CAPITALFIRST TRUST COMPANY

IT'S A MATTER OF TRUST

Initial Trust Intake Form

A. Trust Beneficiary A

Full Legal Name:_____

Nickname:_____ Gender: ☐ Male ☐ Female

Street Address _____

City_____ State_____ Zip_____

Home Phone No._____ Cell No._____

E-mail address_____

Birth Date_____ Social Security No. or ITIN_____

U.S. Citizen ☐ Yes ☐ No Veteran ☐ Yes ☐ No

Married ☐ Yes ☐ No Date of Marriage _____

B. Trust Beneficiary B (If Applicable)

Full Legal Name:_____

Nickname:_____ Gender: ☐ Male ☐ Female

Street Address _____

City_____ State_____ Zip_____

Home Phone No._____ Cell No._____

E-mail address_____

Birth Date_____ Social Security No. or ITIN_____

U.S. Citizen ☐ Yes ☐ No Veteran ☐ Yes ☐ No

Married ☐ Yes ☐ No Date of Marriage _____

C. Is there a Trust Protector, Trust Advisory Committee or Third Party that will be authorized by the Beneficiary to make recommendations, communicate with on their behalf, or be contacted for reassessment of needs? (if applicable)

Full Name:_____

Street Address _____

City_____ State_____ Zip_____

Home Phone No._____ Cell No._____

234 WEST FLORIDA STREET, SUITE 400 | MILWAUKEE, WI 53204 | P: 1.800.521.2359 F: 1.800.494.2429 | INFO@CAPITALFIRSTTRUST.COM

E-mail address_____

Role or Relationship to Beneficiary: □ Legal Guardian □ Conservator □ Representative Payee

□ Power of Attorney □ Trust Protector □ TAC Member □ Pl Atty □ Caregiver

□ Other: _____

D. Insurance and Government Benefit Information

Does the Beneficiary have Private Insurance? □ Yes □ No

Does the Beneficiary receive Supplemental Security Income (SSI)? □ Yes □ No

If yes, how much does the Beneficiary receive per month? _____

Does the Beneficiary receive Social Security Disability Insurance (SSDI)? □ Yes □ No

If yes, how much does the Beneficiary receive per month? _____

Does the Beneficiary receive Medicare? □ Yes □ No

Does the Beneficiary receive Section 8 Housing? □ Yes □ No

Does the Beneficiary receive any kind of food stamps? □ Yes □ No

If yes, how much does the Beneficiary receive per month? _____

Please describe any other type of public benefits that the Beneficiary receives: _____

_____

Local Social Security Office address:

Street Address _____

City_____ State_____ Zip_____

Other Agency office address:

Name _____

Street Address _____

City_____ State_____ Zip_____

E. Settlement Information

Net Settlement Amount (if known): _____

Initial Funding Amount (if known): _____

Cash deposit into trust (if known): _____

Will there be an annuity purchased? □ Yes □ No

If yes, type of annuity: _____

If yes, estimated premium amount(s): _____

Name and Address of Attorney or Law Firm handling the claim: _____

Street Address _____

City_____ State_____ Zip_____

Phone: _____ Email: _____

Will there be a Medicare Set-Aside to be held in trust? □ Yes □ No

F. Disability

What is the nature of the Beneficiary's disability? _____

_____

_____

Has a Life Care Plan been completed: □ Yes □ No

G. Anticipated Funding Needs

Will the Trust be purchasing real estate: □ Yes □ No

Will the Trust be purchasing an automobile: □ Yes □ No

Will the Beneficiary require a caregiver: □ Yes □ No

If yes, name and contact information for the person performing caregiver services:

Name: _____

Street Address _____

City_____ State_____ Zip_____

Phone: _____ Email: _____

Anticipated Monthly Expenses: _____

Anticipated Monthly Medical Costs: _____