ESTATE PLANNING QUESTIONNAIRE

GENERAL INFORMATION

Marital Status: □ Married □ Single □ Single, but with long-term partner

Are you and your partner Registered Domestic Partners? □ Yes □ No □ Don't Know

Client Name Information

First Name: _____ Middle: _____ Last: _____

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

Gender: □ Male □ Female DOB: _____

U.S. Citizen? □ Yes □ No Social Sec. # _____

If No, specify citizenship: _____

Health: □ Excellent □ Reasonably good □ Poor □ Serious Adverse Condition

Legally blind? □ Yes □ No Disabled? □ Yes □ No

Spouse/Partner Name Information (if applicable)

First Name: _____ Middle: _____ Last: _____

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

Gender: □ Male □ Female DOB: _____

U.S. Citizen? □ Yes □ No Social Sec. # _____

If No, specify citizenship: _____

Health: □ Excellent □ Reasonably good □ Poor □ Serious Adverse Condition

Legally blind? □ Yes □ No Disabled? □ Yes □ No

Contact Information

	Client	**Spouse/Partner (if applicable)**
Address		
City		
State		
Zip		
Home Phone		
Home Fax		
Personal email		

Cell Phone		
Business Phone		
Business Fax		
Business email		

Do you consent to our communicating with you via email? □ Yes □ No

Do you consent and authorize us to send draft documents via email? □ Yes □ No

Referral Information

By whom were you referred to this office?

Name	Address	City	State	Zip

CHILDREN (if applicable)

	Name	Living	Gender	Date of Birth	Child of Both	Child of Client only	Child of Spouse only
Child 1		Y / N	M / F		Y / N	Y / N	Y / N
Child 2		Y / N	M / F		Y / N	Y / N	Y / N
Child 3		Y / N	M / F		Y / N	Y / N	Y / N
Child 4		Y / N	M / F		Y / N	Y / N	Y / N
Child 5		Y / N	M / F		Y / N	Y / N	Y / N
Child 6		Y / N	M / F		Y / N	Y / N	Y / N

	Address (if not living with client and Spouse)	Legally Blind	Disabled	Receives SSI	Completed Education
Child 1		Y / N	Y / N	Y / N	Y / N
Child 2		Y / N	Y / N	Y / N	Y / N
Child 3		Y / N	Y / N	Y / N	Y / N
Child 4		Y / N	Y / N	Y / N	Y / N
Child 5		Y / N	Y / N	Y / N	Y / N
Child 6		Y / N	Y / N	Y / N	Y / N

Desired Guardian(s) for minor or disabled children if Client and Spouse deceased (if applicable):

Initial Guardians/Conservators

Name	Address

Successor Guardians/Conservators

Name	Address

Client's Parents:

Name	Address	City	State	Age (or DOD)

Client's Brothers & Sisters:

Name	Address	City	State	Age (or DOD)

Spouse's Parents (if applicable):

Name	Address	City	State	Age (or DOD)

Spouse's Brothers & Sisters (if applicable):

Name	Address	City	State	Age (or DOD)

FAMILY TREE (if applicable)

If you anticipate that grandchildren, siblings, nieces/nephews (or other remote generation) will be part of your estate plan, please draw a family tree for ease of reference.

CLOSELY HELD BUSINESS INTERESTS (if applicable)

Please describe any interests held in a closely held business, including name of entity, type of entity (corporation, partnership, LLC, etc), % owned, and whether a party to any business agreements.

ESTATE PLANNING OBJECTIVES (if applicable)

Please describe especially important (or unusual) estate planning objectives (or problems) or any other legal issues of which I should be aware, including succession planning for any business referred above:

OTHER PROFESSIONALS (if applicable)

Client Spouse

Physician:

Accountant:

Ins. Advisor:

Broker:

Other Advisors:

CLIENT'S POWER OF ATTORNEY

Do you have a current Power of Attorney to give someone power over your financial affairs during your incapacity? □ Yes □ No

If yes, date: _____ Is it Durable or Springing? □ Durable □ Springing □ Don't Know

IF YOU DO NOT HAVE A POWER OF ATTORNEY OR YOUR DOCUMENTS ARE OLDER THAN THREE (3) YEARS OLD, PLEASE COMPLETE THE FOLLOWING:

In preparing a Power of Attorney, would you want to provide that the Power of Attorney is in effect currently and survives incapacity, i.e., a Durable Power of Attorney? □ Yes □ No

Or do you desire for the Power of Attorney only to be effective upon your incapacity, referred to as a Springing Power of Attorney? □ Yes □ No

Primary Agent for Power of Attorney

Name	Address	City	State	Zip	Phone

Alternate Agent for Power of Attorney

Name	Address	City	State	Zip	Phone

SPOUSE'S POWER OF ATTORNEY (if applicable)

Do you have a current Power of Attorney to give someone power over your financial affairs during your incapacity? □ Yes □ No

If yes, date: _____ Is it Durable or Springing? □ Durable □ Springing □ Don't Know

IF YOU DO NOT HAVE A POWER OF ATTORNEY OR YOUR DOCUMENTS ARE OLDER THAN THREE (3) YEARS OLD, PLEASE COMPLETE THE FOLLOWING:

In preparing a Power of Attorney, would you want to provide that the Power of Attorney is in effect currently and survives your incapacity, referred to as a Durable Power of Attorney? □ Yes □ No

Or do you desire for the Power of Attorney only to be effective upon your incapacity, referred to as a Springing Power of Attorney? □ Yes □ No

Primary Agent for Power of Attorney

Name	Address	City	State	Zip	Phone

Alternate Agent for Power of Attorney

Name	Address	City	State	Zip	Phone

CLIENT'S HEALTH CARE DIRECTIVE

Do you have an Advance Directive for Health Care (i.e., Living Will)? □ Yes □ No

If yes, date: _____

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

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

In preparing an Advance Directive for Health Care, would you want continued nutrition/hydration (food/water/feeding tubes) if your death was imminent and you were unconscious? □ Yes □ No

Do you wish to become an organ donor? □ Yes □ No

Primary Health Care Agent

Name	Address	City	State	Zip	Phone

Alternate Health Care Agent

Name	Address	City	State	Zip	Phone

SPOUSE'S HEALTH CARE DIRECTIVE (if applicable)

Do you have an Advance Directive for Health Care (i.e., Living Will)? □ Yes □ No

If yes, date: _____

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

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

In preparing an Advance Directive for Health Care, would you want continued nutrition/hydration (food/water/feeding tube) if your death was imminent and you were unconscious? □ Yes □ No

Do you wish to become an organ donor? □ Yes □ No

Primary Health Care Agent

Name	Address	City	State	Zip	Phone

Alternate Health Care Agent(s)

Name	Address	City	State	Zip	Phone

Prior Marriages:

Has either Client or Spouse ever been married previously? □ Yes □ No

If so, state the name of the Client and/or Spouse, and with respect to each prior marriage, the Former Spouse, the Marriage Date, and when/how terminated.

Describe any Child Support Divorce Obligations to or from any Former Spouse:

A copy of the divorce decree, including any amending decrees, would be helpful.

ASSETS AND LIABILITIES

Please bring a list of all life insurance policies on each of your life and your spouse/partner's life (if applicable) showing the face value, policy loans, the owner and beneficiary of each policy. Please also bring evidence of current beneficiary designation of any retirement accounts/annuities. If unmarried, please differentiate assets below as "Solely Owned" or "Joint"

FINANCIAL SUMMARY

			ASSETS		LIABILITIES
	Description	**Husband**	**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/policies				
Business Interests	Value of Interest				
Total					

OTHER PLANNING ISSUES

	Client	Spouse/Partner
Want to benefit Charity?	Y / N	Y / N
Ownership in farm or ranch?	Y / N	Y / N
Ownership in Closely held business?	Y / N	Y / N
Own stock is SubChapter S corporation?	Y / N	Y / N
Ownership in a Medical, Dental or Veterinarian Practice?	Y / N	Y / N
Own a valuable collection? (e.g., art, stamp collections)	Y / N	Y / N
Owns interest in gas/oil?	Y / N	Y / N
Own a Primary Residence?	Y / N	Y / N
Own a Secondary Residence?	Y / N	Y / N
Own other significant interests in real estate?	Y / N	Y / N

MISCELLANEOUS

Does Client/Spouse have a safe-deposit box? □ Yes □ No

Location of safe-deposit box: _____

Location of important papers:_____

Has Client ever executed a community property agreement or lived in a community property state? If so, list states of residence:

Has Client made gifts to any one person exceeding the gift tax annual exclusion (currently $14,000*) in any one calendar year? □ Yes □ No

Has Spouse/Partner made gifts to any one person exceeding the gift tax annual exclusion (currently $14,000*) 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: _____

* The gift tax annual exclusion was $10,000 for gifts made in 2001 or earlier, $11,000 for gifts made in 2002, 2003, 2004, or 2005, $12,000 for gifts made in 2006, 2007, or 2008 and $13,000 for gifts made in 2009, 2010, 2011 and 2012. For 2013, 2014, 2015 and 2016, the gift tax exclusion is $14,000.