

Estate and Financial Planning Information

We are very pleased that you have contacted us regarding your financial planning. This data sheet can be helpful in organizing your thoughts regarding issues that matter to you and your family most. The totality of the data allows us the opportunity to review and counsel you regarding options available to you in four very important planning disciplines. Those disciplines are tax planning, financial planning, retirement planning, and estate planning. Although these are disparate areas of the financial world, a comprehensive planning approach can help you navigate your family's interests. Completing the form is optional. If you choose to complete it, fill it out as well as possible, leaving blank items you feel may be inapplicable or of which you are unsure. When completed, you may mail the form to us prior to your appointment or you may bring it at that time.

Personal Information		
	You	Your Spouse
Full Name		
Home Address		
Home Telephone		
Work Telephone		
Mobile Telephone		
Email Address		
Social Security Number		
US Citizen (If not, indicate where)		
Date and Place of Birth		
Occupation		
Date and Place of Marriage		

Personal Information		
If you have lived outside Texas during this marriage, please list the location and dates of residence.		
If either of you were previously married, please list the dates of the marriage, name of prior spouse, names of living children from prior marriage(s), state whether the marriage ended in death or divorce and the date of dissolution.	You	Your Spouse
Describe any real estate owned by either or both of you outside the state of Texas (address, acreage, value)		
Location of Safe Deposit Box (If Any)		
Name and Telephone Number of your Attorney		
Name and Telephone Number of your Accountant		
Name and Telephone of Your Insurance Agent (If Any)		
Name and Telephone Number of Your Broker or Financial Planner (If Any)		
Children		
Full Name	Birth Date	Address (If the Child Does Not Reside With You)
Children		

Are any of these children adopted? If so, please give their name.			
Are there any problems with current children? (Disabilities, Drugs, Learning Disorders, Spendthrifts)			
Can you and do you talk to your children about finances?			
Educational Expenses			
Child's Name:	Start Age	End Age	Annual Education Cost in Current Dollars
Pre-Secondary			
Undergraduate			
Graduate			
Post-Graduate			
Child's Name:	Start Age	End Age	Annual Education Cost in Current Dollars
Pre-Secondary			
Undergraduate			
Graduate			
Post-Graduate			
Child's Name:	Start Age	End Age	Annual Education Cost in Current Dollars
Pre-Secondary			
Undergraduate			
Graduate			
Post-Graduate			

Child's Name:	Start Age	End Age	Annual Education Cost in Current Dollars
Pre-Secondary			
Undergraduate			
Graduate			
Post-Graduate			
Other Dependents			
How many grandchildren do you have?			
What are the names, ages, and parents of your grandchildren?	Name	Age	Parents
Will you provide for their education and if so, how much?			
Are there any other persons that you declare as dependents? Please give their name and relationship.			
Are you providing support to non-dependents? Please give their name and relationship.			
Parents			
	You	Your Spouse	

Is your father still alive?		
If so, what is his state of health including any chronic conditions?		
If not, what was the cause of his death and at what age?		
Is your mother still alive?		
If so, what is her state of health including any chronic conditions?		
If not, what was the cause of her death and at what age?		
Do you have an open dialogue with your parents regarding finances, health care, estate planning, etc.? Explain as necessary.		
Do your parents have a will or trust?		
If so, are you aware of the contents?		
Do your parents have a long term care policy?		
Will you be providing financial support for your parents?		
Will you be providing direct personal care for your parents?		
Do your parents have living wills or directions which direct physician care if they become incapacitated?		

Your Health Questionnaire

1. During the past 24 months, have you:
Yes **No** **Description**

- a) Needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?
- b) used a wheelchair, walker, brace, or cane?
- c) used oxygen equipment, received kidney dialysis, or required a catheter?
- d) received home health care services, physical or other rehabilitative therapy?
- e) experienced anemia, confusion, forgetfulness, or memory loss?
- f) experienced dizziness, fainting, weakness or chronic fatigue?
- g) experienced falling, unstable gait, paralysis or loss of balance?
- h) been confined to a nursing facility, assisted living facility, or home for the aged?

2. During the past 10 years, have you been medically diagnosed with or treated for:

- a) AIDS or positive HIV status?
- b) Alzheimer's Disease or dementia?
- c) Amyotrophic Lateral Sclerosis?
- d) Hepatitis C?
- e) Multiple Sclerosis?
- f) Parkinson's Disease or Parkinsonism?

3. During the past 10 years, have you been medically advised or treated for:

- a) high blood pressure?
- b) heart disorder?
- c) circulatory disorder?
- d) diabetes?
- e) emphysema or other chronic lung disorder?
- f) cancer, internal or melanoma?
- g) stroke?
- h) TIA (transient ischemic attack)?
- i) seizures or other neurological disorder?
- j) alcohol or drug dependency or abuse?
- k) arthritis or osteoporosis?
- l) depression or other psychiatric disorder?
- m) breast, prostate or other genitor-urinary disorder?
- n) glaucoma or macular degeneration?
- o) liver disease or disorder?

If you answered "Yes" to any of Questions 1 – 3 please provide full details below:

Question No.	Date From	Date To	Describe Condition and Treatment

Spouse Health Questionnaire

1. During the past 24 months, have you:

- | | | |
|-----------------------|-----------------------|--|
| Yes | No | Description |
| <input type="radio"/> | <input type="radio"/> | a) needed assistance or supervision with dressing, eating, |

- bathing, toileting, transferring, or walking?
- b) used a wheelchair, walker, brace, or cane?
- c) used oxygen equipment, received kidney dialysis, or required a catheter?
- d) received home health care services, physical or other rehabilitative therapy?
- e) experienced anemia, confusion, forgetfulness, or memory loss?
- f) experienced dizziness, fainting, weakness or chronic fatigue?
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- k) arthritis or osteoporosis?
- l) depression or other psychiatric disorder?
- m) breast, prostate or other genitor-urinary disorder?
- n) glaucoma or macular degeneration?
- o) liver disease or disorder?

If you answered "Yes" to any of Questions 1 – 3 please provide full details below:

Question No.	Date From	Date To	Describe Condition and Treatment
Current Annual Income			
Income Type	You	Your Spouse	
Salary			

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Bonus			
Commissions			
Interest – Taxable			
Interest – Nontaxable			
Dividends			
Capital Gains/Losses Short-Term			
Capital Gains/Losses Long- Term			
Previous Year Loss Carryover			
1099 Self-Employment Income			
Real Estate Rentals			
Non-Qualified Annuities			
Pension Plan			
401(k), 403(b), 501(c)(3), Keogh Distributions			
IRA Distributions			
Roth IRA Distributions			
Life Insurance Loans			
Child Support Received			
Alimony Received			
Social Security			
Gifts			
Trusts			
Disability Income			
Other Income			
Sale of Assets			
Total per Spouse			
Total Household Income			
Monthly Household Expense			
Expense Type	You	Your Spouse	Household
Mortgage			

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Property Insurance			
Property Tax			
Electricity			
Gas			
Water			
Food			
Alimony			
Auto Loan			
Auto Fuel			
Auto Insurance			
Auto Maintenance			
Bank Fees			
Child Support			
Clothing			
Charitable Contributions			
Credit Cards			
Dues and Expenses			
Entertainment			
Gifts			
Health Club			
Home Improvement			
Homeowner's Association			
Insurance – Medical			
Insurance – Dental			
Medical – Other			
Dental – Other			
Vision			
Internet			
Legal			

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Miscellaneous			
Personal Grooming			
Pet Expense			
Postage and Delivery			
Publications			
Repairs			
Taxes – FIT			
Taxes – FICA			
Taxes – MEDI			
Telephone			
Telephone – Cellular			
Travel			
401(k) Contribution			
Total Cash Outflow			

Investment Risk Planning		
	You	Your Spouse
At What do you expect to retire?		
What type of lifestyle do you intend to lead after		

retirement?		
What do you anticipate your annual financial needs will be during your retirement?		
As an investor, do you expect that your tolerance for investment risk will lessen as you grow older?		
Please define your current investment asset allocations in %:		
Large Cap Stocks		
Mid Cap Stocks		
Small Cap Stocks		
Foreign Stocks		
Mutual Funds		
Corporate Bonds		
Municipal Bonds		
Money Market		
Treasuries		
Total % should be 100%.		

Assets		
Description	Current Fair Market Value	How Is Title Held? ¹

¹ If you know the property is your separate property, your spouse's separate property or community property, please state that fact. If not, state the name or names which appear on the title, if known, and state whether the property is held with right of survivorship, if known.

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Bank Accounts (not IRAs and Retirement Plans)		
Stocks, Bonds, Mutual Funds (not IRAs and Retirement Plans)		
Closely Held Businesses, Partnerships, etc.		
Real Estate		
Assets		
Description	Current Fair Market Value	How Is Title Held? ²
Automobiles, Boats, and Other Vehicles		

² If you know the property is your separate property, your spouse's separate property or community property, please state that fact. If not, state the name or names which appear on the title, if known, and state whether the property is held with right of survivorship, if known.

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Vehicles	
Child Support	
Alimony	
Bankruptcy	
Other Liabilities	
Total	

Insurance Policies/Life	Cash Value				
	Face Amount				

	Policy Owner				
	Beneficiary(s)				
	Insured				
	Company				

Long Term Care Insurance Policies	Daily Benefit				
	Annual Cost				

	Waiting Period				
	Policy Owner				
	Insured				
	Company				Total

Annuities	Annual Income				
	Amount				

	Company				
	Owner				
	Annuity Type				
Total					

IRAs, 401(k)s, and Other Retirement Plans	Death Benefit						
	Vested Amount						

	Type of Plan						
	Participant						
	Company/Custodian						Total

Dispositive Plan:
 Describe in general terms how you wish to leave your property at death.

[Empty rectangular box for input]

Other Beneficiaries
(Information Regarding Persons Other Than Your Spouse and Descendants Whom You Wish to Benefit)

Full Name	Age	Address	Relationship to You

Estate Issues		
	You	Your Spouse
Do you have a current will?		
When was it last reviewed?		
Do you have a living will?		
Are there separate trusts for beneficiaries of your will?		
Have you discussed the issues regarding the arrangement of your affairs to put some matters beyond the reach of probate?		
Are you currently gifting any assets to anyone?		
Would you be willing to provide copies of the will and trust documents?		

Fiduciaries
List Name, Address, Home Telephone Number and Relationship to You For Each Person

	You	Your Spouse
Executor: The executor is the person responsible for assuring the will is probated, that the estate and gift tax returns are filed and for the ultimate distribution of assets to the beneficiaries.		
First Alternate Executor:		
Second Alternate Executor:		
Trustee: The Trustee is the person responsible for the long-term management of property for the surviving spouse, children, or other beneficiaries.		
First Alternate Trustee:		
Second Alternate Trustee:		
Guardian of Minor Children: The guardian is the person who will take physical care of minor children should both parents die.		
First Alternate Guardian:		
Second Alternate Guardian:		
Property Agent: The property agent is the person who will manage your financial affairs should you become incapacitated.		
First Alternate Property Agent:		
Second Alternate Property Agent:		
Health Care Agent: The Health Care Agent is the person who will make medical decisions for you should you become incapacitated.		
First Alternate Health Care Agent:		
Second Alternate Health Care Agent:		