

CARRIER LAW

Personal Information Form

The information within this document is necessary for the Carrier team to determine the right combination of legal tools to meet your needs.

Your responses can be high level at this stage, however, the more detail provided now will save time during the process.

If you are new to **Carrier Law** and have not yet made the decision to hire us, we will honor “attorney-client” privilege and ensure all information shared verbally and in writing is treated as highly confidential.

Thank you for your trust.

Personal Information Form

All information contained in this form is confidential and protected by attorney-client privilege (this extends to prospective clients and continues even if we are not retained).

Date: _____

Basic Information

First Name: _____ MI: _____ Last: _____	DOB: _____	M / F
Address: _____	SSN: _____	
City, State, Zip: _____	Home #: _____	
Email: _____	Work #: _____	
Occupation: _____ Veteran? Y / N	Cell #: _____	

Please check all that apply:

Married Divorced Not married Widow(er) Living with partner First marriage 2nd 3rd ____th

Spouse Partner (if applicable) Date of Death (if applicable) _____

First Name: _____ MI: _____ Last: _____	DOB: _____	M / F
Email: _____		
SSN: _____	Home #: _____	
Occupation: _____	Work #: _____	
Veteran? Y / N	Cell #: _____	

Please check all that apply:

Married Divorced Not married Widow(er) Living with partner First marriage 2nd 3rd ____th

Professional Contacts (if applicable)

Financial Advisor _____ Firm _____ Phone _____

Accountant _____ Firm _____ Phone _____

Personal Information Form

Estate Planning

Do you have any existing estate planning documents?

	YOU	SPOUSE/PARTNER	When was document executed?
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Financial 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	
Long-Term Care Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Prenuptial Agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Postnuptial Agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health Status

Understanding your current health status plays an important role in designing an estate plan best suited for the needs of you and your loved ones.

Your current health status: Good Concern Problem

Spouse/Partner: Good Concern Problem

Please specify: _____

Personal Information Form

Finances At-A-Glance

Understanding your finances plays an important role in designing an estate plan best suited for the needs of you and your loved ones. Please complete this worksheet with any amounts that apply.

Monthly Income

TYPE	YOU	SPOUSE/PARTNER	JOINT
Wages			
Pension			
Social Security			
Investments			
Other			
TOTAL			

Asset Information

Total number of properties _____

TYPE	YOU	SPOUSE/PARTNER	JOINT
Cash, Checking, Savings			
Retirement Accounts			
Investment Accounts			
House			
Other Real Estate			
Vehicles			
Other			
TOTAL			

Personal Information Form

Liabilities

TYPE	YOU	SPOUSE/PARTNER	JOINT
Mortgage			
Loans Payable			
Other			
TOTAL			

Business Interest

TYPE	YOU	SPOUSE/PARTNER	JOINT
Farm			
LLC			
Corporation (S-Corp? <input type="checkbox"/>)			
TOTAL			

Personal Information Form

Child Information

You & Spouse/Partner Jointly Do you have any children? Yes How many? None
 You Do you have any children? Yes How many? None
 Spouse/Partner Do you have any children? Yes How many? None

First Name: MI: Last:	DOB:	M / F
Address:	Phone:	
City, State, Zip:	Spouse:	

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:	Phone:	
City, State, Zip:	Spouse:	

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:	Phone:	
City, State, Zip:	Spouse:	

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:	Phone:	
City, State, Zip:	Spouse:	

This child is: joint mine spouse's/partner's adopted foster child other: _____

Personal Information Form

Is there anyone in your family with special needs or that requires special consideration?

Need more room to write? Extra spaces for additional children are provided on the following page.

Other Beneficiaries

Who else would you like for your planning to benefit? Grandchild? Church? Charitable Organization? Community Foundation? Friend? Please provide their information below.

Name:	Relationship:
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Name:	Relationship:
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Name:	Relationship:
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Name:	Relationship:
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Name:	Relationship:
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Name:	Relationship:
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Name:	Relationship:
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Personal Information Form

Child Information, Continued

First Name: MI: Last:	DOB:	M / F
Address:		Phone:
City, State, Zip:		Spouse:

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:		Phone:
City, State, Zip:		Spouse:

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:		Phone:
City, State, Zip:		Spouse:

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:		Phone:
City, State, Zip:		Spouse:

This child is: joint mine spouse's/partner's adopted foster child other: _____

First Name: MI: Last:	DOB:	M / F
Address:		Phone:
City, State, Zip:		Spouse:

This child is: joint mine spouse's/partner's adopted foster child other: _____