

Irrevocable Burial Trust Form



415 Horsham Road | Horsham, PA 19044 | Tel 215.672.1184 | Fax 215.674.9372 | www.arlingtonheritagegroup.com

Please fill out this form as completely as possible. If you do not have the information, write "N/A". Please email the form back to Arlington Heritage Group for processing at lmeckling@ahgtrusts.com or fax to 215.674.9372.

Preparer's Information										
Preparer Name:						Date:				
Agency (if applicable):						Phone:				
Address:										
City, State, Zip:						Email:				
Client Information										
Client Name:					SSN:			SEX:	M	F
Address:							DOB:			
Ethnicity:	African American	Asian	Hispanic	Native American	Pacific Islander					
	White/European	Other								
Religion:	Catholic	Protestant	Christian	Jewish	Muslim	Other:				
Education:	Write in highest grade completed:									
Lives With:	Alone	With Parents	With Grandparents	Foster/ Life Sharing Family						
	Group Home (name of):									
Mother's Maiden Name:					Father's Name:					
Next of Kin:	Name: _____ Relationship: _____									
	Address: _____									
	Phone: _____ Email: _____									
Type of Funeral Service										
Direct Cremation		Cremation with Service		Cremation with Viewing		Traditional Burial		Graveside Burial		
Will the family be involved with the planning?			Yes	No	Not Sure					
Financial Information										
Does the client have a burial savings account?			Yes	No	If Yes, most recent statement is required.					
Does the client have burial or life insurance?			Yes	No	If Yes, most recent statement is required.					
Name of Financial Institution: _____					Account/Policy #: _____					
Cemetery Information										
Does the client have a cemetery plot?			Yes	No	If Yes, a copy of the deed is required.					
Name of Cemetery: _____				Deed is in the name of: _____						
Cemetery Address: _____										
Current Benefits										
Does the client receive:		SSI	Yes	No	Amount: _____	Waiver	Yes	No		
		SSDI	Yes	No	Amount: _____	Medical Assistance	Yes	No		
Rep Payee:					Relationship to Client:					
Rep Payee Contact Information:	Phone: _____ Email: _____									
	Address: _____									
For Provider/Agency Only										
Region:	Field:			Program:						