LAW OFFICES OF
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ESTATE PLANNING QUESTIONNAIRE - WILL

Please complete and bring this Questionnaire with you at the time of your consultation to better assist our attorney in preparing your estate planning documents. Complete as much of the information as you are able to, and if you have any questions we will be glad to address them at the time of your appointment.

PLEASE BE ADVISED: If you are married your spouse must also attend the initial consultation with our attorney

THIS FORM MUST BE COMPLETED BY THE INDIVIDUAL(S) retaining our firm

- No other person(s) should complete this form on another person's behalf

NAME: _____

Date of Birth:_____

SPOUSE'S NAME: _____

Date of Birth:_____

HOME ADDRESS: _____

HOME TELEPHONE:_____

CELLULAR TELEPHONE:_____

WORK TELEPHONE: _____

EMAIL ADDRESS: _____

REFERRED BY: _____

DATE OF MARRIAGE: _____ STATE:_____

CHILDREN'S NAMES:

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____

DESCRIBE HOW ASSETS ARE TO BE DISTRIBUTED UPON YOUR DEATH:_____

_____

_____

DISABLED BENEFICIARIES: Identify, Describe disability, Benefits:

_____

_____

GRANDCHILDREN'S NAME: _____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

DISTRIBUTION SCHEME FOR GRANDCHILDREN: Ex: 25% to my granddaughter Elizabeth Simone

_____

_____

GUARDIANS: (Name and address)

1._____

2._____

PERSONAL PROPERTY LIST: **Please attach a list of personal property you desire to specifically bequest.**

ANATOMICAL GIFTS

Yourself Yes ( ) No ( )

Spouse Yes ( ) No ( )

CREMATION

Yourself Yes ( ) No ( )

Spouse Yes ( ) No ( )

PERSONAL REPRESENTATIVE: **If you die first:**

1. _____

2. _____

PERSONAL REPRESENTATIVE: **If spouse dies first:**

1. _____

2._____

BURIAL INSTRUCTIONS:

Yourself: _____

_____

_____

Spouse: _____

_____

_____

GUARDIAN **If you become incapacitated:**

1. _____

2._____

3._____

GUARDIAN **If spouse becomes incapacitated:**

1. _____

2._____

3._____

HEALTH CARE AGENT **if you become incapacitated:**

1. _____

2._____

3._____

HEALTH CARE AGENT **if spouse becomes incapacitated:**

1._____

2._____

3._____

LIMITATIONS ON HEATHCARE POWER OF ATTORNEY:

Yourself:

_____

_____

Spouse:

_____

_____

ATTORNEY IN FACT **You are incapacitated:**

1._____

2._____

3._____

ATTORNEY IN FACT **Spouse is incapacitated**

1._____

2._____

3._____

COPIES OF DEEDS **Please supply copies of deeds to real property**

REAL PROPERTY:

1. _____

2._____

3._____

4._____

HOMESTEAD EXEMPTION: Yes ( ) No ( )

LIFE INSURANCE: (Company and Amount)

Yourself: _____

Spouse:_____

VEHICLES: (Year, Make, Model & Value)

1._____

2._____

BANK ACCOUNTS: (Name of Bank and Account Number)

1._____

2._____

3._____

BROKERAGE ACCOUNTS: (Name of brokerage, type of accounts and account numbers)

1._____

2._____

3._____

PENSION/IRAS: (Name Pension/IRA, account number and value)

1._____

2._____

3._____

INTERESTS IN LIMITED LIABILITY COMPANIES, CORPORATIONS OR LPS: (Identify by Name)

1._____

2. _____

3._____

Transfer restrictions/Buy-sell agreement: Yes ( ) No ( )

MISCELLANEOUS:

_____

_____

_____

The information presented herein is general information only and should not be considered legal advice nor should you rely solely upon this information in taking any actions regarding your matter. While no attorney-client relationship is formed by supplying this information, please do not hesitate to contact us at **(702) 798-4955** to schedule a time to discuss your particular circumstances.