CZEPIGA DALY POPE & PERRI

Estate Planning | Elder Law | Special Needs | Litigation | Probate

It's Time. Plan Today for Your Tomorrow.

Thank you for choosing Czepiga Daly Pope & Perri to help you plan for your future. In order for us to provide you the best service, please provide all information requested on the following pages.

Client 1 Name ________________________	Client 2 Name ________________________
Home Address ________________________	Home Address ________________________
________________________	________________________
Home Phone ________________________	Home Phone ________________________
Cell Phone ________________________	Cell Phone ________________________
Primary Email ________________________	Primary Email ________________________

Client Certification

The enclosed contains a complete listing of all property and assets in which I have an ownership interest and has been completed to the best of my ability. I understand that Czepiga Daly Pope & Perri will rely on this in making recommendations and/or in preparing my estate plan and that if the information included in this form is not complete or accurate the recommendations and estate plan made in reliance on this questionnaire may be adversely affected or inappropriate.

____

(Client 1 signature) (date)

____

(Client 2 signature) (date)

rev. 12/20

Client Questionnaire

Note: Please provide spellings of names as they should appear on legal documents

1) **Client 1 Name**________________________________ SS# __________________ Date of Birth _____________

   Client 2 Name________________________________ SS# __________________ Date of Birth _____________

2) **Date of this Marriage/Union**____

3) **Was Client 1 Married Previously?** Yes _ No ____ **Client 2?** Yes ________ No____

4) **Prenuptial or Marital Agreements?** Yes ____ No____

5) **Primary Care Physician Client 1** __________________________ **Client 2** _____________________________

6) **Is Client 1 a U.S. Citizen?** Yes _____ No _____ **Client 2?** Yes ____ No ____

7) **Is Client 1 a Veteran?** Yes____ No ____ **Client 2?** Yes ______ No _____

   Branch: **Client 1** ____________________ **Client 2** _________________________

   Dates of Service: **Client 1** _____________________________________ Were You on Active Duty? _____

   Dates of Service: **Client 2** _____________________________________ Were You on Active Duty? _____

8) **Does Client 1 or Client 2 Have Children who are Deceased?** Yes ___ No _____

9) **Children — Names and Addresses:**

1. Name_____________________________________
   Address ___________________________________
   ____
   Cell Phone _________________________________
   Home Phone _______________________________
   Date of Birth _______________________________
   Primary Email ______________________________

2. Name_____________________________________
   Address ___________________________________
   ____
   Cell Phone _________________________________
   Home Phone _______________________________
   Date of Birth _______________________________
   Primary Email ______________________________

3. Name_____________________________________
   Address ___________________________________
   ____
   Cell Phone _________________________________
   Home Phone _______________________________
   Date of Birth _______________________________
   Primary Email ______________________________

4. Name_____________________________________
   Address ___________________________________
   ____
   Cell Phone _________________________________
   Home Phone _______________________________
   Date of Birth _______________________________
   Primary Email ______________________________

10) Grandchildren — Names, Age & Parent's Name:

1. Name____________________ Age______
   Parents Names____________________
2. Name____________________ Age______
   Parents Names____________________
3. Name____________________ Age______
   Parents Names____________________
4. Name____________________ Age______
   Parents Names____________________
5. Name____________________ Age______
   Parents Names____________________
6. Name____________________ Age______
   Parents Names____________________

11) Living Brothers/Sisters — Names & Ages:

Client 1

1. Name ____________________ Age ______
2. Name ____________________ Age ______
3. Name ____________________ Age ______
4. Name ____________________ Age ______

Client 2

1. Name____________________ Age______
2. Name____________________ Age______
3. Name____________________ Age______
4. Name____________________ Age______

12) Living Parents:

Client 1's Mother ____________________

Client 1's Father____________________

Client 2's Mother ____________________

Client 2's Father ____________________

13) Do you or does anyone in your immediate family have a disability? If so, who and what is the nature of the disability?

Name ____

Disability ____

Date of onset ____

Are they receiving Social Security Disability Income (SSDI)? Yes_____ No ____

Are they receiving Supplemental Security Income (SSI)? Yes ____ No_____

Are you or any family members on any programs through the Connecticut Department of Social Services (DSS)?

Yes (please explain)______________________________ No____

14) Does anyone to whom you are leaving part of your estate require help or protection in managing money or other property? If so, please explain the nature of your concern:

Name ____

Concern ____

15) Assets:

A) Residence ______________________________

Sole/Joint Owners ______________________________

Market Value $ ______________ Mortgage Amount $ ______________

Mortgage with ______________________________

B) Other Real Estate ______________________________

Sole/Joint Owners ______________________________

Market Value $ ______________ Mortgage Amount $ ______________

Mortgage with ______________________________

C) Other Real Estate ______________________________

Sole/Joint Owners ______________________________

Market Value $ ______________ Mortgage Amount $ ______________

Mortgage with ______________________________

If any of the items listed below are insured under homeowners, riders or other insurance policies, please indicate so by placing an "X" in the box under the insured column.

Insured:

☐ **Cars** Year ______ Make ______________ Model ______________ Value $ __________

☐ Year ______ Make ______________ Model ______________ Value $ __________

☐ **Jewelry** ______________________________ Value $ __________

☐ **Collections** ______________________________ Value $ __________

☐ **Boat** Year ______ Make ______________ Model ______________ Value $ __________

☐ **Airplane** Year ______ Make ______________ Model ______________ Value $ __________

D) Safe Deposit Box No _____ Yes ____ Bank ______________________________

Accessed by ______________________________

15) Assets *(continued):*

E) Financial Assets: Checking, Savings Accounts, Stocks, Bonds

(Including Savings Bonds, IRAs, Mutual Funds, Money Markets, CDs)

Type of Account	Sole/Joint Owners	Financial Institution	Value	Designated Beneficiary
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________
______________	__________________	______________	________	________________

F) Life Insurance:

1. Sole/Joint Owners ________________________ Insured ____________________________________

   Company ______________________________ Policy No. ________________________________

   Group No. ______________________________ Cash Value ________________________________

   Face Value ______________________________ Designated Beneficiary ______________________

2. Sole/Joint Owners ________________________ Insured ____________________________________

   Company ______________________________ Policy No. ________________________________

   Group No. ______________________________ Cash Value ________________________________

   Face Value ______________________________ Designated Beneficiary ______________________

3. Sole/Joint Owners ________________________ Insured ____________________________________

   Company ______________________________ Policy No. ________________________________

   Group No. ______________________________ Cash Value ________________________________

   Face Value ______________________________ Designated Beneficiary ______________________

15) Assets *(continued)*:

G) Have You Made Any Gifts?

Type of Asset	To Whom	Value of Gift	Year
1. ______	______	$ ______	______
2. ______	______	$ ______	______
3. ______	______	$ ______	______
4. ______	______	$ ______	______
5. ______	______	$ ______	______
	TOTAL VALUE OF GIFTS:	$ ______	

H) Have you filed a Gift Tax Return? Yes ____ No____

I) Other Assets (i.e. leases, debts you owe, other):______

______

______

J) Business Interests:

1. ______
2. ______

K) Trusts: ______

______

______

L) Monthly Income:	**Client 1**	**Client 2**
Social Security — Retirement	$ ______	$ ______
Social Security Disability (SSDI)	$ ______	$ ______
Supplemental Security Income (SSI)	$ ______	$ ______
Employment	$ ______	$ ______
Veterans Administration Benefits	$ ______	$ ______
Annuity	$ ______	$ ______
Pension	$ ______	$ ______
Other	$ ______	$ ______

16) Health Insurance:

A) Medicare:

Client 1's Number ______________________ Client 2's Number ______________________

Effective Date ______________________ Effective Date ______________________

Premium $ ______________________ Premium $ ______________________

B) Insurance from Employer:

Name of Company ______________________ Name of Company ______________________

Policy Number ______________________ Policy Number ______________________

Group Number ______________________ Group Number ______________________

Effective Date ______________________ Effective Date ______________________

Premium $ ______________________ Premium $ ______________________

C) Medicare Supplement:

Name of Company ______________________ Name of Company ______________________

Policy Number ______________________ Policy Number ______________________

Group Number ______________________ Group Number ______________________

Effective Date ______________________ Effective Date ______________________

Premium $ ______________________ Premium $ ______________________

D) Long Term Care Insurance:

Name of Company ______________________ Name of Company ______________________

Are there policy time limits? Yes____ No_____ If yes, how many years? _____

What are the policy dollar limits? (Total dollar amount, daily amount) $ ___________

E) Medicaid (Title XIX)**:**

Client 1's Number ______________________ Client 2's Number ______________________

Type______________________ Type ______________________

17) Prepaid Funeral:

Client 1's Funeral Home ______________________________ $ ______________

Client 2's Funeral Home ______________________________ $ ______________

18) Liabilities:

No____ Yes _____ Please describe______________________________________

____

OTHER ISSUES TO DISCUSS: ______________________________________

____

____

____

Please bring the following documents with you to your meeting with the Attorney:

1. Wills and Trusts
2. Living Wills
3. Appointment of Healthcare Agents or Representatives
4. Powers of Attorney
5. Long-Term Care Policies
6. Deeds to Real Estate
7. Annuities
8. Life Insurance Policies
9. Current Bank, IRA, Investment and Annuity Account Statements
10. Prenuptial or Marital Agreements
11. Proof of Disability, if indicated
12. Guardianship or Conservatorship Documents

How did you hear about us? *(check **ALL** that apply)*

- ☐ I am an Existing Client
- ☐ Attorney *(Name)* ______________________________
- ☐ Client Referral *(Name)* ______________________________
- ☐ Financial Planner *(Name)* ______________________________
- ☐ Czepiga Daly Pope & Perri Employee *(Name)* ______________________________
- ☐ Website of Czepiga Daly Pope & Perri
- ☐ Webinar *(Name)*______________________________
- ☐ Seminar *(Name)*______________________________
- ☐ Adult Education *(Town)*______________________________
- ☐ Television
- ☐ Non-Profit or Assoc./Civic or Charity *(Name)* ______________________________
- ☐ Print Ad *(Where)* ______________________________
- ☐ Nursing Home/Assisted Living *(Name)* ______________________________
- ☐ Healthcare Professional *(Name)* ______________________________
- ☐ CPA *(Name)*______________________________
- ☐ Radio
- ☐ Professional Organization *(Name)*______________________________
- ☐ Government Agency *(Name)*______________________________
- ☐ Other *(Please Specify)* ______________________________