By air mail
Par WOTFC

Family Care Package

TO _____

FR _____

Family Care Package

Dear Loved Ones:

In an attempt to simplify matters for you, I have written this letter to provide you with information that will be necessary for you when the time arises:

ADVISORS

Some of the people you will need to contact are listed below:

Attorney:
Name:_____
Address:_____
Phone:_____
Fax:_____

Insurance advisor:
Name:_____
Address:_____
Phone:_____
Fax:_____

Accountant:
Name:_____
Address:_____
Phone:_____
Fax:_____

Financial Planner:
Name:_____
Address:_____
Phone:_____
Fax:_____

Stockbroker:
Name:_____
Address:_____
Phone:_____
Fax:_____

Stockbroker:
Name:_____
Address:_____
Phone:_____
Fax:_____

Pension Benefits:
Name:_____
Address:_____
Phone:_____
Fax:_____

Mortgage Holder:
Name:_____
Address:_____
Phone:_____
Fax:_____

Employer:
Name:_____
Address:_____
Phone:_____
Fax:_____

Other:
Name:_____
Address:_____
Phone:_____
Fax:_____

ASSETS

Here is a list of all stocks, bonds, and other investments, including property. I have listed a contact person and telephone number for each item, as well as the location of any documents. I have _____ I have not _____ attached a financial statement.

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Investment:_____
Contact:_____
Phone:_____
Documents location:_____

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Investment:_____
Contact:_____
Phone:_____
Documents Location:_____

Money is owed to us by:
Name:_____
Address:_____
Phone:_____
Amount:_____

Money is owed to us by:
Name:_____
Address:_____
Phone:_____
Amount:_____

Money is owed to us by:
Name:_____
Address:_____
Phone:_____
Amount:_____

Money is owed to us by:
Name:_____
Address:_____
Phone:_____
Amount:_____

DEPOSITS

I have _____ I have not _____ made any substantial deposits on certain accounts. If applicable, the accounts are:_____
_____
_____

LIABILITIES

Here is a list of our liabilities, including a contact name and phone number of each, as well as the location of any related documents.

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

I am also a guarantor of the following debt:

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

Liability:_____
Contact:_____
Phone:_____
Document's Location:_____

I have the following **life insurance** policies (including company owned):

Type	Owner	Beneficiary	Face Amount	Existing Loans	Cash Value

Any of these policies can be found at _____

I have the following **disability insurance** policies:

Company	Policy Location

I have the following **long term care insurance** policies:

Company	Policy Location

I have the following **health insurance** policies:

Company	Policy Location

I have the following other policies:

Type	Company	Policy Location
Auto		
Umbrella		
Home		

If I become disabled, please make sure to pay the premiums on the policies which will provide me or my family benefits.

If I am disabled, my life insurance policy allows _____ does not allow _____ for pre-payment of death benefits to support me.

If I am disabled, my life insurance policy allows _____ does not allow _____ you to stop making premium payments.

If I am disabled, my disability insurance policy allows _____ does not allow _____ you to stop making premium payments.

EMPLOYMENT

I have the following disability and/or death benefits where I work or worked:

*Retirement Plan(s): _____
*Life Insurance: _____
*Health Insurance: _____
*Long Term Care Insurance: _____
*Disability Insurance: _____
*Deferred Compensation: _____
*Stock Ownership: _____
*Stock Options: _____
*Cafeteria Plan: _____
*Other: _____

DOCUMENTS

I have executed each of the following documents and you can find them where noted:

Document	Date Signed	Location
*Will		
*Living Will		
*Medical Power of Attorney		
*Medical Directive		
*General Power of Attorney		
*Living Trust		
*Insurance Trust		
*Charitable Trust		
*Minor's Trust		
*Custodial Account		
*Organ Donation		
*Pre/Post Nuptials		
*Divorce Decree		
*Burial Agreement		
*Retirement Plan Beneficiary		

I have appointed the following persons to act on my behalf if I become disabled:

Power of Attorney over my Assets:	1st:_____	2nd: _____
Power of Attorney for Medical:	1st:_____	2nd: _____
Guardian of my Property:	1st:_____	2nd: _____
Guardian over my Person:	1st: _____	2nd: _____

It is my desire that the persons having the above power(s) of attorney act on my behalf rather than a guardian being appointed, unless my family believes guardianship is best.

In the event of my incapacity, I do _____ do not _____ want to be kept home as long as possible, taking into account the cost.

I have _____ do not have _____ a divorce decree which may require that certain payments be made after I am disabled or after my death.

GENERAL INFORMATION

I do _____ do not _____ have a safety deposit box. It can be found at _____ and the key can be found _____.

I do _____ do not _____ have a personal safe. The combination is _____ and the safe is found: _____.

I have _____ have not _____ attached a list of the persons I want to receive my personal property when I die.

I may receive an inheritance from: _____

Upon my death, my heirs will _____ will not _____ receive a distribution of benefits from a trust. If yes, the trust instrument was created by:_____.

The trust instrument can be found: _____.

I am _____ am not _____ currently the Trustee for a trust. If I am a Trustee, the trust document is located at: _____

I am _____ am not _____ a beneficiary of a trust. If I am a beneficiary, the trust document is located at: _____

My Social Security # is: _____

My Driver's License # is: _____

My passport # is: _____ The passport can be found: _____

I am _____ am not _____ entitled to military benefits. List the benefits:

I am _____ am not _____ entitled to other benefits. List the benefits:

I am a member of the following religious group: _____

I am a member of the following fraternal groups: _____

I presently carry the following credit cards: _____

IN THE EVENT OF MY DEATH

I have the following final wishes:

Funeral Home: _____
Cemetery: _____ Plot/Drawer # : _____

I have _____ have not _____ prepaid my burial costs _____ for my burial plot _____ for my casket _____. Information can be found at: _____

I have a deceased spouse _____ parent _____ child _____ who is buried at _____.
I wish to be buried next to such person if I check here _____.

I do _____ do not _____ want to be cremated. Crematory: _____

Minister to perform service: _____

Pallbearers:

_____ _____
_____ _____
_____ _____
_____ _____

Special Requests:
Obituary Reading: _____
Tombstone Engraving: _____
Organs for Donation: _____
In Lieu of Flowers please ask for Donations to: _____
Other Special Requests: _____
_____

I have signed this family love letter this _____ day of _____ 20_____. This document is not intended to replace my will or other estate planning documents signed by me. However, it is my express desire that each family member, Executor, Trustee and Guardian will use this love letter and the other documents signed by me in making any discretionary decisions for me and my family.

Print Name: _____ **Signature:** _____

Copies of this document were delivered to:

_____ _____

_____ _____

OUR LEGACY OF FAITH

Use the space below to record monumental moments of triumphs in your Family's life

Date _____

Date _____

Date _____

Date _____

Date _____

My Passwords

Family Care Package

www.wotfc.com