

**** Confidential Planning Information (for Couple-Long Form) ****

For Use by Lovingood McGuffey, P.C.

Your appointment with this office is: _____ at _____.

Our address is Suite 300, 1300 Cleo Way, Dalton, Georgia 30720

These questions pertain to the persons, Husband and Wife, for whom we are planning.

We ask a lot of questions on this form because we need a lot of information about you for our planning for you. Do your best, but don't worry if some of the information you need to complete this form is not available to you.

Please call us at (706) 428-0888 if you have any questions or concerns about completing this form.

Date: _____ Referred by: _____

1. Personal Information

Husband: _____

Wife: _____

Address: _____

Date of birth: _____

Place of birth: _____

Phone: _____

SSN: _____

Email: _____

U. S. citizen?: Yes No

County: _____

Veteran?: Yes No Dates: _____

Date of birth: _____

Address: Same as Husband

Place of birth: _____

Different: _____

SSN: _____

U. S. citizen?: Yes No

Veteran?: Yes No Dates: _____

Phone: _____

Marriage Information

Date and place of marriage: _____

Contact Information

If not you, who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?:

2. Children

Name: _____
Address: _____

Phone: _____
Email: _____
Spouse: _____
Children: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Spouse: _____
Children: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Spouse: _____
Children: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Spouse: _____
Children: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Spouse: _____
Children: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Spouse: _____
Children: _____

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)? Yes No
If yes, who?: _____

Are any of your children receiving Supplement Security Income, Social Security Disability; or, if not, has any major disabilities? Yes No
If yes, who?: _____

3. Information About Your Health

Husband:

- 1. What medical or health problems do you currently have?

- 2. What medical problems have you had in the past?

3. Please list all of the medications you are currently taking:

Medication	Why Are You Taking This Drug?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Does your family have a history of health problems (for example, heart disease, cancer, or Alzheimer’s disease)? Describe:

Tell us about your parents:

	Your Mother	Your Father
Age at Death:		
Cause of Death:		

5. Name of your personal physician(s):

Name: _____

Address: _____

City/State: _____

Medical specialty: _____

Telephone #: _____

Name: _____

Address: _____

City/State: _____

Medical specialty: _____

Telephone #: _____

Wife:

1. What medical or health problems do you currently have?

2. What medical problems have you had in the past?

3. Please list all of the medications you are currently taking:

Medication	Why Are You Taking This Drug?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Does your family have a history of health problems (for example, heart disease, cancer, or Alzheimer’s disease)? Describe:

Tell us about your parents:

	Your Mother	Your Father
Age at Death:		
Cause of Death:		

5. Name of your personal physician(s):

Name:

Address:

City/State:

Medical specialty:

Telephone #:

Name:

Address:

City/State:

Medical specialty:

Telephone #:

4. Functional Limitations and Support

The term “activities of daily living” refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help in order to cope, from either other human beings or mechanical devices (such as a walker or wheelchair) or both.

Why do we want this information? Measurement of the activities of daily living is critical because the more assistance people need with their daily activities, the more likely are they to be admitted to a nursing home or other living arrangement; to use paid home care; to use hospitals and doctors; and to die sooner rather than later.

Place an X in the box that most applies for each activity.

Husband:

Activities of Daily Living			
Activity	Need No Help	Need Some Help	Unable to Do At All
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			

Instrumental Activities of Daily Living			
Activity	Need No Help	Need Some Help	Unable to Do At All
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	Place Where You Live	Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

List the names of all persons who provide assistance or caregiving for you:

Wife:

Activities of Daily Living			
Activity	Need No Help	Need Some Help	Unable to Do At All
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			

Instrumental Activities of Daily Living			
Activity	Need No Help	Need Some Help	Unable to Do At All
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	Place Where You Live	Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

List the names of all persons who provide assistance or caregiving for you:

5. Resources

Monthly Income

Do not list interest or dividend income.

Source	Husband	Wife	Joint
Social Security:			
Pension:			
Other:			
Total:			

A. Personal Residence

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____

Purchase Price: _____

Current Value: _____

Tax-Appraised Value: _____

Mortgage Company: _____

Mortgage Balance: _____

B. Other Real Estate

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____

Purchase Price: _____

Current Value: _____

Tax-Appraised Value: _____

Mortgage Company: _____

Mortgage Balance: _____

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____

Purchase Price: _____

Current Value: _____

Tax-Appraised Value: _____

Mortgage Company: _____

Mortgage Balance: _____

Other Assets

These are your bank accounts, CDs, annuities, stocks, retirement plans, and the like.

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Total Value of Assets on this Page: _____

(Use additional pages as necessary)

List all life insurance.

Company Name:

Owner:

Insured:

Beneficiary:

Death Benefit (face value):

Cash surrender value:

Loan against policy (if any):

Company Name:

Owner:

Insured:

Beneficiary:

Death Benefit (face value):

Cash surrender value:

Loan against policy (if any):

Company Name:

Owner:

Insured:

Beneficiary:

Death Benefit (face value):

Cash surrender value:

Loan against policy (if any):

Personal Property.

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins and stamps, guns, etc.):

Personal Property (Item)	Value

Do either or both of you have a prepaid funeral or burial? Yes No

If yes, describe the arrangements:

Husband: _____

Wife: _____

Other Insurance

Please complete the following health insurance information as it applies to both of you:

Husband:

Medicare

Traditional Medicare Fee-for-Service? Yes No

OR

Medicare HMO, PSO, PPO, Private Plan? Yes No

Company: _____ Premium Amt: \$ _____

Medicare Supplement (“Medigap”)

Company: _____

Type (Plan A through J): _____ Premium Amt: \$ _____

Medicare Prescription Drug Plan

Company: _____ Premium Amt: \$ _____

Employer Retiree Health Plan

Company: _____ Premium Amt: \$ _____

Private Health Insurance

Company: _____ Premium Amt: \$ _____

Long Term Care Insurance

Company: _____

Daily Benefit Amount: _____

Length of Coverage: _____

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: _____

Type: _____

Company: _____

Type: _____

Company: _____

Type: _____

Would you like us to try to get you a quote on Long-term care insurance? _____

Wife:

Medicare

Traditional Medicare Fee-for-Service? Yes No

OR

Medicare HMO, PSO, PPO, Private Plan? Yes No

Company: _____ Premium Amt: \$ _____

Medicare Supplement (“Medigap”)

Company: _____

Type (Plan A through J): _____ Premium Amt: \$ _____

Medicare Prescription Drug Plan

Company: _____ Premium Amt: \$ _____

Employer Retiree Health Plan

Company: _____ Premium Amt: \$ _____

Private Health Insurance

Company: _____ Premium Amt: \$ _____

Long Term Care Insurance

Company: _____

Daily Benefit Amount: _____

Length of Coverage: _____

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: _____

Type: _____

Company: _____

Type: _____

Company: _____

Type: _____

Would you like us to try to get you a quote on Long-term care insurance? _____

6. Monthly Expenses

Item	Amount
Property tax	_____
Home maintenance and upkeep	_____
Homeowners insurance	_____
Utilities (gas, electric, water & sewer, security)	_____
Residential facility	_____
Private health care services	_____
Telephone	_____
Cable television	_____
Auto operation (gas and maintenance)	_____
Auto insurance	_____
Clothing	_____
Groceries and other household	_____
Hair cuts, personal grooming	_____
Laundry and cleaning	_____
Checking account charges/bank fees	_____
Newspapers and magazines	_____
Recreation, vacation, entertainment	_____
Health insurance (such as Medicare supplement)	_____
Unreimbursed medical expense (such as for drugs)	_____
Life insurance	_____
Charitable contributions	_____
Other: _____	_____
Other: _____	_____
Total Monthly Expenses:	_____

Anticipated maintenance needs to homestead (examples: roof, windows, painting, foundation repair, driveway, etc.)

Item	Cost
_____	_____
_____	_____
_____	_____
Total	_____

7. Money You Owe

Creditor's Name	Amount Owed
_____	_____
_____	_____
Total	_____

8. Public Benefits and Community Services

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, (in Tennessee, TennCare), CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs.

Yes No

If yes, please list them below:

Provider	Form of assistance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9. Gifts and Transfers

Have you made *any* gifts or transfers, greater than \$500.00, to any individuals or to a trust within the last 60 months? Yes No

If yes, please furnish the indicated information for each gift or transfer:

To whom: _____
 Date of gift: _____
 Item: _____
 Value: _____

To whom: _____
 Date of gift: _____
 Item: _____
 Value: _____

To whom: _____
 Date of gift: _____
 Item: _____
 Value: _____

To whom: _____
 Date of gift: _____
 Item: _____
 Value: _____

10. Estate Planning

Do you have any of the following documents?	Husband	Wife
Durable Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Place an X in the box that applies. Please bring the existing documents with you to our meeting. If there are any other documents you have questions about, please bring them as well.

Please provide the remaining information below only if the above documents are not in place or you want to make changes to these documents in our planning process.

There is a section to be completed for each of you (Husband and Wife).

Note: Please read all of the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.) We will discuss your choices at our meeting.

Husband:

Upon my death, I want to give
<input type="checkbox"/> Everything to my wife, if she survives me, otherwise to my children in equal shares OR
<u>Alternative #1</u>
<input type="checkbox"/> Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age _____
<u>Alternative #2</u>
<input type="checkbox"/> Everything to my children and to my deceased spouse's children in equal shares.
<u>Alternative #3</u>
<input type="checkbox"/> I want to make bequests different from those above.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

Whom do you want to serve as your executor? Please give name and full addresses for a first choice, and for an alternate second choice.

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Husband's Decision Making

Health Care

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? (List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want to be an organ donor? Yes No Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference? Yes No

If yes, what religion are you?: _____

Legal and Financial

If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? (List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?:

- Yes No Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

- No restrictions, I trust my attorney-in-fact to make the right decision.

- My restrictions are: _____

Wife:

Upon my death, I want to give
<input type="checkbox"/> Everything to my husband, if he survives me, otherwise to my children in equal shares OR
Alternative #1
<input type="checkbox"/> Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age _____
Alternative #2
<input type="checkbox"/> Everything to my children and to my deceased spouse's children in equal shares.
Alternative #3
<input type="checkbox"/> I want to make bequests different from those above.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

Whom do you want to serve as your executor? Please give name and full addresses for a first choice, and for an alternate second choice.

1. Name:

Address:
City/State:
Relationship:
Telephone #:

2. Name:

Address:
City/State:
Relationship:
Telephone #:

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name:

Address:
City/State:
Relationship:
Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Wife's Decision Making

Health Care

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)?
(List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want to be an organ donor? Yes No Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference? Yes No

If yes, what religion are you?: _____

We cannot provide accurate advice without accurate information. Lovingood McGuffey and its attorneys will rely on the information you provide to us in this Workbook. By signing below, you are stating that the information provided in this document is true and accurate to the best of your knowledge.

Signature

Date

Revised: October 2007