Personal Planning Guide

Provided by:

Esteemed
LIFE SOLUTIONS

"Death ends a life, not a relationship. All the love you created is still there. All the memories are still there. You live on- in the hearts of everyone you have touched and nurtured while you were here."

— Morrie Schwartz

Esteemed Life Solutions, LLC
Office: 623-594-1419
Fax: 602-532-7800
PO Box 42136
Phoenix AZ 85080

www.esteemedlifesolutions.com

Personal Information

Please complete all relevant information about yourself, loved one, or other:

1. Name: ____
   Given Name Middle Name Last Name

2. Date of Birth (DOB): _____/____/_____
   month date year

3. Address: ____
   Street and Number City State Zip Code

4. Home Telephone Number: (____) ____-_______

5. Cell Telephone Number: (____) ____-_______

6. Social Security Number: ____-____-______

7. Driver's License Number: _________________________ Issuing State: _______

8. Father's Full Name _________________________________

9. Mother's Full Name______________________________ Maiden ___________

10. Birthplace ______________________ 11. Veteran ______________________

12. Emergency Contact Person: ____
    Address: ____
    Street and Number City State Zip Code

    Home Telephone Number: (____) ____-_______
    Cell Telephone Number: (____) ____-________
    Work Telephone Number: (____) ____-________
    Relationship: ____

13. Doctor (Primary Care Physician): ______________________________________
    Address: ____
    Street and Number City State Zip Code

    Office Telephone Number: (____) ____-_______

14. Hospital Name: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

15. Person with Medical Power of Attorney: ______________________________

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

16. Person with Financial Power of Attorney: _____________________________

Title/Relationship: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

17. Personal Attorney's Name: ____

Firm Name/Title: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

18. I have a pet(s) ____

named____

*In case of emergency I would like __________________________________

to care for my pet(s).

19. Veterinarian's Name: ____

Location Title: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

20. Family/Friends: (to notify in case of emergency/upon death)

Name: ____
First and Last Name Telephone Number

Relationship: ________________________________

Name: ____
First and Last Name Telephone Number

Relationship: ____________________________________

Name: ____
First and Last Name Telephone Number

Relationship: ____________________________________

Name: ____
First and Last Name Telephone Number

Relationship: ____________________________________

Name: ____
First and Last Name Telephone Number

Relationship: ____________________________________

Important Documents Locator

Critical Documents	Location
1. Social Security Card	
2. Medicare Card	
3. HMO Card	
4. Primary Health Insurance Policy	
5. Long-Term Care Ins. Policy	
6. Secondary Health Ins. Policy	
7. Medicare Supplement Policy	
8. Life Insurance Policy	
9. Additional Life Insurance Policies	
10. Burial/Funeral Policy	
11. Deed to Burial Plot	
12. Homeowner's Policy	
13. Automobile Policy	
14. Living Will	
15. Medical Power of Attorney	
16. Financial Power of Attorney	
17. Pre-Hospital Advance Directive	

Personal Documents	Location
1. Birth Certificate	
2. Marriage Certificate(s)	
3. Divorce Decree	
4. Citizenship Papers	
5. Military Discharge Papers	
6. Other (Please specify)	

Financial Documents	Location
1. Last year's tax return	
2. Previous year's tax returns	
3. Will	
4. Trust Papers	
5. Credit Cards	
6. Previous month's bank statement	
7. Annual award letter from Social Security	
8. Statements from retirement or pension plan	
9. Safe/Safety deposit boxes and keys	
10. Most current bank statements	

11. Check book

12. Savings book

Property Information	Location
1. Deed to house	
2. Mortgage papers	
3. Lease agreements	
4. Rental property agreements	
5. Automobile title	
6. Last property tax statement	
7. Verification of homeowners' association fee	
8. Verification of mobile home lot rent	
9. Other insurance or titles	

List and Estimate of the Value of Other Valuable Articles:

Medical and Personal Insurance Information

1. Name of Primary Health Insurance Carrier: ______________________________

Address of Company: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

Type of Policy: _________________ Policy Number: __________________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

2. Medicare Supplement Insurance Carrier Name: __________________________

Address of Company: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

Type of Policy: _________________ Policy Number: __________________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

3. Long-Term Care Insurance Carrier Name: ________________________________

Address of Company: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

Type of Policy: _________________ Policy Number: __________________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

4. Secondary Health Insurance Carrier Name: ________________________________

Address of Company: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

Type of Policy: ________________ Policy Number: ________________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

5. Life Insurance Company #1: ____

Address of Company: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______ Type of Policy: ________________

Policy Number: _________________________ Face Value: $_________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

6. Life Insurance Company #2: ____

Address of Company: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______ Type of Policy: ________________

Policy Number: ________________________ Face Value: $_________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

7. Burial Insurance Carrier Name: ____________________________________

Address of Company: ____
Street and Number City State Zip Code

Policy Number: ___________________ Value of Policy: $_______________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

8. Auto Insurance Carrier: ____________________________________

Address of Company: ____
Street and Number City State Zip Code

Policy Number: ________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

9. Homeowner's Insurance Carrier: ____________________________________

Address of Company: ____
Street and Number City State Zip Code

Policy Number: ______________________ Deductible: $_______________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

(Circle One) Paid with Mortgage or Paid Directly by Homeowner

10. Other Insurance: ____________________________________

Address of Company: ____
Street and Number City State Zip Code

Policy Number: ____________________________ Type: ___________________________

Agent's Name: ____

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

Important Financial Contacts

Financial Advisor:

Name: ____

Name of Firm: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

Accountant/CPA:

Name: ____

Name of Firm: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

Other:

Name: ____

Name of Firm: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______ Fax Number: (____) ____-_______

Financial Assessment

The following pages will help you understand what financial resources exist to support care, a higher level of care, or whatever needs you or your loved one has now or will need in the future. It also helps determine if you or your loved one might qualify for Medicaid or other governmental programs based on need.

Inventory Sheet: Income

This information will help determine what financial resources exist to support the various needs you or your loved one has now or will have in the future.

Income	Monthly	Annual
Social Security		
Pension		
Wages/Salary		
Interest		
Rental Income		
Dividends		
Loan Repayment		
Other		
Other		
Total Income		

Funeral Service Instructions Questionnaire

Use this questionnaire to determine what you or your loved one's wishes are regarding your or his or her memorial service and burial.

Name of Funeral Home: ____

Name of Contact Person: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

Do you want cremation? (circle one) Yes or No

If yes, how do you want the remains handled?

- ❒ Burial When and Where? __________________________
- ❒ Scattered When and Where? __________________________
- ❒ Columbarium When and Where? _________________________
- ❒ Other When and Where? __________________________

If yes, do you want an open casket viewing prior to cremation? (circle one)

Yes or No (If Yes, see instructions below)

Do you want a funeral or memorial service? (circle one) Yes or No

If yes, where?

- ❒ Church
- ❒ Temple
- ❒ Synagogue

- ❒ Gravesite
- ❒ Funeral Home
- ❒ Other

Name of your choice above: ____

Location of your choice above: ____

Name of person to officiate: ____

Telephone Number: (_____) _____-________

Music selections, vocal or instrumental or both?

____

____

____

____

Bible verses, poems, spiritual readings, anecdotes to be read or told:

____

____

____

____

____

____

Readers or Speakers: ____

____

____

Do you want the casket open for viewing? (circle one) Yes or No

If yes, for whom? (circle one) Family Only or Everyone

Clothing choices: ____

____

____

Jewelry choices: ____

____

Wedding Rings: (circle one) On or Off

Glasses: (circle one) On or Off

Have you prepaid for the funeral home? (circle one) Yes or No

If yes, what has been paid for and where are the receipts kept? _________________

____

____

If no, is there a price beyond which you do not want your family to spend? _______

Approximate amount: $_____________________

Special Instructions or wishes: ____

____

Memorial Information Questionnaire

Name of cemetery: ____

Address: ____
Street and Number City State Zip Code

Telephone Number: (____) ____-_______

Do you already own a plot: (circle one) Yes or No

Type of Plot:

- ❐ Mausoleum
- ❐ Crypt
- ❐ Ground Burial
- ❐ Urn/Niche

Do you want a headstone or other memorial marker? (circle one) Yes or No

Have you already paid for this? (circle one) Yes or No

If yes, what would you like the marker to say? ___________________________

____

____

Do you have any special instructions or thoughts about your memorial?

____

____

____