

TIAH M. WORKMAN

*Estate and Living Estate Services
....Giving You Peace of Mind*

**Client Profile
Questionnaire**

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The following form will be helpful to your Power of Attorney or your Executor. You should complete this questionnaire in as much detail as you can.

If we are acting on your behalf under a Power of Attorney or as your Executor, we ask that you complete this form and provide it to us. For these purposes we ask that you complete this questionnaire and assure you that the information provided remains confidential, will not be used by outside sources and will only be used in the conduct of your personal affairs.

NOTE YOU MAY WRITE ON THE BACK OF THE FORM IF YOU ARE SHORT OF SPACE

(For One or Two Persons)

Full Legal Name (include all given names):	Full Legal Name (include all given names):
Alias:	Alias:
Birth Name:	Birth Name:
Address:	Address:
Telephone No:	Telephone No:
Fax:	Fax:
Email:	Email:
Occupation:	Occupation:
Spiritual/Religious Affiliation:	Spiritual/Religious Affiliation:
PERSONAL PARTICULARS	
Birth Date:	Birth Date:
Birth Place (City, Province/State & Country):	Birth Place (City, Province/State & Country):
SIN:	SIN:
Driver's Licence Number:	Driver's Licence Number:

When you need someone to trust

PARENTS PARTICULARS	
Father's name:	Father's name:
Father's place of birth:	Father's place of birth:
Father's birthdate:	Father's birthdate:
Mother's name:	Mother's name:
Mother's maiden name:	Mother's maiden name:
Mother's place of birth:	Mother's place of birth:
Mother's birthdate:	Mother's birthdate:
MARITAL STATUS	
<input type="checkbox"/> Married <input type="checkbox"/> Divorced Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Common-law	<input type="checkbox"/> Married <input type="checkbox"/> Divorced Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Common-law
Spouse's Name (or as set out herein):	Spouse's Name (or as set out herein):
If Widowed, Date of Death of Spouse:	If Widowed, Date of Death of Spouse:
HEALTH CARE PARTICULARS	
Personal Health Number:	Personal Health Number:
Allergies:	Allergies:
Drug:	Drug:
Food:	Food:
Medical procedures:	Medical procedures:
Hip/knee replacement Yes <input type="checkbox"/> No <input type="checkbox"/>	Hip/knee replacement Yes <input type="checkbox"/> No <input type="checkbox"/>
Pace maker Yes <input type="checkbox"/> No <input type="checkbox"/>	Pace maker Yes <input type="checkbox"/> No <input type="checkbox"/>
Any other apparatus inserted? Yes <input type="checkbox"/> No <input type="checkbox"/>	Any other apparatus inserted? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, provide details:	If yes, provide details:
Hearing aids Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing aids Yes <input type="checkbox"/> No <input type="checkbox"/>
Eyeglasses Yes <input type="checkbox"/> No <input type="checkbox"/>	Eyeglasses Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Optician:	Name of Optician:
Telephone:	Telephone:
Extended Health Care Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide details of plan provider and plan number	Extended Health Care Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide details of plan provider and plan number

When you need someone to trust

HEALTH CARE CONTACT INFORMATION	
Name & Telephone Number	(List or indicate same)
Doctor:	Doctor:
Telephone:	Telephone:
Dentist:	Dentist:
Telephone:	Telephone:
Specialist:	Specialist:
Telephone:	Telephone:
Home Care:	Home Care:
Telephone:	Telephone:
Other who may provide you with a health care service:	Others who may provide you with a health care service:
Name:	Name:
Telephone:	Telephone:
Name:	Name:
Telephone:	Telephone:
PHARMACY	
Name:	Name:
Location:	Location:
Telephone:	Telephone:
FINANCIAL AND PARTICULARS	
Income Tax advisor	Income Tax advisor
Name:	Name:
Telephone:	Telephone:
Financial advisor	Financial advisor
Name:	Name:
Telephone:	Telephone:
When was last T1 General filed/Notice of Assessment issued? Year: _____	When was last T1 General filed/Notice of Assessment issued? Year: _____
Claiming CPP? Yes <input type="checkbox"/> No <input type="checkbox"/>	Claiming CPP? Yes <input type="checkbox"/> No <input type="checkbox"/>
Claiming OAS? Yes <input type="checkbox"/> No <input type="checkbox"/>	Claiming OAS? Yes <input type="checkbox"/> No <input type="checkbox"/>
Taking RRIF Income? Yes <input type="checkbox"/> No <input type="checkbox"/>	Taking RRIF Income? Yes <input type="checkbox"/> No <input type="checkbox"/>
Where is your RRIF?	Where is your RRIF?
Other pension?	Other pension?
Foreign pension? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide Reference # If yes, is there a POA in place for that foreign country? Yes <input type="checkbox"/> No <input type="checkbox"/>	Foreign pension? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide Reference # If yes, is there a POA in place for that foreign country? Yes <input type="checkbox"/> No <input type="checkbox"/>

When you need someone to trust

FAMILY/NEXT OF KIN and all surviving direct family members including spouse, children, grandchildren, parents, siblings, their telephone number and addresses (attach an additional sheet if necessary):	
Spouse (as noted above):	Spouse (as noted above):
Telephone (if different from your own)	Telephone: (if different from your own)
Children	
Name:	Age: Tel/email:
Address:	
Name:	Age: Tel/email:
Address:	
Name:	Age: Tel/email:
Address:	
Name:	Age: Tel/email:
Address:	
Name:	Age: Tel/email:
Address:	
Other Family Members	(List or indicate same)
Name/Relationship:	Name/Relationship:
Tel/email:	Tel/email:
Name/Relationship:	Name/Relationship:
Tel/email:	Tel/email:
Name/Relationship:	Name/Relationship:
Tel/email:	Tel/email:
IF MORE SPACE IS NEEDED WRITE ON THE BACK OF THIS FORM	
BENEFICIARIES (list all as per your Will)	
Name:	Name:
Tel/email:	Tel/email:
Name:	Name:
Tel/email:	Tel/email:
Name:	Name:
Tel/email:	Tel/email:
IF MORE SPACE IS NEEDED WRITE ON THE BACK OF THIS FORM	
POWERS OF ATTORNEY	
Name:	Name:
Tel/email:	Tel/email:
Name:	Name:
Tel/email:	Tel/email:
IF MORE SPACE IS NEEDED WRITE ON THE BACK OF THIS FORM	

When you need someone to trust

EXECUTORS/TRUSTEES	
Name:	Name:
Tel/email:	Tel/email:
Name:	Name:
Tel/email:	Tel/email:
IF MORE SPACE IS NEEDED WRITE ON THE BACK OF THIS FORM	
REPRESENTATIVES under a Representative Agreement	
Name:	Name:
Tel/email:	Tel/email:
Name:	Name:
Tel/email:	Tel/email:
Do you have:	Do you have:
Living will? Yes <input type="checkbox"/> No <input type="checkbox"/>	Living will? Yes <input type="checkbox"/> No <input type="checkbox"/>
DNR order? Yes <input type="checkbox"/> No <input type="checkbox"/>	DNR order? Yes <input type="checkbox"/> No <input type="checkbox"/>
Advanced Directive? Yes <input type="checkbox"/> No <input type="checkbox"/>	Advanced Directive? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, provide location:	If yes, provide location:
Do you have Lifeline? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have Lifeline? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, with who?	If yes, with who?
Name:	Name:
Telephone:	Telephone:
ASSETS including real estate, vehicles, bank accounts, securities and investments (attach an additional sheet, if necessary)(List or indicate same)	
a. Real Estate – provide addresses:	a. Real Estate – provide addresses:
1. _____	1. _____
Joint Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Yes <input type="checkbox"/> No <input type="checkbox"/>
2. _____	2. _____
Joint Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Vehicles – provide make/model year/VIN:	b. Vehicles – provide make/model year/VIN:
_____	_____
_____	_____
Joint Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Bank Accounts:	c. Bank Accounts:
Bank:	Bank:
Location:	Location:
Bank:	Bank:
Location:	Location:
Bank:	Bank:
Location:	Location:

When you need someone to trust

Other (i.e. stock, shares):	Other (i.e. stock, shares):
CREDITORS: include mortgages, loans, credit cards, list type, creditor's name (attach an additional sheet if necessary)	
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
Do you collect any reward points?	Do you collect any reward points?
Type:	Type:
Number:	Number:
Username: Password:	Username: Password:
Type:	Type:
Number:	Number:
Username: Password:	Username: Password:
INSURANCE (attach additional sheet, if necessary) (List or indicate same)	
a. Homeowner:	a. Homeowner:
Agent:	Agent:
Telephone:	Telephone:
Policy No.:	Policy No.:
b. Vehicle/Recreational Vehicle	b. Vehicle/Recreational Vehicle
Agent:	Agent:
Telephone:	Telephone:
(other than ICBC)	(other than ICBC)

When you need someone to trust

c. Life/Accident/Disability	c. Life/Accident/Disability
Agent:	Agent:
Telephone:	Telephone:
Policy No.:	Policy No.:
ARRANGEMENTS/REQUESTS AT TIME OF DEATH (List or indicate same)	
1. <input type="checkbox"/> Burial <input type="checkbox"/> Cremation	1. <input type="checkbox"/> Burial <input type="checkbox"/> Cremation
2. <input type="checkbox"/> Funeral Service <input type="checkbox"/> Memorial Service <input type="checkbox"/> Graveside <input type="checkbox"/> Alternate Service <input type="checkbox"/> No Service	2. <input type="checkbox"/> Funeral Service <input type="checkbox"/> Memorial Service <input type="checkbox"/> Graveside <input type="checkbox"/> Alternate Service <input type="checkbox"/> No Service
3. I request that my funeral or memorial service be held in/at:	3. I request that my funeral or memorial service be held in/at:
4. Additional instructions (i.e. clergy, flowers charitable donations, obituary, reception):	4. Additional instructions (i.e. clergy, flowers charitable donations, obituary, reception):
5. Name/location of cemetery:	5. Name/location of cemetery:
6. If cremation, I wish my ashes to be: <input type="checkbox"/> Returned to Executor <input type="checkbox"/> Returned to family <input type="checkbox"/> Scattered at: <input type="checkbox"/> Buried in:	6. If cremation, I wish my ashes to be: <input type="checkbox"/> Returned to Executor <input type="checkbox"/> Returned to family <input type="checkbox"/> Scattered at: <input type="checkbox"/> Buried in:
7. I have pre-paid arrangements with: a) Funeral Home: b) Cemetery: c) Insurance:	7. I have pre-paid arrangements with: a) Funeral Home: b) Cemetery: c) Insurance:
8. Donation arrangements for: a) Organs <input type="checkbox"/> Yes <input type="checkbox"/> No b) Body <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Donation arrangements for: a) Organs <input type="checkbox"/> Yes <input type="checkbox"/> No b) Body <input type="checkbox"/> Yes <input type="checkbox"/> No
TECHNOLOGY	
Wi-Fi? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name:	Wi-Fi? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name:
Password:	Password:

When you need someone to trust

Social Media accounts? Yes <input type="checkbox"/> No <input type="checkbox"/>	Social Media accounts? Yes <input type="checkbox"/> No <input type="checkbox"/>
Type:	Type:
Username:	Username:
Password:	Password:
Type:	Type:
Username:	Username:
Password:	Password:
Email? Yes <input type="checkbox"/> No <input type="checkbox"/>	Email? Yes <input type="checkbox"/> No <input type="checkbox"/>
Email Address:	Email Address:
Password:	Password:
Password Manager? Yes <input type="checkbox"/> No <input type="checkbox"/>	Password Manager? Yes <input type="checkbox"/> No <input type="checkbox"/>
Manager Name:	Manager Name:
Username:	Username:
Master Password:	Master Password:

Is there anything else you think we should be aware of?

DATED at the City of Nanaimo, BC, this _____ day of _____, 201____.

Name: _____ Signature _____

Name: _____ Signature _____

I thank you for taking the time to complete this questionnaire. The more I know about your needs and preferences, the better I can serve you. At any time your personal profile changes, please feel free to contact my office and the updated information will be added to your file.