



CZEPIGA DALY POPE & PERRI

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

It's Time. Plan Today for Your Tomorrow.

Thank you for choosing CzepigaDalyPope&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.

Primary Name _____

Spouse 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 CzepigaDalyPope&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.

(signature)

(date)

(signature)

(date)

CLIENT QUESTIONNAIRE

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

1) Primary Name _____ SS# _____ Date of Birth _____

Spouse Name _____ SS# _____ Date of Birth _____

2) Date of this Marriage/Union _____

3) Were you Married Previously? Yes ___ No ___ Your Spouse? Yes ___ No ___

4) Prenuptial or Marital Agreements? Yes ___ No ___

5) Primary Care Physician _____ Spouse _____

6) Are You a U.S. Citizen? Yes ___ No ___ Your Spouse? Yes ___ No ___

7) Are You a Veteran? Yes ___ No ___ Your Spouse? Yes ___ No ___

Branch: You _____ Your Spouse _____

Dates of Service: You _____ Were You on Active Duty? _____

Dates of Service: Spouse _____ Were You on Active Duty? _____

8) Do You or Your Spouse Have Children who are Deceased? Yes ___ No ___

9) Children — Names and Addresses:

1. Name _____

Address _____

Cell Phone _____

Home Phone _____

Date of Birth _____

Primary Email _____

3. Name _____

Address _____

Cell Phone _____

Home Phone _____

Date of Birth _____

Primary Email _____

2. 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 _____	4. Name _____ Age _____ Parents Names _____
2. Name _____ Age _____ Parents Names _____	5. Name _____ Age _____ Parents Names _____
3. Name _____ Age _____ Parents Names _____	6. Name _____ Age _____ Parents Names _____

11) Living Brothers/Sisters — Names & Ages:

Primary

Spouse

1. Name _____ Age _____	1. Name _____ Age _____
2. Name _____ Age _____	2. Name _____ Age _____
3. Name _____ Age _____	3. Name _____ Age _____
4. Name _____ Age _____	4. Name _____ Age _____

12) Living Parents:

Your Mother _____	Spouse’s Mother _____
Your Father _____	Spouse’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	Name(s)	Bank	Value	Beneficiary
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

F) Life Insurance:

1. Owner _____ Insured _____
Company _____ Policy No. _____
Group No. _____ Cash Value _____
Face Value _____ Beneficiary _____

2. Owner _____ Insured _____
Company _____ Policy No. _____
Group No. _____ Cash Value _____
Face Value _____ Beneficiary _____

3. Owner _____ Insured _____
Company _____ Policy No. _____
Group No. _____ Cash Value _____
Face Value _____ 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:

	Primary	Spouse
Social Security — Retirement	\$ _____	\$ _____
Social Security Disability (SSDI)	\$ _____	\$ _____
Supplemental Security Income (SSI)	\$ _____	\$ _____
Employment	\$ _____	\$ _____
Veterans Administration Benefits	\$ _____	\$ _____
Annuity	\$ _____	\$ _____
Pension	\$ _____	\$ _____
Other	\$ _____	\$ _____

16) Health Insurance:

A) Medicare:

Primary's Number _____	Spouse'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):

Primary's Number _____	Spouse's Number _____
Type _____	Type _____

17) Prepaid Funeral:

Primary's Funeral Home _____	\$ _____
Spouse'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)*

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