

Family member 1:

Full Name: _____

Date of Birth: _____

Social Security #: _____

Place of Birth: _____

Birth certificate is located: _____

Last Will and Testament

Date: _____

Safety Deposit Box location: _____

DD 214 (military service) is located: _____

Life insurance policies:

Company _____

Policy number _____

Contact phone _____

Company _____

Policy number _____

Contact phone _____

Advance Directive Date: _____

Location of original: _____

Chronic medical conditions, medications, physicians' names and numbers: _____

Other information:

Banking relationships: _____

Investment relationships: _____

Dental records are located: _____

Health insurance provider/policy #: _____

Employment or retirement benefits contact: _____

Family contact numbers: _____

Social Media Accounts and Passwords: _____

**IMPORTANT
LEGAL AND PERSONAL
INFORMATION**

For my family and/or close personal friends;
this information is provided
so that you will have some personal
information in the event of a natural or
manmade disaster or other tragedy.

(Print Name)

Info is current as of _____, 201__.

Copies of important documents are attached:
Wills, Advance Directives, Powers of
Attorney

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Family member 2:

Full Name:_____

Date of Birth:_____

Social Security #:_____

Place of Birth:_____

Birth certificate is located:_____

Last Will and Testament

Date:_____

Safety Deposit Box location:_____

DD 214 (military service) is located:_____

Life insurance policies:

Company_____

Policy number_____

Contact phone_____

Company_____

Policy number_____

Contact phone_____

Advance Directive Date:_____

Location of original:_____

Chronic medical conditions, medications, physicians' names and numbers:_____

Family member 3:

Full Name:_____

Date of Birth:_____

Social Security #:_____

Place of Birth:_____

Birth certificate is located:_____

Last Will and Testament

Date:_____

Safety Deposit Box location:_____

DD 214 (military service) is located:_____

Life insurance policies:

Company_____

Policy number_____

Contact phone_____

Company_____

Policy number_____

Contact phone_____

Advance Directive Date:_____

Location of original:_____

Chronic medical conditions, medications, physicians' names and numbers:_____

Family member 4:

Full Name:_____

Date of Birth:_____

Social Security #:_____

Place of Birth:_____

Birth certificate is located:_____

Last Will and Testament

Date:_____

Safety Deposit Box location:_____

DD 214 (military service) is located:_____

Life insurance policies:

Company_____

Policy number_____

Contact phone_____

Company_____

Policy number_____

Contact phone_____

Advance Directive Date:_____

Location of original:_____

Chronic medical conditions, medications, physicians' names and numbers:_____

