Estate Planning Workbook
(Individual)

FAMILY INFORMATION

Full Name: _____

Date of Birth: _____

Social Security Number: _____

United States citizen? ☐ Yes ☐ No

Home Phone: (_____) _____

Email address: _____

Home Address (include zip): _____

_____

Do you ☐ Own or ☐ Rent your home?

MARRIAGE INFORMATION

Do you have a prior marriage? ☐ No ☐ Yes

Name of Former Spouse: _____

Date Marriage Ended: _____

How was marriage ended? ☐ Widowed ☐ Divorced

CHILDREN

Child's Full Name	Birth Date	Does this child have any special physical or mental needs?

Do you have any deceased children?

Child's Full Name	Date of birth/loss	

YOUR ASSETS

REAL ESTATE OWNED *(include your residence, rental properties, and time shares, etc.)*

Address	City	State	Zip	% Owned	Estimated Value	Amount Owed	Rental Property?

FINANCIAL ACCOUNTS *(include stocks, bonds, certificates of deposits, savings, etc.)*

Company Name	Type of Account	Name of Owner	Estimated Value

LOCATION OF PERSONAL PROPERTY *(Please list the location of all of your furniture, furnishings, clothing, jewelry, artwork, collectibles, and all other tangible, non-titled property). Personal property may be in your home, storage unit, safe deposit box.*

Location/Address	Box/Account Number

TRUSTEES: WHOM DO YOU TRUST TO TAKE CARE OF YOUR PROPERTY AFTER YOU PASS AWAY?

Please list the full names, in order of preference, of those who will be in charge of your trust after you pass away:

Name	Address	Phone Number	Relationship

EXECUTORS OF YOUR WILL

Should the executors of your will be the same persons, in the same order, as your trustees listed above? ☐ Yes ☐ No

If no, than list in order of preference, the full names of your Executors:

Name	Address	Phone Number	Relationship

GENERAL DISTRIBUTION OF PROPERTY

Should all of your property be distributed equally to your children upon your death? ☐ Yes ☐ No

If "No", how do you want your property distributed after your death?

Beneficiary's Name, Address & Phone Number	Relationship	Share (%)

If your property should be distributed equally to your children upon your death, then when should they receive distributions from your estate?

☐ Outright on death, regardless of their age
☐ According to the chart below:

Child's Name	Age at which child can receive from your estate			Percentage child can received at this age		
Example: Bobby	25	30	35	33%	33%	Remainder

Note: these distributions are in addition to the amounts your Trustee will make available to your children for their ongoing health, maintenance, education, and support.

If a child or children of yours predecease(s) you, would you like their children (your grandchildren) to receive their distribution? ☐ Yes ☐ No

If yes, at same ages listed above? ☐ Yes ☐ No

If no, shall your surviving children equally divide the deceased child's share? ☐ Yes ☐ No

GIFTS OF SPECIFIC PROPERTY TO SPECIFIC PEOPLE

Please list any specific gifts of personal property you wish to make after your death. In the event the individual or organization does not survive you, please specify to whom you would like the gift to go to or if it should become a part of your general estate and be distributed per the trust directions.

Item description or dollar amount if cash	Who would you like it to be given to?	Who would you like it to be given to in case that person predeceases you?

DISINHERITANCE

Do you wish to specifically disinherit an individual or group of people? ☐ Yes ☐ No

Name	Address	Relationship	Reason

DURABLE POWER OF ATTORNEY FOR FINANCIAL MANAGEMENT

List those, in order of preference, who will make financial decisions for you should you become incapacitated (ex: manage financial accounts, pay bills, etc.):

Name	Address	Phone Number	Relationship

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

List those, in order of preference, who will make healthcare decisions for you should you become incapacitated:

Name	Address	Phone Number	Relationship

PRIMARY CARE PHYSICIAN

Do you have a primary care physician you wish to include in your Advance Health Care Directive? If so, please list the doctor's name, address, and phone number below:

Name	Address	Phone Number

If not, do you grant your agent the authority to select a primary care physician on your behalf? (write your initials next to one):

_____ Yes _____ No

LIFE SUSTAINING TREATMENT/ANATOMICAL GIFTS

Which of the following reflects your desires? (write your initials on the line next to one):

1. I do not wish to receive medical treatment if I am in an irreversible coma or persistent vegetative state; or terminally ill and life-sustaining procedures would only artificially delay death; or otherwise if burdens of treatment outweigh expected benefits. _____

2. I want to receive medical treatment that will allow me to live as long as possible. _____

Which of the following reflects your desires (write your initials on the line next to one):

1. My agent shall be authorized to make anatomical gifts of any needed parts of my body upon my death. _____

2. My agent shall be authorized to make anatomical gifts of specific parts of my body upon my death (list the specific parts). _____

3. My agent shall not be authorized to make anatomical gifts. _____

Shall your agent have the power to authorize an autopsy? (write your initials on the line next to one):

_____ Yes _____ No

CHURCH AFFILIATION

Is there a church with which you wish to remain affiliated, even if you are in a care facility? If so, please list the name and city of the church:

_____

BURIAL INSTRUCTIONS

☐ Executor will choose

☐ Prior arrangements have been made/I have specific wishes.

Please explain briefly:_____