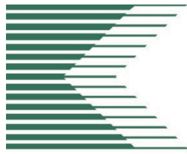

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Canton, Ohio 44718
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ASSET & ESTATE PROTECTION PLANNING QUESTIONNAIRE

(Single)

PERSONAL AND CONFIDENTIAL

Date: ___________________________________

BACKGROUND INFORMATION

LEGAL NAME: ____
First *MI* *Last*

ADDRESS: ____
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S): ____
Home *Cell* *Work*

E-MAIL ADDRESS: ____
We do not recommend work emails as these are not considered private, and void the attorney client privilege.

DATE OF BIRTH: ____

U.S. CITIZENSHIP: ☐ Yes ☐ No

OCCUPATION: ____
Employer

If Widowed, name(s) of deceased spouse(s): ______________________________
First *MI* *Last*

____
First *MI* *Last*

If Divorced, name(s) of former spouse(s): ______________________________
First *MI* *Last*

____
First *MI* *Last*

MILITARY SERVICE: ____
(Provide Branch & Dates of Service)

FAMILY MEMBERS – CHILDREN

(Please state child's legal name)

Child 1 NAME:______________________________
First *MI* *Last*

ADDRESS:______________________________
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S):______________________________
Home *Cell* *Work*

OCCUPATION (if applicable)______________________________

DATE OF BIRTH: ____________________ E-mail:____________________

Adopted: ☐ Yes ☐ No Name of Other Parent____________________

Disabled: ☐ Yes ☐ No If disabled, complete: Special Needs Section

Married: ☐ Yes ☐ No Spouse:____________________

Child 1's Children:

Name:____________________ Date of Birth ____________

Name:____________________ Date of Birth ____________

Name:____________________ Date of Birth ____________

Child 2 NAME:______________________________
First *MI* *Last*

ADDRESS:______________________________
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S):______________________________
Home *Cell* *Work*

OCCUPATION (if applicable)______________________________

DATE OF BIRTH: ____________________ E-mail:____________________

Adopted: ☐ Yes ☐ No Name of Other Parent____________________

Disabled: ☐ Yes ☐ No If disabled, complete: Special Needs Section

Married: ☐ Yes ☐ No Spouse:____________________

Child 2's Children:

Name:____________________ Date of Birth ____________

Name:____________________ Date of Birth ____________

Name:____________________ Date of Birth ____________

Child 3 NAME:______________________________
First *MI* *Last*

ADDRESS:______________________________
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S):______________________________
Home *Cell* *Work*

OCCUPATION (if applicable)______________________________

DATE OF BIRTH: ______________________ E-mail: ______________________

Adopted: ☐ Yes ☐ No Name of Other Parent ______________________

Disabled: ☐ Yes ☐ No If disabled, complete: Special Needs Section

Married: ☐ Yes ☐ No Spouse: ______________________

Child 3's Children:

Name: ______________________ Date of Birth ______________

Name: ______________________ Date of Birth ______________

Name: ______________________ Date of Birth ______________

Child 4 NAME: ______________________

First *MI* *Last*

ADDRESS: ______________________

Street Number and Name

____

City *State* *Zip* *County*

PHONE NUMBER(S): ______________________

Home *Cell* *Work*

OCCUPATION (if applicable) ______________________

DATE OF BIRTH: ______________________ E-mail: ______________________

Adopted: ☐ Yes ☐ No Name of Other Parent ______________________

Disabled: ☐ Yes ☐ No If disabled, complete: Special Needs Section

Married: ☐ Yes ☐ No Spouse: ______________________

Child 4's Children:

Name: ______________________ Date of Birth ______________

Name: ______________________ Date of Birth ______________

Name: ______________________ Date of Birth ______________

Child 5 NAME: ______________________

First *MI* *Last*

ADDRESS: ______________________

Street Number and Name

____

City *State* *Zip* *County*

PHONE NUMBER(S): ______________________

Home *Cell* *Work*

OCCUPATION (if applicable) ______________________

DATE OF BIRTH: ______________________ E-mail: ______________________

Adopted: ☐ Yes ☐ No Name of Other Parent ______________________

Disabled: ☐ Yes ☐ No If disabled, complete: Special Needs Section

Married: ☐ Yes ☐ No Spouse: ______________________

Child 5's Children:

Name: ______________________ Date of Birth ______________

Name: ______________________ Date of Birth ______________

Name: ______________________ Date of Birth ______________

Child 6 NAME:______________________________
First *MI* *Last*

ADDRESS:______________________________
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S):______________________________
Home *Cell* *Work*

OCCUPATION (if applicable)______________________________

DATE OF BIRTH: ____________________ E-mail:____________________

Adopted: ☐ Yes ☐ No Name of Other Parent____________________

Disabled: ☐ Yes ☐ No If disabled, complete: Special Needs Section

Married: ☐ Yes ☐ No Spouse:____________________

Child 6's Children:

Name:____________________ Date of Birth ____________

Name:____________________ Date of Birth ____________

Name:____________________ Date of Birth ____________

PARENTS

(Please state parent's legal name)

Father NAME:______________________________
First *MI* *Last*

ADDRESS:______________________________
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S):______________________________
Home *Cell* *Work*

Mother NAME:______________________________
First *MI* *Last*

ADDRESS:______________________________
Street Number and Name

____
City *State* *Zip* *County*

PHONE NUMBER(S):______________________________
Home *Cell* *Work*

FINANCIAL & TAX ADVISORS

Name of Stockbroker or financial advisor: ______________________________

Address:____

Telephone: ____________________ E-mail:__________________________

Name of Accountant or tax preparer: ________________________________

Address:____

Telephone: ____________________ E-mail:__________________________

REAL ESTATE - HOME

Address: ____

This property is: ☐ A house ☐ A mobile home ☐ A condominium ☐ An apartment

If other, describe: ____

If mobile home: ☐ Own the lot ☐ Rent the lot

Name(s) on the deed: ____

Is there a mortgage? ☐ Yes ☐ No Mortgage balance $______________

Tax assessor's value $____

What price would you expect to receive if you sold this property? $________________

Date of purchase ____________ Purchase Price $ ______________________

OTHER REAL ESTATE

Address: ____

This property is: ☐ A house ☐ A mobile home ☐ A condominium ☐ An apartment

If other, describe: ____

If mobile home: ☐ Own the lot ☐ Rent the lot

Name(s) on the deed: ____

Is there a mortgage? ☐ Yes ☐ No Mortgage balance $__________

Tax assessor's value $____

What price would you expect to receive if you sold this property? $________________

Date of purchase ____________ Purchase Price $ ______________________

Do you receive rental income? ☐ Yes ☐ No Monthly rental amount $__________

LIFE INSURANCE

Company	Insured/Owner (if different, list both)	Beneficiary	Death Benefit	Loans	Cash Surrender Value
			$	$	$
			$	$	$
			$	$	$

MONEY OWED TO YOU

(Loans, mortgages, promissory notes)

Receivable #1:

Names on the note or mortgage ____________________

Balance due: $____________________

Can the note or mortgage be sold? ☐ Yes ☐ No

Amount you could sell it for: $____________________

Receivable #1:

Names on the note or mortgage ____________________

Balance due: $____________________

Can the note or mortgage be sold? ☐ Yes ☐ No

Amount you could sell it for: $____________________

RETIREMENT ACCOUNTS

(IRA's, SEP's, 401(k)'s, Keogh, Profit sharing, etc.)
Please provide copy of most recent statement(s).

Company	Type (e.g. IRA)	Beneficiary(ies)	Current Value
			$
			$
			$

ANNUITIES

Please provide copy of most recent statement(s).

Company	Owner	Annuitant	Beneficiary(ies)	Current Value	Current Monthly Payment (if any)
				$	$
				$	$
				$	$

BANK ACCOUNTS

Please provide copy of most recent statement(s).

Checking Accounts:

#1 Name of Bank: ______________________________ Current Balance $ ________________

Name(s) on account: ____

#2 Name of Bank: ______________________________ Current Balance $ ________________

Name(s) on account: ____

Savings Accounts:

#1 Name of Bank: ______________________________ Current Balance $ ________________

Name(s) on account: ____

#2 Name of Bank: ______________________________ Current Balance $ ________________

Name(s) on account: ____

Money Market Accounts:

#1 Name of Bank: ______________________________ Current Balance $ ________________

Name(s) on account: ____

#2 Name of Bank: ______________________________ Current Balance $ ________________

Name(s) on account: ____

CERTIFICATE OF DEPOSIT

Please provide copy of most recent statement(s).

CD #1:

Name of Bank: ______________________________ Amount $ ________________

Name(s) on CD: ____

Maturity date _________________________

CD #2:

#1 Name of Bank: ___________________________ Current Balance $ _______________

Name(s) on CD: ____

Maturity date _________________________

MOTOR VEHICLES

Automobiles, Trucks, Boats, Trailers, etc.

Make/Model/Year ______________________________

Owner's Name(s) ______________________________

____

Make/Model/Year ______________________________

Owner's Name(s) ______________________________

____

Additional motor vehicle(s)

☐ Automobile ☐ Van ☐ Recreational vehicle ☐ Truck ☐ Boat

Make/Model/Year ____________________________

Value $________________

Owner's Name(s) ____________________________

____

Additional motor vehicle(s)

☐ Automobile ☐ Van ☐ Recreational vehicle ☐ Truck ☐ Boat

Make/Model/Year ____________________________

Value $________________

Owner's Name(s) ____________________________

____

BROKERAGE ACCOUNT

Please attach a copy of most recent brokerage statement

Name of brokerage firm: ______________________________

Name(s) on account: ______________________________

Account balance: $ ______________

STOCKS, BONDS & MUTUAL FUNDS NOT IN BROKERAGE ACCOUNT

Company	Owner	Beneficiary(ies)	Current Value
			$
			$
			$

U.S. SAVINGS BONDS

Number of U.S. Savings Bonds: Series E _____ Series EE _____ Series H _____

Has the income tax been paid on the bonds? ☐ Yes ☐ No

Name(s) on bonds ______________________________

Total cash value of bonds: $ ______________________________

OTHER ASSETS

Please identify any additional assets you own that have not been identified above. (i.e. business interests, etc.)

Type of Asset	How Titled	Current Value
		$
		$
		$

ESTATE PLANNING DOCUMENTS

Please check which documents you already have, and **provide us with copies.**

☐ Will

☐ Durable Financial Power of Attorney

☐ Power of Attorney for Health Care

☐ Living Will

☐ Living (revocable) Trust

☐ Irrevocable Trust

☐ Other ____

____

____

ESTATE PLANNING

POWER OF ATTORNEY FOR HEALTH CARE

Under Ohio law, you have the right to designate an agent (and alternates) to make health care decisions if you are unable to convey your desires to a physician. This document is called a "Durable Power of Attorney for Health Care." Who do you want to make your health care decisions? Please state names below.

Primary Agent:

Name____Relationship______________
First *MI* *Last*

Street____

City, State & Zip

Telephone:____

Alternate agent(s):

Name____Relationship______________
First *MI* *Last*

Street____

City, State & Zip

Telephone:____

Name____Relationship______________
First *MI* *Last*

Street____

City, State & Zip____

Telephone:____

Do you want to name your alternates to serve in the order: ☐ as listed above OR ☐ as co-agent(s)

DURABLE POWER OF ATTORNEY FOR PROPERTY

Under Ohio law, you have the right to designate an agent to make financial decisions on your behalf during your lifetime. This document is called a "Durable Power of Attorney for Property." Who do you want to make your financial decisions?

Primary Agent:

Name____Relationship______________
First *MI* *Last*

Street____

City, State & Zip

Telephone:____

Alternate agent(s):

Name____Relationship______________
First *MI* *Last*

Street____

City, State & Zip____

Telephone:____

Name____Relationship______________
First *MI* *Last*

Street____

City, State & Zip____

Telephone:____

Do you want to name your alternates to serve in the order: ☐ as listed above OR ☐ as co-agent(s)

LIVING WILL

Ohio law also allows you to sign a "Living Will," in which you can specify whether or not you want your life to be prolonged by artificial hydration and nutrition if either (a) you are in the final stages of a terminal illness and death is close at hand, or (b) you are in a "permanent unconscious state." Before life support can be withdrawn, you have the right to direct that certain individuals be notified.

Do you want a Living Will? ☐ Yes ☐ No

Individuals to be Notified:

Name____Relationship________________
First MI Last

Street____

City, State & Zip____

Telephone:____

Name____Relationship________________
First MI Last

Street____

City, State & Zip____

Telephone:____

Name____Relationship________________
First MI Last

Street____

City, State & Zip____

Telephone:____

HIPAA AUTHORIZATION

List the individuals below whom you authorize to receive health information about you.

Name____Relationship________________
First MI Last

Name____Relationship________________
First MI Last

Name____Relationship________________
First MI Last

Name____Relationship________________
First MI Last

Name____Relationship________________
First MI Last

WILL

Primary Executor ____Relationship_______________
First MI Last

First
Alternate executor ____Relationship_______________
First MI Last

Second
Alternate executor ____Relationship_______________
First MI Last

TRUST

Primary Trustee____Relationship_______________
First MI Last

First
Successor Trustee____Relationship_______________
First MI Last

Second
Successor Trustee____Relationship_______________
First MI Last

Do you want to name your alternates to serve in the order: ☐ as listed above OR ☐ as co-agent(s)

TANGIBLE PERSONAL PROPERTY

Your Will will provide you the opportunity to make a separate writing apart from your Will to list items of tangible personal property to be distributed to certain individuals. If, however, you have any special items that have significant monetary or sentimental value that you want to mention in your Will, please list these below. If you fill out this section, please indicate whether or not the beneficiary is to receive the item upon your death, or after both you and your spouse are deceased.

Item	**Beneficiary**	**Relationship of beneficiary to you**	**Mark "X" if Beneficiary to receive at your death**	**Mark "X" if Beneficiary to receive after 2nd death**

PLANNING FOR CHILDREN

Guardianship of Minor or Incapacitated Children

Guardian of the Child's Person (Medical):

Name____Relationship____________
First MI Last

Name____Relationship____________
First MI Last

Alternate ____Relationship____________
First MI Last

Alternate ____Relationship____________
First MI Last

Guardian of the Child's Estate (Financial):

Name____Relationship____________
First MI Last

Name____Relationship____________
First MI Last

Alternate ____Relationship____________
First MI Last

Alternate ____Relationship____________
First MI Last

Distributions To Children

Optional choices for distributing assets to your children:

A. ☐ **Outright Distribution.**

NOTE: If a child is under 18 years of age and receives an outright distribution exceeding $25,000 in value, a guardian of the minor's estate will be appointed by the Probate Court and the law requires that the guardian distribute such assets directly to the minor upon attaining age 18.

B. **In Trust.**

1. ☐ Children are to receive their share at a specific age.
Indicate age: ______

2. ☐ Children are to receive their share in two (2) installments:

Age for 1st installment (i.e. 22, 25, etc.): ______
Age for 2nd installment (i.e. 3 to 5 years after 1st): ______

3. ☐ Children are to receive their share in three (3) installments:

Age for 1st installment (i.e. 22, 25, 30, etc.): ______
Age for 2nd installment (i.e. 3 to 5 years after 1st): ______
Age for 3rd installment (i.e. 3 to 5 years after 2nd): ______

C. **Other wishes:**

Explain:____

TAKERS OF LAST RESORT

If after you are deceased, if you have no surviving descendants, who should receive your estate? Select only one of the following:

1. ☐ Legal next-of-kin (i.e. parents, if living, otherwise brothers and sisters, etc.)
2. ☐ Charities:

   Please identify:____

3. ☐ Other:

   Please identify:____

Beneficiary	**Relationship of beneficiary to you**	**Percentage that this beneficiary is to receive**

SPECIAL NEEDS

Complete this portion of the questionnaire only if your planning involves an individual with special needs. Your accuracy and completeness in responding to the following questions is critical for proper advice and planning.

Full Name of Beneficiary with Special Needs:

____
First *MI* *Last*

Street Address:____

City:______________________ State:__________ Zip:______________

Home Phone No.:______________________ Cell Phone No.:______________________

Date of Birth:______________________ Social Security No.:______________________

E-mail:______________________ Gender: ☐ Male ☐ Female

Spouse's Name (if any):____

Diagnosis / Nature of Disability:____

____

Beneficiary Receives: ☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare
☐ Section 8 Housing ☐ No Public Benefits
☐ Other ______________________________

1. Has the Beneficiary filed for or receiving Social Security benefits? ☐ Yes ☐ No

   If Yes, date of filing:____

   Name of Caseworker:____

   Street Address:____

   City, State, Zip:____

   Telephone No.:______________________ Fax No.:______________________

2. Will the Beneficiary likely be eligible for Medicare with the next 24 months? ☐ Yes ☐ No

3. Has Beneficiary filed for any other public benefits? ☐ Yes ☐ No

   If Yes, please describe:____

   ____

4. Where is Beneficiary living: ☐ At Home ☐ At a Group home ☐ At an institution

   If not at home, please list:

   Name of Institution:____

   Street Address:____

   City, State, Zip:____

   Telephone No.:____

   Name of Contact Person at Institution:______________________________

5. Is the Beneficiary a U.S. Citizen? ☐ Yes ☐ No

6. If the Beneficiary is not a U.S. Citizen, is he/she a qualified alien? ☐ Yes ☐ No ☐ Don't Know.

7. Is the Beneficiary an adult? ☐ Yes ☐ No

   If Yes, is the Beneficiary: ☐ Competent ☐ Incompetent

   If No, is the Disable Person: ☐ A minor expected to be competent at majority (age 18).
   ☐ A minor expected to be incompetent at majority (age 18).

8. Social Security Office with which Beneficiary has contact:

   Name of Caseworker:______________________________

   Street Address:______________________________

   City, State, Zip:______________________________

   Telephone No.:_______________ Fax No.:_______________

9. Does the Beneficiary have a court-appointed guardianship? ☐ Yes ☐ No

   If Yes, please provide the following:

   Name of Court:_______________ Case No._______________

   Name of Guardian:______________________________

   Street Address:______________________________

   City, State, Zip:______________________________

   Home Phone No.:_______________ Cell Phone No.:_______________

   E-mail:______________________________

SPECIAL NEEDS TRUST INFORMATION

1. Who will contribute assets to a trust for the Beneficiary?

   ☐ The Beneficiary. Source of Funds: ______________________________

   ☐ Settlement / Lawsuit. Anticipated Amount: $______________________________

   ☐ Inheritance from:_______________ Amount: $__________

   ☐ Payment of back benefits from:_______________ Amount: $__________

   ☐ Parent(s):______________________________

   ☐ Paternal Grandparent(s):______________________________

   Street Address:______________________________

   City, State, Zip:______________________________

   Home Phone No.:_______________ Cell Phone No.:_______________

   E-mail:______________________________

   ☐ Maternal Grandparent(s):______________________________

   Street Address:______________________________

   City, State, Zip:______________________________

   Home Phone No.:_______________ Cell Phone No.:_______________

   E-mail:______________________________

   ☐ Other(s):______________________________

   Street Address:______________________________

   City, State, Zip:______________________________

   Home Phone No.:_______________ Cell Phone No.:_______________

   E-mail:______________________________

2. Who should serve as Trustee(s)?

Name____Relationship______________
First *MI* *Last*

Contact Person (if corporate trustee):____

Street Address:____

City, State, Zip:____

Phone No.:____________________________ Cell Phone No.:________________________

Fax No.:______________________________ E-mail:_____________________________

Name____Relationship______________
First *MI* *Last*

Contact Person (if corporate trustee):____

Street Address:____

City, State, Zip:____

Phone No.:____________________________ Cell Phone No.:________________________

Fax No.:______________________________ E-mail:_____________________________

---

3. Is the Beneficiary receiving a structured settlement? If yes, provide copy.

Name of Settlement Company:____

Contact Person:____

Street Address:____

City, State, Zip:____

Phone No.:____________________________ Cell Phone No.:________________________

Fax No.:______________________________ E-mail:_____________________________

Annuity Contract No.:____

4. Will the Trust own any real estate? ☐ Yes ☐ No

If Yes, provide the following: information for the property:

Street Address:____

City, State, Zip:____

☐ Single Family Dwelling ☐ A mobile home ☐ A condominium ☐ An apartment

---

If there are assets remaining after the death of the Beneficiary, to whom should such assets pass:

☐ Individual(s); if so, identify:____

____

____

☐ Charity(ies); if so, identify:____

____

____

ELDER & ASSET PROTECTION PLANNING

Complete this portion if the planning involves protecting assets and long-term care planning.

HEALTH STATUS

Health problems:____

Current Living Arrangement: ☐ At Home ☐ In Assisted Living ☐ In Nursing Home

If in a Facility:____

Physician(s): ____

Address: ____

Phone:____

ACTIVITIES OF DAILY LIVING

Please identify which of the following abilities apply:

☐ Feeds self

☐ Bathes self

☐ Needs help with meds

☐ Speech impaired

☐ Able to sign documents

☐ Able to walk

☐ Other ____

____

____

BENEFITS

Has an application for Medicaid, Veteran's benefits, Social Security (SSI or SSDI), or any other public benefit been filed? ☐ Yes ☐ No

If Yes, type of benefit _______________, Date: _______________ ☐ Approved ☐ Denied

AVERAGE MONTHLY INCOME

Source	Gross	Net
Earned Income	$	$
Social Security (Add $54.00 for gross)	$	$
Private Pension	$	$
Civil Service	$	$
Railroad Retirement	$	$
IRA Distribution	$	$
Annuity	$	$
Veterans Benefits	$	$
Interest Income	$	$
Dividend Income	$	$
Alimony	$	$
Rental Income	$	$
Other Income	$	$
Total Income	$	$

AVERAGE MONTHLY EXPENSES

(All amounts should be *monthly* amounts. Divide annual expenses by 12)

Monthly Shelter Expenses		***Non-Shelter Expenses***	
Mortgage	$	Food	$
Rent	$	Life Insurance	$
Maintenance Expense	$	Clothing	$
Real Estate Taxes	$	Transportation including Auto Insurance	$
Homeowners/Renters Insurance	$	Cable TV	$
Condominium Fees	$	Federal, State, Local Income Taxes	$
Lawn care/snow removal	$		$

Utilities		*Medical Expenses*	
Electric	$	Health Insurance	$
Gas	$	Prescriptions	$
Water	$	Unreimbursed medical expenses	$
Sewer	$	Long Term Care Insurance	$
Trash Collection	$		

CURRENT ASSISTED LIVING OR NURSING HOME EXPENSES

Monthly Facility Expense	$
Monthly Prescription Cost	$
Monthly Supplies	$
Monthly Other Cost	$
Total Monthly Expenses	**$**

HEALTH/MEDICAL INSURANCE

Insurance Name	**Company Name and Address**	**Monthly Premium**
		$
		$

LONG TERM CARE INSURANCE

Insured Name	**Company Name**	**Monthly Benefit**	**No. of Mos. Of Benefits**	**Annual Premium**

FUNERAL ARRANGEMENTS

Prepaid Funeral Plan: ☐ Yes ☐ No If Yes: ☐ Paid ☐ Still paying for

Contract is: ☐ Revocable ☐ Irrevocable

Contract Amount $______________________________

Own Cemetery Plot ☐ Yes ☐ No

Funeral Home:

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ______________________________

GIFTS TO SOMEONE WITHIN THE PAST FIVE YEARS

Please provide information on any gifts made to any person within the last five (5) years.

Gift No. 1 *(i.e. cash, savings bonds, CD, stock, car, real estate, etc.)*

Type of Asset:______________________________

Beneficiary of gift: ______________________________

Date of gift: ______________________________

Value of gift: $______________________________

Gift No. 2 *(i.e. cash, savings bonds, CD, stock, car, real estate, etc.)*

Type of Asset:______________________________

Beneficiary of gift: ______________________________

Date of gift: ______________________________

Value of gift: $______________________________

Gift No. 3 *(i.e. cash, savings bonds, CD, stock, car, real estate, etc.)*

Type of Asset:______________________________

Beneficiary of gift: ______________________________

Date of gift: ______________________________

Value of gift: $______________________________

WHO REFERRED YOU TO OUR OFFICE

Name:____

Relationship:____________________________________

☐ Seminar ☐ Internet Search ☐ Other (please specify)____________________

____

DOCUMENTS TO BRING

Please bring the following to your appointment:

☐ Any existing estate planning documents (Will, Powers of Attorney, etc.)

☐ Driver's License

☐ Social Security Card

☐ Most recent brokerage account statement(s)

☐ Most recent federal income tax return

After you have completed the Questionnaire, please sign the following statement:

The undersigned hereby represent to Krugliak, Wilkins, Griffiths & Dougherty Co., L.P.A. and each of its attorneys, that the information contained in this questionnaire is accurate and complete and that the undersigned understand that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Sign:______________________________ Date ____________________