

The First Maryland Disability Trust

EXHIBIT B

GRANTOR, BENEFICIARY & ADVOCATE CONTACT INFORMATION

**GRANTOR**

Mr./Ms./Mrs: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Beneficiary: \_\_\_\_\_

**BENEFICIARY**

Mr./Ms./Mrs: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ADVOCATE**

Mr./Ms./Mrs: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Beneficiary: \_\_\_\_\_

**SUCCESSOR ADVOCATE:**

Mr./Ms./Mrs:

Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Email Address:

Social Security Number:

Date of Birth:

Relationship to Beneficiary: