

PERSONAL AND CONFIDENTIAL

INFORMATION FOR ESTATE PLANNING DOCUMENTS

Marital Status: Married Unmarried, with long-term partner (domestic partner)
Are you Registered Domestic Partners? Yes No Don't Know

Client Name and Information

First Name: _____ Middle: _____ Last: _____

Nickname (if any): _____ Alias Name (if any): _____

Gender: Male Female SS#: _____ DOB: _____

U.S. Citizen? Yes No

If No, specify citizenship: _____

Health: Excellent Reasonably Good Poor Serious Adverse Condition

Legally Blind? Yes No Disabled? Yes No

Spouse/ Partner Name and Information

First Name: _____ Middle: _____ Last: _____

Nickname (if any): _____ Alias Name (if any): _____

Gender: Male Female SS#: _____ DOB: _____

U.S. Citizen? Yes No

If No, specify citizenship: _____

Address: _____

Cell: _____ Home: _____ Work: _____

Health: Excellent Reasonably Good Poor Serious Adverse Condition

Legally Blind? Yes No Disabled? Yes No

Notes: _____

Contact Information:

	CLIENT	SPOUSE/ PARTNER
Address		
City		
State		
Zip		
Home Phone		
Home Fax		
E-mail		
Cell Phone		
Work Phone		
Work Fax		
Work E-mail		

CHILDREN (if applicable)

	Name	Living	Gender	Date of Birth	Child of Both	Child of Client Only	Child of Spouse Only
Child 1		Y N	<input type="checkbox"/> M <input type="checkbox"/> F		Y N	Y N	Y N
Child 2		Y N	<input type="checkbox"/> M <input type="checkbox"/> F		Y N	Y N	Y N
Child 3		Y N	<input type="checkbox"/> M <input type="checkbox"/> F		Y N	Y N	Y N
Child 4		Y N	<input type="checkbox"/> M <input type="checkbox"/> F		Y N	Y N	Y N
Child 5		Y N	<input type="checkbox"/> M <input type="checkbox"/> F		Y N	Y N	Y N
Child 6		Y N	<input type="checkbox"/> M <input type="checkbox"/> F		Y N	Y N	Y N

	Address (if not living with client and spouse/partner)	Legally Blind	Disabled	Receives SSI	Completed Education
Child 1		<input type="radio"/> Y <input type="radio"/> N	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Child 2		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Child 3		Y <input type="checkbox"/> N <input type="checkbox"/>	Y N	Y N	Y N
Child 4		Y <input type="checkbox"/> N <input type="checkbox"/>	Y N	Y N	Y N
Child 5		Y <input type="checkbox"/> N <input type="checkbox"/>	Y N	Y N	Y N
Child 6		Y N	Y N	Y N	Y N

CLIENT'S DISPOSITIVE PROVISIONS

List any property you want to go to specific beneficiaries. Normally we provide in the Will a paragraph that will allow you to leave with your Will a handwritten memo stating where personal property should pass. Thus, you can do that independent of your documents. However, that is not suggested for cash, real estate or gifts of substantial value. Therefore, if there is any specific beneficiary for any cash, real estate or valuable property, please provide the name and property description:

Cash Gifts (cash and cash-equivalent gifts)

Name of Recipient	Relationship	Amount

Gifts of Real Estate

Name of Recipient	Relationship	Description of Property

Gift of Tangible Property (autos/ jewelry/ art/ etc.)

Name of Recipient	Relationship	Description of Property

Gifts of Intangibles (stocks/ bonds/ annuities/ etc.)

Name of Recipient	Relationship	Description of Property

SPOUSE'S DISPOSITIVE PROVISIONS

Cash Gifts (cash and cash-equivalent gifts)

Name of Recipient	Relationship	Amount

Gifts of Real Estate

Name of Recipient	Relationship	Description of Property

Gift of Tangible Property (autos/ jewelry/ art/ etc.)

Name of Recipient	Relationship	Description of Property

Gifts of Intangibles (stocks/ bonds/ annuities/ etc.)

Name of Recipient	Relationship	Description of Property

CLIENT’S RESIDUAL GIFTS (after specific gifts, above)

Spouse/ Partner

Want to provide primarily for your Spouse/ Partner (and then secondarily for children/ descendants, if any)?

Yes No

If Yes, prefer gift to Spouse/ Partner to be given: Outright In a Trust

Children/ Descendants

Prefer gift to children (if any) to be given: Outright In a Trust

Do you wish to treat children equally? Yes No

Prefer gift to grandchildren (if any) to be given: Outright In a Trust

Do you wish to treat grandchildren equally? Yes No

Other Beneficiaries

Specify gift to other beneficiary(ies):

Children’s Trusts

-Your wills will set up basic trusts for any minor children, grandchildren, or other relatives who might inherit under your will.

At what age should children have opportunity to become a co-trustee of their trust (if at all)? _____

At what age should these trusts terminate and distribute the assets outright to the children? _____

SPOUSE’S RESIDUAL GIFTS (after specific gifts, above)

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If Yes, prefer gift to Spouse/ Partner to be given: Outright In a Trust

Children/ Descendants

Prefer gift to children (if any) to be given: Outright In a Trust

Do you wish to treat children equally? Yes No

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At what age should these trusts terminate and distribute the assets outright to the children? _____

INDEPENDENT EXECUTOR (for wills)

Your executor is responsible for probating your will and distributing your assets to your beneficiaries. Married persons often appoint their spouses as primary executor. Many banks and other institutions will serve as executor for a fee, but often it is best to appoint one of your heirs or family member or close personal friend who is willing to serve for free.

CLIENT’S INDEPENDENT EXECUTOR:

Initial Independent Executor under Client’s Will (will serve concurrently)

Name:
Check if Spouse/ Partner is first choice:
Address:
Phone/Email:

Successor Independent Executor under Client’s Will (will serve at death/ disability of Initial Independent Executor)

Name:
Relationship:
Address:
Phone/Email:

SPOUSE’S/ PARTNER’S INDEPENDENT EXECUTOR:

Initial Independent Executor Under Spouse/ Partner’s Will (will serve concurrently)

Name:
Relationship:
Address:
Phone/Email:

Successor Independent Executor Under Spouse/ Partner’s Will (will serve at death/ disability of Initial Independent Executor)

Name:
Relationship:
Address:
Phone/Email:

GUARDIANS

Guardians for minor or disabled children (if applicable):

If you have minor children, you should appoint a guardian to take care of them if both parents die before they reach age 18 (you can also appoint a married couple as co-guardians). There are two different Guardianship roles, Guardian of the Estate/Financial (responsible for all financial decisions) and Guardian of the Person (Health care support and maintenance). The same person can be appointed as Guardian of the Estate and Person.

Initial Guardians *Financial Purposes*

Name/Relationship	Address/Phone/Email

Successor Guardians

Name/Relationship	Address/Phone/Email

Initial Guardians *Health Care Purposes*

Name/Relationship	Address/Phone/Email

Successor Guardians

Name/Relationship	Address/Phone/Email

TRUSTEES (if applicable)

CLIENT'S TRUSTEES

The trustee and the guardian are frequently the same person; if you prefer to appoint different people to these posts, please make a note in the margin. If you wish to appoint more alternates than the space below allows, please use the back of this sheet.

Initial Trustees for Client (applicable if trusts being considered)

Name
Relationship:
Address:
Phone/Email:

Successor Trustees for Client (applicable if trusts being considered)

Name
Relationship:
Address:
Phone/Email:

SPOUSE/ PARTNER'S TRUSTEES

Initial Trustees for Spouse/ Partner (applicable if trusts being considered)

Name
Relationship:
Address:
Phone/Email:

Successor Trustees for Spouse/ Partner (applicable if trusts being considered)

Name
Relationship
Address:
Phone/Email:

CLIENT’S HEALTHCARE DIRECTIVES

This document instructs physicians and hospitals what action to take if you are suffering from a terminal or irreversible condition and are unable to communicate or make decisions for yourself. We can discuss this document more fully when we meet, but for now please consider the following questions:

Do you have a current Living Will? Yes No If yes, date: _____

Do you have a current Health Care Directive (also called Health Care Power of Attorneys)?
 Yes No If yes, date: _____

Do you have a HIPAA Authorization? Yes No If yes, date: _____

IF YOU DO NOT HAVE A LIVING WILL OR HEALTH CARE DIRECTIVE OR YOUR DOCUMENTS ARE OLDER THAN THREE (3) YEARS OLD, PLEASE COMPLETE THE FOLLOWING:

A “**terminal condition**” is one from which you are expected to die within six months even with all available life-sustaining treatments. If you are suffering from a terminal condition, do you request only those treatments needed to keep you comfortable, or do you request all available life-sustaining treatments?

In preparing a Living Will or Health Care Directive, would you want to provide for continued nutrition/ hydration (food/water) if your death was imminent? Yes No

An “**irreversible condition**” is one from which you are expected to die even with all available life-sustaining treatments, but with which you may remain alive for more than six months. If you are suffering from an irreversible condition, do you request only those treatments needed to keep you comfortable, or do you request all available life-sustaining treatments?

In preparing a Living Will or Health Care Directive, would you want to provide for continued nutrition/ hydration (food/water) if your death was imminent? Yes No

Do you wish to become an organ donor? Yes No

CLIENT’S MEDICAL POWER OF ATTORNEY

This document allows your designated agent to make decisions on your behalf regarding your health care in the event you cannot make them yourself. It becomes effective only upon your incapacity as certified by your physician. Your agent will have authority to consent to surgery, check you into a nursing home, obtain records about your care, etc.

Primary Health Care Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

Alternate Health Care Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

Name of Primary Care Physician

Name/Relationship	Address/Phone/Email	City	State	Zip

SPOUSE’S HEALTHCARE DIRECTIVES

This document instructs physicians and hospitals what action to take if you are suffering from a terminal or irreversible condition and are unable to communicate or make decisions for yourself. We can discuss this document more fully when we meet, but for now please consider the following questions:

Do you have a current Living Will? Yes No If yes, date: _____

Do you have a current Health Care Directive (also called Health Care Power of Attorneys)?

Yes No If yes, date: _____

Do you have a HIPAA Authorization? Yes No If yes, date: _____

IF YOU DO NOT HAVE A LIVING WILL OR HEALTH CARE DIRECTIVE OR YOUR DOCUMENTS ARE OLDER THAN THREE (3) YEARS OLD, PLEASE COMPLETE THE FOLLOWING:

A “**terminal condition**” is one from which you are expected to die within six months even with all available life-sustaining treatments. If you are suffering from a terminal condition, do you request only those treatments needed to keep you comfortable, or do you request all available life-sustaining treatments?

In preparing a Living Will or Health Care Directive, would you want to provide for continued nutrition/ hydration (food/water) if your death was imminent? Yes No

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In preparing a Living Will or Health Care Directive, would you want to provide for continued nutrition/ hydration (food/water) if your death was imminent? Yes No

Do you wish to become an organ donor? Yes No

SPOUSES’S MEDICAL POWER OF ATTORNEY

This document allows your designated agent to make decisions on your behalf regarding your health care in the event you cannot make them yourself. It becomes effective only upon your incapacity as certified by your physician. Your agent will have authority to consent to surgery, check you into a nursing home, obtain records about your care, etc.

Primary Health Care Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

Alternate Health Care Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

Name of Primary Care Physician

Name/Relationship	Address/Phone/Email	City	State	Zip

CLIENT'S DURABLE POWER OF ATTORNEY

This document allows your designated agent to handle all of your personal financial affairs, including the execution of contracts, motor vehicle registrations, real estate sales, bank account transactions, etc., and is important if you become incapacitated in any way. Spouses often name each other as their primary agents.

Primary Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

Alternate Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

SPOUSE'S DURABLE POWER OF ATTORNEY

Primary Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

Alternate Agent(s)

Name/Relationship	Address/Phone/Email	City	State	Zip

FINANCIAL SUMMARY

	Description	Husband	ASSETS		LIABILITIES
			Wife	Joint	
Cash/Liquid					
	Savings				
	Checking				
	Money Market				
	Other				
Real Estate					
	Primary				
	Secondary				
	Other				
Personal Property					
	Automobiles				
	Jewelry				
	Art or Other Collections				
	Boats				
	Other				
Intangibles					
	Bonds				
	Stock				
	Mutual Funds				
	Note & Mortgages Receivables				
	Future Inheritance				
	Interests in Trusts				
	Annuities				
	Other				
Retirement Benefits					
	IRAs				
	401K				
	Keough Plan				
	SEP				
	Other				
Life Insurance					
	Cash Value of all policies				

OTHER PLANNING ISSUES

	Client				Spouse/ Partner			
Want to benefit charity?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Ownership in farm or ranch?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Ownership in closely held business?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Ownership in closely held business?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Own stock in subchapter S corporation?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Ownership in a Medical, Dental or Veterinarian Practice?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Own a valuable collection? (e.g. art, stamp collections)	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Owns interest in gas/oil?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Own a primary residence?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Own a secondary residence?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Own other significant interests in real estate?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>

MISCELLANEOUS

Do you have a safe-deposit box? Yes No

Location of safe-deposit box, if yes: _____

Location of important papers: _____

Has client made gifts to any one person exceeding \$13,000 in any one calendar year? Yes No

Has spouse/ partner made gifts to any one person exceeding \$13,000 in any one calendar year? Yes No

Has client ever filed a Federal Gift Tax Return? Yes No

If yes, years of Returns filed: _____

Has spouse/ partner ever filed a Federal Gift Tax Return? Yes No

If yes, years of Returns filed: _____

Do you have any other legal issues of which I should be aware? Yes No

If Yes, please describe:

