you or your spouse expect an inheritance? ☐Yes ☐No

If yes, please describe: _____

Are you or your spouse the beneficiary of any trust? ☐Yes ☐No

If yes, please describe: _____

Legal Information

Please provide us with copies of any applicable existing Legal Estate Planning and Trust documents at your meeting.

When were the following legal documents created?

	Date Executed
Last Will and Testament:	_____
Community Property Agreement:	_____
Pre/Post-Nuptial Agreement:	_____
Durable Power of Attorney:	_____
Living Will/Healthcare Proxy:	_____
Revocable or Irrevocable Trust:	_____
Deed for Residence (if trust exists or is desired):	_____
Funeral or Burial Plan:	_____

What is the location of your important papers? _____

I am the legally appointed guardian of: _____

I have been appointed agent under a Power of Attorney: ☐Yes ☐No

I am serving as executor or administrator of an estate: ☐Yes ☐No

I am involved in a lawsuit: ☐Yes ☐No

I have lived in a separate property state: ☐Yes ☐No
(any state except: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, Wisconsin)

Who do you want to inherit your assets? _____

Do you have any special needs beneficiaries? _____

Fiduciary Assignment

Personal Representative/Trustee

Please identify your choices of trusted individuals who will be your Personal Representatives/Trustee:

Your personal representative will be identified in your legal documents & may be: executor of your Will, administrator of your estate, and/or trustee of any Trusts created within your Last Will and Testament.

	Client #1		Client #2	
	Name	Relationship	Name	Relationship
1st Choice				
2nd Choice				
3rd Choice				

Durable Power of Attorney for Finances

Please identify your choices of trusted individuals who will be your Agent Under Durable Power of Attorney for Finances:

Your Durable Power of Attorney for Finances gives your choice of individual (agent) legal authority to manage your finances on your behalf.

	Client #1		Client #2	
	Name	Relationship	Name	Relationship
1st Choice				
2nd Choice				
3rd Choice				

Durable Power of Attorney for Healthcare

Please identify your choices for Agent Under Durable Power of Attorney for Healthcare:

Your Durable Power of Attorney for Healthcare gives your choice of individual (agent) legal authority to make necessary decisions on your behalf concerning healthcare.

	Client #1		Client #2	
	Name	Relationship	Name	Relationship
1st Choice				
2nd Choice				
3rd Choice				

Living Will

If you were diagnosed with a terminal illness
(no reasonable hope of living more than 6 months)
and unable to communicate

OR

in a persistent vegetative state (comatose)

AND

Your loved ones concurred that there is no reasonable hope of you getting better.

What instructions do you want to give to your loved ones with regards to the use of artificial means of life support?

Please identify your choices for your Living Will:

Client #1

I want **MAXIMUM TREATMENT**:	☐Yes	☐No
I want **LIFE SUPPORT WITHDRAWN**:	☐Yes	☐No

Do you want the following treatments:

Cardiopulmonary Resuscitation (CPR)?	☐Do Want	☐Don't Want
Artificially provided hydration?	☐Do Want	☐Don't Want
Artificially provided nutrition?	☐Do Want	☐Don't Want
Antibiotic treatment for side conditions?	☐Do Want	☐Don't Want
Other heroic measures?	☐Do Want	☐Don't Want

Client #2

I want **MAXIMUM TREATMENT**:	☐Yes	☐No
I want **LIFE SUPPORT WITHDRAWN**:	☐Yes	☐No

Do you want the following treatments:

Cardiopulmonary Resuscitation (CPR)?	☐Do Want	☐Don't Want
Artificially provided hydration?	☐Do Want	☐Don't Want
Artificially provided nutrition?	☐Do Want	☐Don't Want
Antibiotic treatment for side conditions?	☐Do Want	☐Don't Want
Other heroic measures?	☐Do Want	☐Don't Want

Anatomical Gifts

	Client #1		Client #2	
Do you wish to be an organ donor?	☐Yes	☐No	☐Yes	☐No
Do you wish to donate your body for scientific research?	☐Yes	☐No	☐Yes	☐No

Handling of Remains

Please identify your choices for the handling of your remains (Use additional paper if necessary):

	Client #1		Client #2	
Do you wish to be cremated?	☐Yes	☐No	☐Yes	☐No

If yes, what do you want done with your ashes? _____ _____

Further Explanatio

Do you wish to have a funeral/memorial service? ☐Yes ☐No ☐Yes ☐No

Cemetery

	Client #1		Client #2	
Have you made arrangements for the disposition of your remains with any funeral establishment or cemetery?	☐Yes	☐No	☐Yes	☐No

If so, please provide the following information:

Name of Establishment: _____

Address: _____

_____

City _____ State: _____ Zip Code: _____

Email: _____

Main Phone: _____ Plot Number: _____

These arrangements are to be **followed without deviation**. ☐Yes ☑No

These arrangements may be supplemented by my representative. ☐Yes ☐No

Burial Policy

	Client #1		Client #2	
Do you have a burial plot or niche?	☐Yes	☐No	☐Yes	☐No

If so, please provide the following information:

Name of Company: _____

Address: _____

_____

City _____ State: _____ Zip Code: _____

Email: _____

Main Phone: _____ Alternate Phone: _____

What instructions do you wish to leave for your funeral and/or memorial service?

Type Response Here