Client Information Form

NON-CRISIS Life Planning

Mr.& Mrs. Gregory,

Thank you for taking time to complete the online organizer. It should prove to be a program that you will maintain over time without having to put the work you put in to create the first one. The information will be useful not only for you but your agents and family members, when they have to fulfill their obligations under the various documents in which you may have named them to be your agents. Though there is no need to print the form, many people like to have a hard copy. You can get that hard copy here. If you have any questions please contact us https://lifepointlaw.com/.

We are grateful for the opportunity to be of service to you. If you have any feedback on how we can make this process better please do provide us feedback. If you found this process to be valuable, please consider sharing this form with your friends and family (they should be able to enter emails and the form should be sent to these people with an explanation of what the form does).

Gratefully,

Your Legal Team at

LIFE POINT LAW
Trusted Attorneys

Personal Information

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

Full name: George Gregory

Previous name:

Date of Birth: 01-12-1971

Occupation: software

At what age do you anticipate retiring?

Place Of Birth: Ayodhya Uttar Pradesh, India, 26.7921605, 82.1997954

Address: 11411 Brookshire Avenue, Downey, CA, USA

Home Phone:

Cell Phone: +91 (620) 441-3269

Personal Information

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

Full name: George Gregory

Previous name: | Date of Birth: 01-12-1971

Occupation: software | At what age do you anticipate retiring?

Place Of Birth: Ayodhya Uttar Pradesh, India, 26.7921605, 82.1997954

Address: 11411 Brookshire Avenue, Downey, CA, USA | Home Phone:

Cell Phone: +91 (620) 441-3269

City: Downey State: California | Work Phone:

Country: United States Zip: 90241 | Email: GeorgeGreory@mailinator.com

US Citizen: ☑ Yes ☐ No

Are you a U.S. Veteran? ☐ Yes ☑ No

If married please provide The following information

Full name: Anika Gregory

Previous name: | Date of Birth: 02-19-2000

Occupation: | At what age do you anticipate retiring?

Place Of Birth:

Address: | Home Phone:

Cell Phone: +91 (620) 441-3269

City: State: | Work Phone:

Country: | Email: Anikagregory@mailinator.com

Spouse Full Name : Karan - Spouse null Name | Spouse DOB:

Current Age: 0

US Citizen

Are you a U.S. Veteran? ☐ Yes ☑ No

Child's Full Name: Adam Gregory

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

Child's Full Name: Karan Kumar

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

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

Occupation:

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

Date of Birth: 02-12-1995 | Current Age: 28

1st Name and Ages of Grandchildrens: Veshali Saxena

Date of Birth:

Country: Email: Anik

Spouse Full Name : Karan - Spouse null Name Spouse DOB:

Current Age: 0

US Citizen

Are you a U.S. Veteran? ☐ Yes ☑ No

Child's Full Name: Adam Gregory

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

Child's Full Name: Karan Kumar

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

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

Occupation:

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

Date of Birth: 02-12-1995 Current Age: 28

Occupation:

1st Name and Ages of Grandchildrens: Veshali Saxena

Date of Birth:

Child's Full Name: Abhi Kumar

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

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

Occupation:

Date of Birth: 12-12-2002 Current Age: 20

Child's Full Name: Agatha Gregory

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

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

Occupation:

Date of Birth: 07-14-1993 Current Age: 30

Child's Full Name: Jjjjj Lkjlkj

☐ Ours ☐ His ☐ Hers ☐ Deceased ☐ Speical Needs

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

Occupation:

Date of Birth: Current Age: 0

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

Spouse Full Name : Jjjj Spouse null Name Spouse DOB:

Current Age: 0

Family Medical History

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.

	Client #1		Client #2	
	Father	Mother	Father	Mother
Age, If Living				0
Age at passing			55	
Reason for			55	

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

Occupation:

Date of Birth:

Current Age: 0

Spouse Full Name : Jjjj Spouse null Name

Spouse DOB:

Current Age:

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:

Client #2:

Family Medical History

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.

	Client #1		Client #2	
	Father	Mother	Father	Mother
Age, If Living				0
Age at passing			55	
Reason for passing:			55	
Number of siblings:	Living	Deceased	55 Living	55 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
Meds you are allergic to		
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	☐	☐

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 habbits?	☐ Yes	☐ No	☐ Yes	☐ No
Do you worry about your health?	☐ Yes	☑ No	☑ Yes	☐ No
Do You have daily social interaction?	☐ Yes	☐ No	☐ Yes	☐ No

Dementia/Alzheimer's

Meds you are allergic to

Parkinson's

Current Lifestyle

Heart Disease

	Client #1		Client #2	
Stroke				
Are you at a healthy weight?	☑ Yes	☐ No	☑ Yes	☐ No
Diabetes				
How Often do you exercise?				
Blood Pressure Issues				
Do You Get Regular checkups?	☐ Yes	☑ No	☑ Yes	☐ No
Elevated Cholesterol				
Do you have good eating habbits?	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma				
Do you worry about your health?	☐ Yes	☑ No	☑ Yes	☐ No
Grew up in a smoking household				
Do You have daily social interaction?	☐ Yes	☐ No	☐ Yes	☐ No
Conditions that limit physical ability				
Do you have a history of drug use?	☐ Yes	☑ No	☑ Yes	☐ No
Difficulty with gait, balance, or ambulation				
# of alcoholic drinks per week?	0		51	
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? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

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 ☐ 4 ☐ More ☐

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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.

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On a scale of 0 to 5, how likely is it that you will remain in your current home? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

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 ☐ 4 ☐ More ☐

Is it split level? Yes ☐ No ☐

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

What floor is the laundry on? _____

What is the (maintained) yard size? _____

How many steps do you have to climb to get to the front door _____

How many steps do you have to navigate to get to the backyard? _____

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 ☐

Your Feelings About Retirement Housing Options

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

Who would be the closet relative from that place? _____

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

Would you consider living with a child/family member? Yes ☐ No ☐ Not Sure ☐

Would you consider moving to a condominium? Yes ☐ No ☐ Not Sure ☐

Would you consider moving to a lifestyle community? Yes ☐ No ☐ Not Sure ☐

Would you consider moving to a retirement community? Yes ☐ No ☐ Not Sure ☐

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 _____

Would you consider moving to a condominium? Yes ☐ No ☐ Not Sure ☐

Would you consider moving to a lifestyle community? Yes ☐ No ☐ Not Sure ☐

Would you consider moving to a retirement community? Yes ☐ No ☐ Not Sure ☐

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

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- ☐ 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: _____ Cell 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? _____

Accountant

Accountant's Full Name: _____

Company: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Cell 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.)

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

Accountant

Accountant's Full Name:

Company:

Address:

City:

State:

Zip Code:

Cell Number (s):

Email:

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?		
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:

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)
					Client #2
			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.

Please summarize your currently monthly expenses, including expenses you may incur only once a year, or occasionally(eg, property taxes, prescription drug costs, etc)

Total	$0

Non-Monthly Expenses	
Example: Property Taxes, etc.	
Description	Amount
Tester	$2,500
Sample	$5,000

Monthly Income:

			Complete if yet Not Retired	
	Primary	Spouse	Primary Projected Retirement	Spouse Projected Retirement
Social Security (gross)	$0	$0	$0	$0
Employment (gross)	$0	$0	$0	$0
Pension (gross)	$0	$0	$0	$0
IRAs	$0	$0	$0	$0
Annuities	$0	$0	$0	$0
Income from investments	$0	$0	$0	$0

Monthly Income:

			Complete if yet Not Retired	
	Primary	Spouse	Primary Projected Retirement	Spouse Projected Retirement
Social Security (gross)	$0	$0	$0	$0
Employment (gross)	$0	$0	$0	$0
Pension (gross)	$0	$0	$0	$0
IRAs	$0	$0	$0	$0
Annuities	$0	$0	$0	$0
Income from investments	$0	$0	$0	$0
Rental income (net,before taxes)	$0	$0	$0	$0
Business Interestes (net,EBITDA)	$0	$0	$0	$0
Salary	$0	$0	$0	$0
etc	$0	$0	$0	$0
Other	$0	$0	$0	$0
TOTAL:	$0	$0	$0	$0

From your net income, how much do you contribute towards savings or retirement each month? _____

Tax Information:

Tax Year	YYYY
Adjusted Gross Income	$0
Taxable Income	$0
Total Taxes:	$0
Marginal Tax Rate	$0
Effective Tax Rate	$0

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?

Documents	Date Executed
Gun Trust	09-07-1999

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

Marginal Tax Rate	$0
Effective Tax Rate	$0

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?

Documents	Date Executed
Gun Trust	09-07-1999

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

Name Relationship

Client-#2

Name Relationship

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:

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

Name Relationship

Client-#2

Name Relationship

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

Name Relationship

Client-#2

Name Relationship

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

Living Will Details

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		Client #2	
I want **MAXIMUM TREATMENT:**	☐ Yes	☐ No	☐ Yes	☐ No
I want **LIFE SUPPORT WITHDRAWN:**	☐ Yes	☐ No	☐ Yes	☐ No
Cardiopulmonary Resuscitation (CPR)?	☐ Do Want	☐ Don't Want	☐ Do Want	☐ Don't Want

Living Will Details

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(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		Client #2	
I want **MAXIMUM TREATMENT:**	☐ Yes	☐ No	☐ Yes	☐ No
I want **LIFE SUPPORT WITHDRAWN:**	☐ Yes	☐ No	☐ Yes	☐ No
Cardiopulmonary Resuscitation (CPR)?	☐ Do Want	☐ Don't Want	☐ Do Want	☐ Don't Want
Artificially provided hydration?	☐ Do Want	☐ Don't Want	☐ Do Want	☐ Don't Want
Artificially provided nutrition?	☐ Do Want	☐ Don't Want	☐ Do Want	☐ Don't Want
Antibiotic treatment for side conditions?	☐ Do Want	☐ Don't Want	☐ Do Want	☐ Don't Want
Other heroic measures?	☐ Do Want	☐ Don't Want	☐ 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?				
Do you wish to have a funeral/memorial service?	☐ Yes	☐ No	☐ Yes	☐ No
These arrangements may be supplemented by my representative.	☐ Yes	☐ No		

Cemetery

	Client #1		Client #2	
Have you made arrangements for handling of remains with any funeral establishment or cemetery?	☐ Yes	☐ No	☐ Yes	☐ No
Burial Policy/Cremation				
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:
Main Phone:

If so, please provide the following information:
Name of Company:
Address:
City: State:
Zip Code:
Email:
Main Phone:
These arrangements a Alternate Phone: ☐ Yes

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

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

Cemetery

	Client #1	Client #2
Have you made arrangements for handling of remains with any funeral establishment or cemetery?	☐ Yes ☐ No	☐ Yes ☐ No
Burial Policy/Cremation	**Client #1**	**Client #2**
Do you have a burial plot or niche?	☐ Yes ☐ No	☐ Yes ☐ No
If so, please provide the following information:		
If so, please provide the following information:		

Name of Company:
Name of Company: _____

Address:
Address: _____

_____

City: State: State:
City: Zip Code:
Zip Code: _____ ail: _____

Email:
Main Phone: _____ Number:
Main Phone: Alternate Phone:
These arrangements a _____ ☐ Yes _____

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

_____

_____