



IT'S A MATTER OF TRUST

Initial Trust Intake Form

CLIENT NAME: _____ DOB: _____

ADDRESS: _____

SOC SEC#: _____ PHONE #: _____ EMAIL: _____

CLIENT CAPACITY: Competent Adult _____ Minor _____ Incompetent Adult _____

PARENT/GUARDIAN NAME & CONTACT INFO (if minor or incompetent adult: _____

DESCRIPTION OF INJURY & CURRENT HEALTH CONDITION: _____

CURRENTLY ELIGIBLE FOR PUBLIC BENEFITS: Y N If Yes what specific benefits and \$ amounts received.

Medicare _____ Medicaid _____
SSDI _____ SSI _____

FIRST 2 YEARS ANTICIPATED FUNDING NEEDS (Settlement Select will help you gather this information):

Real Estate: _____ Automobile: _____
Care Giver Pmt: _____ Medical Costs: _____
Monthly Expenses: _____ Other: _____

TYPE OF TRUST: SPT___ SNT___ SAM___ Directed Trust ___

NET SETTLEMENT AMOUNT: _____

TRUST SEED MONEY: _____

OTHER PRODUCTS FUNDED (SS ANNUITY, SPIA, FIA): _____

DATE OF COURT HEARING: _____

IF DIRECTED TRUST NAME OF ADVISOR OR RIA: _____

FORM OF CLIENT ID (ss card, birth cert or state ID): _____

IS AN MSA INVOLVED _____

Please include copies of: Client ID, LCP, Settlement Statement and annuity quotes along with this completed form.

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