



EMERGENCY PREPAREDNESS PLAN  
OF

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Updated: \_\_\_\_\_

# PERSONAL EMERGENCY PREPAREDNESS PLAN

*This document is intended to help you gather and provide personal information that would be useful for your loved ones in an emergency.*

## SECTION ONE: PERSONAL INFORMATION

### Client A

Full Name (First, Middle Initial, Last):		Any other names you have been known by (maiden)	
Mailing Address (Street, City, County, State, Zip)			
Residence Address (if different)			
Date of Birth	SSN	US Citizen?	Veteran?
Home Phone	Cell Phone	Email	

### Client B (if applicable)

Full Name (First, Middle Initial, Last):		Any other names you have been known by (maiden)	
Mailing Address (Street, City, County, State, Zip)			
Residence Address (if different)			
Date of Birth	SSN	US Citizen?	Veteran?
Home Phone	Cell Phone	Email	

If married, date and place of marriage: \_\_\_\_\_

If married, have you entered into agreements with your spouse? Y / N (*if yes, keep with important documents*)

**SECTION TWO: FAMILY INFORMATION**

**Children & Grandchildren**

(If more than 4 children, attach a separate sheet of paper)

(Please indicate if *not* a mutual child)

<b>Child #1</b>	SSN	Phone	Date of Birth
Address		Email	Child's spouse (if applicable)
<b>Names of Grandchildren</b>	Address		Dates of Birth

<b>Child #2</b>	SSN	Phone	Date of Birth
Address		Email	Child's spouse (if applicable)
<b>Names of Grandchildren</b>	Address		Dates of Birth

**Children & Grandchildren**  
(continued)

(Please indicate if *not* a mutual child)

<b>Child #3</b>	SSN	Phone	Date of Birth
Address		Email	Child's spouse (if applicable)
<b>Names of Grandchildren</b>	Address		Dates of Birth

<b>Child #4</b>	SSN	Phone	Date of Birth
Address		Email	Child's spouse (if applicable)
<b>Names of Grandchildren</b>	Address		Dates of Birth

**EXTENDED FAMILY  
(Parents and Siblings)**

<b>Client A</b>	<b>Date of Death</b>	<b>Address</b>	<b>Phone</b>
Father:			
Mother:			
Sibling 1:			
Sibling 2:			
Sibling 3:			
Sibling 4:			

<b>Client B</b>	<b>Date of Death</b>	<b>Address</b>	<b>Phone</b>
Father:			
Mother:			
Sibling 1:			
Sibling 2:			
Sibling 3:			
Sibling 4:			

### SECTION THREE: PROFESSIONAL ADVISORS

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	NAME, FIRM & TELEPHONE/EMAIL
Accountant	
Stock Broker	
Insurance Agent (Life)	
Insurance Agent (Casualty)	
Financial Planner	
Trust Officer	
Other Attorneys	

### SECTION FOUR: INCOME INFORMATION

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	CLIENT A	CLIENT B
Salary	\$	\$
Social Security		
Retirement/Pension		
IRA Withdrawals		
Dividends and Interest		
Rental Property		
Mortgage/Promissory Notes ( <i>income to you</i> )		
Other		
<b>Total Annual Income</b>	\$	\$

**SECTION FIVE: FINANCIAL INFORMATION**

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	<b>CLIENT A</b>	<b>CLIENT B</b>	<b>JOINT</b>
Residence <i>Mortgage?</i>	\$	\$	\$
Other Real Property			
Investment Account(s)			
Stocks, Bonds and Notes <i>(in certificate form)</i>			
Bank Accounts <i>(provide location, type &amp; account # below, e.g. KeyBank checking #1234)</i> _____ _____ _____ _____			
Business Interest(s)			
Retirement Accounts <i>(provide location, type &amp; account # below, e.g. Merrill Lynch 401K)</i> _____ _____ _____ _____			
Annuities (Non-Qualified)			
Mortgage/Promissory Notes			
Interests in Other Estates/Trusts (inheritance)			
Automobiles			
Miscellaneous Assets <i>(of significant value e.g. artwork, jewelry)</i>			
<b>Gross Assets</b>	\$	\$	\$
<i>Less: Mortgages, Loans and Other Liabilities</i>	\$	\$	\$
<b>Net Assets</b>	\$	\$	\$

**Life Insurance**

Company & Type of Policy (e.g. whole, term)	Insured	Owner	Death Benefit / Cash Value	Beneficiaries

Do you have a safe deposit box? Yes \_\_\_ No \_\_\_

If yes, bank & branch where located: \_\_\_\_\_

Owner(s): \_\_\_\_\_

**SECTION SIX: HEALTH INFORMATION**

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My medical professionals:

Dr. Name \_\_\_\_\_  
Office \_\_\_\_\_  
Phone No. \_\_\_\_\_  
Address \_\_\_\_\_

Dr. Name \_\_\_\_\_  
Office \_\_\_\_\_  
Phone No. \_\_\_\_\_  
Address \_\_\_\_\_

I am allergic to the following drugs: \_\_\_\_\_  
\_\_\_\_\_

I am prescribed the following (name and dosage): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have had treatment for:  Cancer  Tuberculosis  Kidney Disorder  Diabetes  Circulatory problems  Heart  Arthritis  Dementia  Other \_\_\_\_\_

Emergency contact(s)? \_\_\_\_\_  
*(name and contact info)* \_\_\_\_\_

**SECTION SEVEN: ESTATE INFORMATION**

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	<b>CLIENT A</b>	<b>CLIENT B</b>
<b>Do you have a Will?</b>	YES / NO	YES / NO
Location?		
Executor?		
Successor Executor(s)?		
Guardian of minors?		
<b>Do you have a Power of Attorney (POA)?</b>	YES / NO	YES / NO
Location?		
Agent(s)?		
Successor Agent(s)?		
<b>Do you have a Health Care Proxy (HCP)?</b>	YES / NO	YES / NO
Location?		
Agent?		
Successor Agent(s)?		
Does your doctor have a copy?	YES / NO	YES / NO
<b>Do you have a Living Will?</b>	YES / NO	YES / NO
Location?		
<b>Do you have a Trust?</b>	YES / NO	YES / NO
Location?		
Trustee?		
Successor Trustee(s)?		



**SECTION NINE: IN THE EVENT OF DEATH**

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**I. Notify the following:**

	<b>Name</b>	<b>Phone No.</b>	
Funeral Home:	_____	_____	
Employer:	_____	_____	
Utilities Providers:			
Gas:	_____	_____	
Electric:	_____	_____	
Hot Water:	_____	_____	
Phone:	_____	_____	
Cable TV:	_____	_____	
Landlord:	_____	_____	
Attorney:	_____	_____	
Doctor:	_____	_____	
Property Insurer:	_____	_____	
Newspaper Delivery:	_____	_____	
Magazines:	_____	_____	
Other Subscriptions:	_____	_____	
Credit Cards:			
	Account No.	Phone No.	Called?
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**II. Things to Do:**

- Arrange mail forwarding
- Call Newspapers to post death notice/obituary
- Contact attorney
- Determine debts
- File final income tax returns
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

