BENEFICIARY INFORMATION FORM

SPRINGHILL
POOLED ACCOUNTS TRUST

The information gathered on this form is important for the proper administration of your trust sub-account.
Please read this form carefully and fill it out as completely as possible.
You are encouraged to seek independent, professional advice before signing.

Section I: Beneficiary Information

Name		
☐ Male ☐ Female	Date of Birth	SSN
Primary Phone	Email Address	
Current Address		
City	State	Zip
Living Arrangement: ☐ House ☐ Apartment ☐ Semi-Independent Program ☐ Group Home ☐ Assisted Living ☐ Nursing Home		
Monthly mortgage or rent	How long have you lived at your current address?	

Section II: Mailing Address

Please indicate where you would like monthly statements and correspondence sent.

☐ Same address as Beneficiary's current address.		
Name		
Address		
City	State	Zip

Section III: Medical Background

Please briefly describe the nature of the beneficiary's disability.

Section IV: Grantor Information

Only complete this section if someone other than the beneficiary is signing the Joinder Agreement.

Name		
Primary Phone	Email Address	
Current Address		
City	State	Zip
Relationship to Beneficiary		

Section V: Beneficiary Representative

Complete this section if the Beneficiary has a Guardian, Conservator, Power of Attorney, Representative Payee or Healthcare Agent.

Name:		
Primary Phone	Email Address	
Current Address		
City	State	Zip
Check all that apply: ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Representative Payee ☐ Healthcare Agent		
Please provide Letters of Authority, Power of Attorney, Healthcare Power, or Social Security Letter		

Name:		
Primary Phone	Email Address	
Current Address		
City	State	Zip
Check all that apply: ☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Representative Payee ☐ Healthcare Agent		
Please provide Letters of Authority, Power of Attorney, Healthcare Power, or Social Security Letter		

Section VI: Referring Attorney

Please provide the name and contact information for the attorney helped you established your Springhill Pooled Trust.

Name		
Address		
City	State	Zip
Phone	Email Address	

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Section VII: Beneficiary Income and Benefits

Please check all that apply and provide documentation (statement from Social Security and copies of all medical cards).

☐ Supplemental Security Income (SSI)	Gross Monthly Amount:
☐ Social Security Disability Income (SSDI)	Gross Monthly Amount:
☐ Social Security Retirement / Survivors (RSDI)	Gross Monthly Amount:
☐ Veteran's Pension / Disability	Gross Monthly Amount:
☐ Other Income: Please describe:	Gross Monthly Amount:

☐ Medicare	☐ Medicaid	☐ Prescription Drug Plan	☐ Food Assistance	☐ Section 8 Housing
☐ Medicaid Home Care assistance	☐ NIFTY Waiver	☐ Other Home Waiver care		
☐ Other Health Insurance	Name of Insurance Carrier:			

Section VIII: First-Party Benefit Carrier

Complete this section if the Beneficiary was involved in an auto-related accident and the insurance company is paying for injury related costs.

Insurance Company		
Claim Number	Date of Loss/Claim	
Adjustor's Name		
Phone Number	Email Address	
Address		
City	State	Zip

Section IX: Prepaid Funeral

The Grantor and Beneficiary are hereby advised and acknowledge, through their signature below, that no funeral expenses can be paid from a Beneficiary's trust sub-account after the death of the Beneficiary. Springhill Housing Corporation stresses the necessity of purchasing a pre-paid funeral contract for the Beneficiary. If you already have a pre-paid funeral contract, please complete the section below.

Company	Policy/Contract Number	
Contact Name		
Phone Number	Email Address	
Address		
City	State	Zip
Please provide a copy of the pre-paid funeral contract.		

Section X: Emergency Contact Information

If Springhill is unable to contact the Grantor, Beneficiary, or the Beneficiary's legal representative, please provide contact information for any additional person that may be consulted regarding the needs of the Beneficiary.

Name	Allow this person to request distributions? ☐ Yes ☐ No	
Primary Phone	Email Address	
Current Address		
City	State	Zip

Name	Allow this person to request distributions? ☐ Yes ☐ No	
Primary Phone	Email Address	
Current Address		
City	State	Zip

Name	Allow this person to request distributions? ☐ Yes ☐ No	
Primary Phone	Email Address	
Current Address		
City	State	Zip

I affirm that all of the information provided on this form is true to the best of my knowledge. I understand that I may be required to provide proof of any information I have provided. I understand that if I have left off any information, whether intentionally or not, it may directly or indirectly affect the Beneficiary's public benefits. Furthermore, I understand that Springhill is not liable for any claim, liability, or damage of any kind resulting in any way from any errors or omissions of information on this form.

Signature _____ Date _____