BENEFITS ANALYSIS FORM

(Confidential)

FAX TO: (919)324-6987 OR EMAIL TO info@carolinafep.com
OR MAIL TO 51 Kilmayne Dr., Suite 203, Cary, NC 27511

Client Name: ____________________ DOB: __________ Spouse (if applicable): ____________________ DOB: _______
Address: ____ Phone: __________________________

Existing Estate Planning:	**You**	**Spouse** ☐ NA	
Will	☐ Yes ☐ No	☐ Yes ☐ No	Date: ______________
Trust	☐ Yes ☐ No	☐ Yes ☐ No ☐ Rev ☐ Irr	Date: ______________
Power of Attorney	☐ Yes ☐ No	☐ Yes ☐ No	Date: ______________
Health Care Power/Living Will	☐ Yes ☐ No	☐ Yes ☐ No	Date: ______________
Long-Term Care Insurance	☐ Yes ☐ No	☐ Yes ☐ No Daily benefit: $________	Term ______(yrs)
In a Nursing Home?	☐ Yes ☐ No	☐ Yes ☐ No	

Monthly Cost of Nursing Home: $________ Unpaid. Balance: $_________

Your health plays an important role in designing an estate plan best suited for you and your loved ones.

You - current health: ☐ Good ☐ Concern ☐ Problem (Details) ______________________________________
Spouse - current health: ☐ Good ☐ Concern ☐ Problem (Details) ______________________________________

Have you given away any assets or added any children to your bank accounts or deeds since November 1, 2007? ☐ No ☐ Yes
Total Value of Gift or Transfer $ ____________________
Do you have children: **You:** ☐ Yes How many? ______ ☐ No **Spouse:** ☐ Yes How many? ______ ☐ No
Any children disabled: ☐ Yes ☐ No ☐ Yes ☐ No

MONTHLY INCOME		**CLIENT**	**SPOUSE**	**TOTAL**
Pension		$		$
Social Security		$		$
Other: ________________________		$		$
Total Monthly Income		$		$
ASSETS (CURRENT VALUE)		**IN CLIENT/JOINT NAME**	**IN SPOUSE NAME**	**TOTAL**
Cash, Checking, Savings, CD's, Money Market & Cash Mgmt Accts.		$	$	$
Brokerage Accounts		$	$	$
Qualified Accounts: IRA, 401K, 403B, SEP, etc.		$	$	$
Life Insurance	Cash Surrender Value	$	$	$
	Death Benefit	$	$	
Annuities: (Current Value)		$	$	$
Home	Assessed Value:	$	$	$
	Fair Market Value:	$	$	$
Other Assets		$	$	$
Total Assets		$	$	$
LIABILITIES / DEBTS		**CLIENT/JOINT**	**SPOUSE**	**TOTAL**
Mortgage(s)/Other Debts		$	$	$
MONTHLY LIVING EXPENSES		**CLIENT/JOINT**	**SPOUSE**	**TOTAL**
Medical (Complete detail on back of form)		$	$	$
Non-Medical (How much you spend on other expenses monthly)		$	$	$

MONTHLY MEDICAL EXPENSES

(Complete all that apply)

MONTHLY EXPENSES:	Client's Expenses	Spouse's Expenses	TOTAL
Assisted Living Costs			
Nursing Home Costs			
In Home Care			
Day Program			
Medications			
Co-Pays for Doctor			
Medicare A			
Medicare Supplement			
Medicare B			
Medicare D			
Hygienic Supplies			
Other			
TOTAL			$______________

ELIGIBILITY:

1. Are either you or your spouse a veteran?
   ☐ Yes, I (or my spouse) am/is a veteran ☐ Yes, both of us are veterans ☐ No

2. Are you the surviving spouse of a veteran? ☐ Yes ☐ No
   ☐ Have you remarried since your prior spouse's death? ☐ Yes ☐ No

3. Did the veteran serve for at least 90 days active duty and one day during war time?
   (World War II: 12/7/1941 to 12/31/1946; Korean Conflict: 6/27/1950 to 1/31/1955; Vietnam Era: 8/5/1964 to 5/7/1975 (2/28/1961 if they physically served in Vietnam); or Gulf Wars: 8/2/1990- TBD)
   ☐ Yes ☐ No Dates of service: ________________________________

4. Did the veteran receive discharge under honorable, general, or medical discharge? ☐ Yes ☐ No

5. Is the Veteran/Spouse under 65 and unable to work due to disability? ☐ Yes ☐ No

6. Is the Veteran/Spouse over the age of 65? ☐ Yes ☐ No

NOTES/INSTRUCTIONS:

Please simply fill out the form to the best of your ability. If you have any difficulties or questions while completing the above form, please simple leave that section or line blank. Once you return the form to our office, we will review the form and if needed, call you for clarification regarding any of the information provided or missing information.

To return the form to us, simply use whichever of the following methods that is most convenient for you:

FAX TO: (919)324-6987

EMAIL TO: info@carolinafep.com

MAIL TO: Carolina Family Estate Planning, 51 Kilmayne Dr., Suite 203, Cary, NC 27511