

INFORMATION NEEDED IN THE EVENT OF SERIOUS ILLNESS OR DEATH

A Publication of the Neighbors-Helping-Neighbors Program
Spanish Lakes Country Club Village
Ft. Pierce FL www.SLCCV.org

WHY COMPLETE THIS FORM?

Completing this form is very much like taking out an insurance policy. The premium is time taken to write down the information. In the event of serious illness or disability or death the potential beneficiaries will include relatives or close friends trying to help or a spouse not familiar with all the details of your affairs or the executor of your will. Since a great deal of important information is recorded even you could benefit if a fire or hurricane caused serious damage and you had preserved this form in a safe place.

What you do with the completed form will depend on your circumstances and preferences. If you have a safe box a copy should probably be there. The document could be scanned and saved on a CD. You may want to share it with a trusted friends or relative. In any event care should be taken since a great deal of personal information will be included.

Note: This form is specifically designed for residents of Spanish Lakes Country Club Village. It is, however, adaptable for others. Also, each household will not likely need to complete every question. Use your judgment on which items are pertinent to your situation. Don't hesitate to add additional pages, more information or attachments.

Your Address: _____

Date Form Completed Or Last Revised: _____

Resident #1: Name: _____ **Birth Date** _____

Birthplace _____

Resident #2: Name: _____ **Birth Date** _____

Birthplace _____

Home Phone: _____ **Cell Phone(s):** _____

ARMED FORCES SERVICE INFORMATION

Resident #1: Branch: _____ Dates: From _____ To _____

Location of Service Records: _____

Resident #2: Branch: _____ Dates: From _____ To _____

Location Of Service Records: _____

FAMILY/FRIENDS TO CONTACT IF SERIOUS ILLNESS OR DEATH

A. Name: _____ **Phone:** _____ **Relationship (e.g. Friend/Relative, etc):** _____

Address: _____

Notes: _____

B. Name: _____ **Phone:** _____ **Relationship(eg. Friend/Relative, etc):** _____

Address: _____

Notes: _____

C. Name: _____ **Phone:** _____ **Relationship(eg. Friend/Relative, etc):** _____

Address: _____

Notes: _____

D. Name: _____ **Phone:** _____ **Relationship(eg. Friend/Relative, etc):** _____

Address: _____

Notes: _____

E. Name: _____ **Phone:** _____ **Relationship(eg. Friend/Relative, etc):** _____

Address: _____

Notes: _____

WILL INFORMATION

Resident #1: Has a Will? ()Yes ()No If Yes, Location:_____

Name Of Executor:_____ Phone:_____

Resident #2: Has a Will? ()Yes ()No If Yes, Location:_____

Name Of Executor:_____ Phone:_____

If two residents name each other as executors or personal representatives, give name & phone of a successor executor if any:

Name of Successor Executor(s) _____ Phone _____

LIVING WILL INFORMATION

Resident #1: Has a Living Will? ()Yes ()No If Yes, Location:_____

Name Of Health Care Surrogate _____ Phone:_____

Resident #2: Has a Living Will? ()Yes ()No If Yes, Location:_____

Name Of Health Care Surrogate: _____ Phone:_____

DURABLE POWER OF ATTORNEY

Resident #1: Has Given Durable Power of Attorney? ()Yes ()No

If Yes, Location _____

Power Granted To: _____ Phone:_____

Resident #2: Has Given Durable Power of Attorney? ()Yes ()No

If Yes, Location _____

Power Granted To: _____ Phone:_____

UPON DEATH

Resident #1: Cremation? ()Yes ()No Standard Burial? ()Yes () No

Are burial expenses pre-paid? ()Yes ()No Where & Amount: _____

Cemetery plot purchased? ()Yes () No If Yes, Where: _____

Where are any written directions you have for after death (eg. disposition of effects)?

Resident #2: Cremation? ()Yes ()No or Standard Burial? ()Yes () No

Are burial expenses pre-paid? ()Yes ()No Where & Amount: _____

Cemetery plot purchased? ()Yes () No if Yes, Where: _____

Where are any written directions you have for after death (e.g. disposition of effects)

HOME OWNERSHIP

Is your home: ()Owned or ()Rented

If owned. what is(are) the name(s) on the title? _____

If rented, who is the landlord? _____ Phone: _____

Address: _____

FAMILY TRUST

If you have established a family trust with your spouse (or with another family member) list the full name of the trust here. **IMPORTANT: You are urged to write "IN THE TRUST" beside any assets listed below (stocks, bonds, checking accounts, etc) that are in the trust.**

Full name of Family Trust: _____

Location of Trust Documents: _____

Name(s) Of Successor Trustee(s): _____

MORTGAGE? ()Y ()N If yes, Mortgage Company Information:

Name: _____ Phone #: _____

Address: _____

CAR LOAN: ()Y ()N If yes, Lending Company Information:

Name: _____ Phone #: _____

Address: _____

HOUSE PHONE COMPANY: ()AT&T ()Other Company--Give address & Phone #

Name Of Other Company: _____ Their Phone #: _____

Address: _____

CELL PHONE COMPANY:

Name: _____ Phone #: _____

Address: _____

INSECT CONTROL COMPANY:

Name: _____ Phone #: _____ Address: _____

YARD MAINTENANCE COMPANY

Name: _____ Phone #: _____

Address: _____

MAGAZINE SUBSCRIPTIONS

Magazine #1: _____ Magazine #2: _____

Magazine #3: _____ Magazine #4: _____

CHECKING ACCOUNT(S)/MONEY MARKET ACCOUNTS

A. Bank Name: _____ Address _____

Account #: _____ Name(s) On Account _____

B. Bank Name: _____ Address _____

Account #: _____ Name(s) On Account _____

C. Bank Name: _____ Address _____

Account #: _____ Name(s) On Account _____

SAVINGS ACCOUNT(S)

A: Bank Name: _____ Address _____

Account #: _____ Name(s) On Account _____

B: Bank Name: _____ Address _____

Account #: _____ Name(s) On Account _____

C: Bank Name: _____ Address _____

Account #: _____ Name(s) On Account _____

AUTOMATIC PAYMENTS

List payees who are currently authorized to receive automatic payments from your checking or savings accounts. (E.g. FPL, Spanish Lakes, etc.)

Payee & Bank	Frequency (monthly, annually)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DIRECT DEPOSITS

Resident #1:

A. If you receive social security is it deposited directly in your checking or savings account?

() Yes () No If yes, which bank? _____

B. Do you have one or more pensions or annuities that are deposited directly? () Yes () No

If yes, which bank? _____ Name of pension _____

Telephone Number and/or Address of Pension _____

(If more than one pension or annuity, give information on each)

C. Any other regular direct deposits of funds to checking or savings accounts? () Yes () No

If Yes, list the source and give an address or phone number to reach them:

Resident #2:

A. If you receive social security is it deposited directly in your checking or savings account?

()Yes ()No If yes, which bank? _____

B. Do you have one or more pensions or annuities that are deposited directly? ()Yes ()No

If yes, which bank? _____ Name of pension _____

Telephone Number and/or Address of Pension Provider _____

(If more than one pension or annuity, give information on each)

C. Any other regular direct deposits of funds to checking or savings accounts? ()Yes ()No

If Yes, list the source and give an address or phone number to reach them:

BROKERAGE FIRM(S) (IF ANY)

If you have brokerage account(s) that retain(s) one or more of your assets (e.g. stocks, bonds or mutual funds) please list their names below. Please attach to this document a copy of the last statement you received from each which will show account information and list the assets they have retained. If you have bonds or stocks or mutual funds that are NOT listed in these attachments they should be noted in the next sections.

A. Brokerage Firm: _____ **Account Number** _____

Name(s) On Account: _____ **Phone Number:** _____

B. Brokerage Firm: _____ **Account Number** _____

Name(s) On Account: _____ **Phone Number:** _____

C. Brokerage Firm: _____ **Account Number** _____

Name(s) On Account: _____ **Phone Number:** _____

SAVINGS BONDS (Not Held By A Brokerage Firm Listed Above)

A: Description: _____ **Location:** _____

B: Description: _____ **Location:** _____

C: Description: _____ Location: _____

CD'S/IRA/TDA: (Not Held By A Brokerage Firm Listed Above)

A: Issuer _____ Phone Number: _____

B: Issuer _____ Phone Number: _____

C: Issuer _____ Phone Number: _____

D: Issuer _____ Phone Number: _____

MUTUAL FUNDS (Not Held By A Brokerage Firm Listed Above)

A. Name of Fund: _____ Account #: _____ Phone Number _____

B. Name of Fund: _____ Account #: _____ Phone Number _____

C. Name of Fund: _____ Account #: _____ Phone Number _____

D. Name of Fund: _____ Account #: _____ Phone Number _____

STOCKS (Not Held By A Brokerage Firm Listed Above)

A. Name of Company _____ Number of Shares _____

Location of Stock Certificates: _____

B. Name of Company _____ Number of Shares _____

Location of Stock Certificates: _____

C. Name of Company _____ Number of Shares _____

Location of Stock Certificates: _____

BONDS (Not Held By A Brokerage Firm Listed Above)

A. Description: _____ Date Of Maturity: _____

Location of Bond certificates: _____

B. Description: _____ **Date Of Maturity:** _____

Location of Bond certificates: _____

C. Description: _____ **Date Of Maturity:** _____

Location of Bond certificates: _____

CASH/VALUABLES

Location of petty cash:: _____

Location of Valuables (e.g. Jewelry): _____

SAFE DEPOSIT/FIRE PROOF BOX

Safe Deposit Box? ()Yes ()No **Location of box:** _____

Location Of Key: _____

Fire-proof Box? ()Yes ()No **Location of Box:** _____

Location of Key or Combination: _____

OWNERSHIP OF PROPERTY (OTHER THAN SLCCV HOME)

List Real Estate Properties Owned Other Than SLCCV Home. If the disposition of these is not handled elsewhere (e.g. in Wills) attach a statement of your wishes:

CAR OWNERSHIP

Car A: Name(s) On Title: _____

Make: _____ **Model** _____ **Year:** _____ **Plate Number** _____

Car B: Name(s) On Title: _____

Make: _____ **Model:** _____ **Year:** _____ **Plate Number** _____

GOLF CART

List Owner(s) of a golf cart (if any) _____

INCOME TAX RECORDS

Location of a copy of the last submitted Federal (and State) Income Tax Forms: (Suggest attach copy of last 1040)

CREDIT CARD INFORMATION

A. Issuer: _____ Type(e.g. Visa): _____ Card Holder: _____

Last Four Digits In Card Number; _____ Phone: _____:

If Used To Make Periodic Payments, List To Whom: _____

B. Issuer: _____ Type(e.g. Visa): _____ Card Holder: _____

Last Four Digits In Card Number; _____ Phone: _____:

If Used To Make Periodic Payments, List To Whom: _____

C. Issuer: _____ Type(e.g. Visa): _____ Card Holder: _____

Last Four Digits In Card Number; _____ Phone: _____:

If Used To Make Periodic Payments, List To Whom: _____

D. Issuer: _____ Type(e.g. Visa): _____ Card Holder: _____

Last Four Digits In Card Number; _____ Phone: _____:

If Used To Make Periodic Payments, List To Whom: _____

DEBTS/LOANS: (OTHER THAN AUTO OR MORTGAGE)

A. Name of company: _____ Phone: _____

Monthly Payment: _____ Amount owed: _____

B. Name of company: _____ Phone: _____

Monthly Payment: _____ Amount owed: _____

LIFE INSURANCE

(List Each)

A. Company: _____ Phone Number _____

Name of Person Covered _____ Beneficiary: _____

Policy #: _____ Amount: _____

B. Company: _____ Phone Number _____

Name of Person Covered _____ Beneficiary: _____

Policy #: _____ Amount: _____

C. Company: _____ Phone Number _____

Name of Person Covered _____ Beneficiary: _____

Policy #: _____ Amount: _____

DISABILITY INSURANCE

Company: _____

Policy #: _____ Phone Number _____

HOMEOWNER'S INSURANCE

Company: _____

Policy #: _____ Phone Number _____

CAR INSURANCE

Company: _____

Policy #: _____ Phone Number _____

UMBRELLA INSURANCE

Company: _____

Policy #: _____ Phone Number _____

MEDICARE SUPPLEMENTARY INSURANCE

Resident #1:

Name of Insurer: _____ Address _____

Policy Number _____ Phone Number _____

Resident #2:

Name of Insurer: _____ Address _____

Policy Number _____ Phone Number _____

LONG TERM CARE INSURANCE

Resident #1:

Name of Insurer: _____ Address _____

Policy Number _____ Phone Number _____

Resident #2:

Name of Insurer: _____ Address _____

Policy Number _____ Phone Number _____

MEDICARE PART D/DRUGS

Resident #1:

If covered, name of plan _____ Phone Number _____

Resident #2:

If covered, name of plan _____ Phone Number _____

SOCIAL SECURITY INCOME

Resident #1: Receives Social Security Income? ()Yes ()No

Resident #2: Receives Social Security Income? ()Yes ()No

PENSION INCOME

Resident #1

A. Name of Company or Annuity _____ Amount/Month: _____

Address/Phone Number: _____

B. Name of Company or Annuity _____ **Amount/Month:** _____

Address/Phone Number: _____

Resident #2

A. Name of Company or Annuity _____ **Amount/Month:** _____

Address/Phone Number: _____

B. Name of Company or Annuity _____ **Amount/Month:** _____

Address/Phone Number: _____

MEDICAL INFORMATION

Resident #1

A. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

B. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

C. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

D. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

Resident #2

A. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

B. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

C. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

D. Doctor's Name: _____ **Specialty:** _____

Phone Number: _____

MEDICINES PRESCRIBED (Effective Date _____)

Resident #1			Resident #2		
Medicine	Strength	Prescribed By	Medicine	Strength	Prescribed By
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

[CONTINUED OVER]

OTHER (e.g. Medical History, etc.)