NOTES TO MY BENEFICIARIES

As my beneficiary, there are some very important facts that you may need to know. When the time comes; which is inevitable, the process of estate transfer can be made easier if you know the answers to some basic questions. This is not a pleasant topic; however the outcome is extremely important to me. Please take some time to review these pages and retain them for future reference. I may change this information from time to time.

My Name _____ My Spouse's Name_____

My Date of Birth ____/____/____ My Place of Birth _____ My SS#_____-____-_____

Father's Name _____ Mother's Name _____

Mother's Maiden Name _____

Date I became a Florida resident ____/____/____ My county is _____

Marital Status _____ Date of Marriage ___/____/____ Place of Record _____

If Divorced, Date of Divorce ____/____/____ Place of Record _____

Military Service/Veteran (Yes or No) _____ Military ID# _____

My Important Records/Discharge papers are located _____

_____

I have a Durable Power of Attorney _____ My Power of Attorney is _____

I have a Health Care Surrogate _____ My Surrogate is _____

I have a Living Will _____ I have special concerns about Life Support. Please know: _____

_____

_____

I have the following personal financial concerns: _____

_____

_____

NOTES TO MY BENEFICIARIES

My Employment History

Employer _____ End Date ____/____/____

Address _____

Current Benefits _____

Location of Documents _____

Employer _____ End Date ____/____/____

Address _____

Current Benefits _____

Location of Documents _____

Taking Care of My Pet(s):

Pet's Name _____

Veterinarian's Information _____

Secured Places:

Safe Deposit Box (Yes or No) _____ If yes, Where: _____

Where is the key: _____

Does anyone else have a key (Yes or No) _____ If yes, Who: _____

Mailbox/P. O. Box (Yes or No) _____ If yes, Where: _____

Where is the key: _____

Does anyone else have a key (Yes or No) _____ If yes, Who: _____

NOTES TO MY BENEFICIARIES

Product and Services with Passwords:

Bank Name: _____

User Name: _____

Password/Pin or key location: _____

Bank Name: _____

User Name: _____

Password/Pin or key location: _____

Home Alarm: _____

User Name: _____

Password/Pin or key location: _____

Telephone Company: _____

User Name: _____

Password/Pin or key location: _____

Electric Company: _____

User Name: _____

Password/Pin or key location: _____

Cable Company: _____

User Name: _____

Password/Pin or key location: _____

NOTES TO MY BENEFICIARIES

Product and Services with Passwords (continued):

Gate/Garage Entry: _____

User Name: _____

Password/Pin or key location: _____

Credit Card Name and Number:_____

User Name: _____

Password/Pin or key location: _____

Credit Card Name and Number:_____

User Name: _____

Password/Pin or key location: _____

Email Address: _____

User Name: _____

Password/Pin or key location: _____

People to be contacted in the event of my death.

Financial Advisor __Barbara Stetzko_____ Phone __352-795-4411__

Executor Name _____ Phone _____

Lawyer Name _____ Phone _____

Accountant Name _____ Phone _____

Employer/Business Partner _____ Phone _____

NOTES TO MY BENEFICIARIES

People to contact (continued)

Doctor _____ Phone _____

Dentist _____ Phone _____

Family/Friends

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

NOTES TO MY BENEFICIARIES

My Place of Worship is _____

My Funeral Arrangements have been made with _____

_____

My personal disposition requests are _____

_____

My Personal Representative is _____

Date and Name of Trust _____

My Trustee is _____

My Successor Trustee is _____

I expect you to do the following: _____

_____

_____

_____

_____

Additional information of importance: _____

_____

_____

_____

_____

NOTES TO MY BENEFICIARIES

Home Care and Services:

Lawn Care

Company Name: _____

Phone Number: _____

Pool Maintenance

Company Name:_____

Phone Number: _____

Repair Companies (A/C, Plumbing, Roofer, etc.)

-Company Name:_____

Phone Number: _____

-Company Name:_____

Phone Number:_____

-Company Name: _____

Phone Number: _____

-Company Name: _____

Phone Number:_____

People with a house key

Name and Phone Number:_____

Name and Phone Number:_____

Name and Phone Number: _____

NOTES TO MY BENEFICIARIES

Insurance:

Homeowners Insurance:

Company Name: _____

Policy Number: _____

Phone Number: _____

Automobile Insurance:

Company Name:_____

Policy Number: _____

Phone Number: _____

Medical Insurance:

Company Name:_____

Policy Number: _____

Phone Number: _____

Life Insurance:

Company Name:_____

Policy Number: _____

Phone Number:_____

LTC (Long Term Care)

Company Name: _____

Policy Name: _____

Phone Number: _____

NOTES TO MY BENEFICIARIES

Insurance (continued)

Disability Insurance:

Company Name:_____

Policy Number: _____

Phone Number:_____

Umbrella Insurance:

Company Name: _____

Policy Name: _____

Phone Number: _____

NOTES TO MY BENEFICIARIES

Medical/Health Information

Doctors:

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

-Doctor Name/Specialty:_____

Phone Number: _____

NOTES TO MY BENEFICIARIES

Medical/Health Information (continued)

Prescriptions:

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

-Name of Rx:_____ Dosage:_____

Prescribed for: _____Directions: _____

NOTES TO MY BENEFICIARIES

Medical/Health Information (continued)

Over The Counter Medications/Vitamins:

-Name:_____ Dosage:_____

Taken for: _____Directions: _____

-Name:_____ Dosage:_____

Taken for: _____Directions: _____

-Name:_____ Dosage:_____

Taken for: _____Directions: _____

-Name:_____ Dosage:_____

Taken for: _____Directions: _____

-Name:_____ Dosage:_____

Taken for: _____Directions: _____

Medical Conditions:

Condition:_____

Condition:_____

Condition:_____

Condition:_____

Condition:_____

Condition:_____

NOTES TO MY BENEFICIARIES

Medical/Health Information (continued)

Allergies:

Allergy: _____

Allergy: _____

Allergy: _____

Allergy: _____

Allergy: _____

Allergy: _____

Surgeries and Date of Surgery:

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

NOTES TO MY BENEFICIARIES

Medical/Health Information (continued)

Additional Information: