



Estate Planning Fact Finder

Prepared for:

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Provided by:

Family Information

	Name	Age	Health Problems or Special Needs, if Any
Client	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
Residence Address	_____		Telephone (____) _____

Your Occupation	_____		Employer _____
Business Address	_____		Telephone (____) _____

Spouse's Occupation	_____		Employer _____
Business Address	_____		Telephone (____) _____

Attorney	_____		Telephone (____) _____
Accountant	_____		Telephone (____) _____
Other Professional Advisor	_____		Telephone (____) _____

Trusted Contact Information

A **trusted contact** who you designate can be a friend, relative...anyone you trust. Designating someone as your trusted contact does **not** give that person authority to access or control your account. Instead, it gives your financial advisor someone to contact in the event of possible financial exploitation or suspected health issues.

Trusted Contact Name: _____ Relationship: _____ Phone: _____ E-Mail: _____
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Financial and Estate Planning Objectives

Be specific. (Examples: survivor income; minimize estate taxes; pass the business on to children; make a charitable bequest)

1. _____
2. _____
3. _____
4. _____

Is there anything else I should know about your family, your plans and objectives, obligations or anything that is of particular concern?

Current Estate Plan

Do you have a will? Yes No Dated _____

Does your spouse have a will? Yes No Dated _____

Provisions of your and your spouse's wills:

Simple Will, all to surviving spouse Yes No

A will with provisions for a trust Yes No

Were you and your spouse married in another state? Yes No

If yes, where? _____

Do you or your spouse own a residence or business in another state? _____

Are you, spouse or children the beneficiaries of any trust? (Describe)

Describe any existing trusts or any special bequests (such as to a charity or others):

Post-Death Monthly Income Objectives

Monthly Income to Spouse/Family _____ for _____ years

then _____ for _____ years

Presently covered by Social Security: Self: Yes No Spouse: Yes No

Other monthly income sources available? (Describe)

Education Fund Per Child _____

Emergency Fund _____

Mortgage Payoff Fund _____

Other Needs (Describe)

Retirement Plans

Retirement Monthly Income Objective: _____
 Planned Retirement Age: Client _____ Spouse _____
 Projected Monthly Benefit _____ Death Value _____
 Qualified Plans: Client's Life _____
 Spouse's Life _____
 Nonqualified Salary Continuation Plans? (Describe benefits)

Other Funds Available for Retirement? (Describe)

Annual Income

Client	Salary _____	Bonus _____	Other _____	Tax Bracket _____%
Spouse	Salary _____	Bonus _____	Other _____	

Assets and Liabilities

Assets

* Jointly owned and community property assets and liabilities are generally split equally between the spouses

	Current Fair Market Value (\$)		Value in Quick/ Forced Sale	Should this asset be disposed of at 1 st death? (Yes/No)
	Self	Spouse		
Residence	_____	_____	_____	
Other Real Estate	_____	_____	_____	
Business Interest	_____	_____	_____	
Marketable Securities	_____	_____	_____	
Checking and Savings	_____	_____	_____	
Life Insurance Owned on Your Life	_____	_____	_____	
Cash Value of Life Insurance Policies Owned on Others	_____	_____	_____	
Personal Property	_____	_____	_____	
Retirement Funds	_____	_____	_____	
Revocable Trusts	_____	_____	_____	
Future Inheritance	_____	_____	_____	
Other Assets	_____	_____	_____	
Subtotal	_____	_____	_____	_____

Liabilities

Mortgage on Residence	_____	_____	_____	
Other Mortgages	_____	_____	_____	
Consumer Loans	_____	_____	_____	
Other Debts	_____	_____	_____	_____
Subtotal	_____	_____	_____	_____
TOTAL (Assets – Liabilities)	_____	_____	_____	_____

Life Insurance

Company	Insured	Owner	Beneficiary	Total Face Amount	Cash Value	Type*	Loan Outstanding	Annualized Premium

* (P)ermanent, (U)niversal, (V)ariable, (T)erm, (G)roup, (C)redit Life, (M)ortgage Life, (S)econd-to-die

Health Insurance

Disability Income Insurance

Benefit Period: _____
 Waiting Period: _____
 Monthly Benefit: _____

Long-Term Care Insurance

Benefit Period: _____
 Waiting Period: _____
 Benefit Amount: _____
 Maximum Benefit: _____

Other Health Insurance

Describe: _____

Notes

Important Information

This fact finder serves to help identify your financial needs and priorities and may be used in developing proposed solutions consistent with your needs and objectives. In completing this fact finder, you are entrusting our organization with certain personal and confidential financial data. We recognize that our relationship with you is based on trust and we hold ourselves to the highest standards in the safekeeping and use of your confidential information.

The information, general principles and conclusions presented in this report are subject to local, state and federal laws and regulations, court cases and any revisions of same. While every care has been taken in the preparation of this report, VSA, L.P. is not engaged in providing legal, accounting, financial or other professional services. This report should not be used as a substitute for the professional advice of an attorney, accountant, or other qualified professional.

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