ESTATE PLAN QUESTIONNAIRE
PERSONAL INFORMATION

Name: _____

Name: _____

Address: _____

Cell Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Date of Birth: _____ Social Security #: _____

✍

The Revocable Trust Package Includes the Following:

- ➢ RevocableTrust with Pour-Over Will(s)
- ➢ Advance Health Care Directive(s)
- ➢ Statutory Form Power(s) of Attorney
- ➢ General Authorization(s)
- ➢ Trust Transfer Deed(s)

Revocable Trust Package Pricing:

Marital Trust Package	$650.00
Single-Person Trust Package	$450.00

*** These prices include the fees due to the county recorder's office for recording of one (1) transfer trust deed. If you have more than one (1) property you are transferring to your trust, an additional $25.00 per property will be due to cover the cost of the recording fees if you wish to have this office record the deed (s) for you**.

****These prices are exclusive of any notary fees due.**

PLEASE LIST YOUR CHILDREN ***(Name, Date of Birth, Address, Telephone #)***

1. _____

_____

2 _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

7. _____

_____

8. _____

_____

9. _____

_____

10. _____

_____

1. TRUST INFORMATION

Name of Trust: _____

Successor Trustee (if a marital trust, husband or wife would be the successor trustee)

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

First Successor Trustee (the person you want to carry out the terms of the trust):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Second Successor Trustee: (the person you want to carry out the terms of the trust if the First Successor Trustee is unavailable or unwilling to act):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Custodian for Minor Children:

Name(s): _____
Address: _____
Date of Birth: _____ Social Security #: _____
Date of Birth: _____ Social Security #: _____

Specific Gifts (specific property you want to give to specific people):

_____

_____

_____

_____

_____

_____

Residuary Beneficiaries (the people you want to receive the remainder of your property after the specific gifts; please indicate percentages to be given to each individual):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Property to be included in the trust estate:
(Please attach a copy of the deed to your real property and list the license plate numbers for all vehicles)

_____

_____

_____

_____

_____

_____

No Contest Provision: Yes _____ No _____
(This clause penalizes any heir/beneficiary who legally challenges your trust-recommended)

Have you purposely omitted any heirs: Yes _____ No _____

2A. POUR-OVER WILL (HUSBAND)

Executor/Executrix: _____
(Again, husband/wife would be the first choice; and, tt is recommended that you utilize the same individuals as the trust)

First Alternate Executor/Executrix: _____

Second Alternate Executor/Executrix: _____

2B. POUR-OVER WILL (WIFE)

Executor/Executrix: _____
(Again, husband/wife would be the first choice; and, tt is recommended that you utilize the same individuals as the trust)

First Alternate Executor/Executrix: _____

Second Alternate Executor/Executrix: _____

3A. ADVANCE HEALTH CARE DIRECTIVE (If a marital estate plan, please complete 3B; if a single-person estate plan, ignore)

Designation of Health Care Agent (if married, husband or wife):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

First Alternate Health Care Agent:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Second Alternate Health Care Agent:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Statement of desires concerning life-prolonging care, treatment, services, and procedures:

If the extension of my life would result in a mere biological existence, devoid of cognitive function, with no reasonable hope for normal functioning, then I do not desire any form of life-sustaining procedures, including nutrition and hydration unless necessary for my comfort or alleviation of pain or, if life-sustaining treatment has been instituted, I desire that it be withdrawn. It is my desire that my agent consider relief from suffering, preservation, or restoration of functioning, and the quality, as well as extent, of the life being preserved when decisions are made concerning life-sustaining care, treatment, services, and procedures. In making the decision to withhold or remove treatment, my agent should ask the question: " Is the proposed treatment an aid to recovery or merely a prolongation of inevitable death?" What is "reasonable," what is "an aid to recovery," and what is "merely a prolongation of inevitable death" shall be determined by my agent after consulting with my attending physician(s).

Please initial here if the above wording is acceptable: _____

Do you want relief from pain? ☐ Yes ☐ No

Do you want to authorize an autopsy? ☐ Yes ☐ No

Do you want to donate any organs? ☐ Yes ☐ No

If yes, specify which organs _____

If the above wording is not acceptable, please provide a statement of your desires concerning life-prolonging care, treatment, services, and procedures:

Please indicate any preferences as to burial, cremation, or if you have already obtained " pre-need" services:

Additional statement of desires, special provisions, and limitations:

The duration of a Power of Attorney for Health Care is perpetual unless otherwise so stated. If this acceptable to you? Yes _____ No _____

3B. ADVANCE HEALTH CARE DIRECTIVE

Designation of Health Care Agent (if married, husband or wife):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

First Alternate Health Care Agent:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Second Alternate Health Care Agent:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Statement of desires concerning life-prolonging care, treatment, services, and procedures:

If the extension of my life would result in a mere biological existence, devoid of cognitive function, with no reasonable hope for normal functioning, then I do not desire any form of life-sustaining procedures, including nutrition and hydration unless necessary for my comfort or alleviation of pain or, if life-sustaining treatment has been instituted, I desire that it be withdrawn. It is my desire that my agent consider relief from suffering, preservation, or restoration of functioning, and the quality, as well as extent, of the life being preserved when decisions are made concerning life-sustaining care, treatment, services, and procedures. In making the decision to withhold or remove treatment, my agent should ask the question: " Is the proposed treatment an aid to recovery or merely a prolongation of inevitable death?" What is "reasonable," what is "an aid to recovery," and what is "merely a prolongation of inevitable death" shall be determined by my agent after consulting with my attending physician(s).

Please initial here if the above wording is acceptable: _____

Do you want relief from pain? ☐ Yes ☐ No

Do you want to authorize an autopsy? ☐ Yes ☐ No

Do you want to donate any organs? ☐ Yes ☐ No

If yes, specify which organs _____

If the above wording is not acceptable, please provide a statement of your desires concerning life-prolonging care, treatment, services, and procedures:

Please indicate any preferences as to burial, cremation, or if you have already obtained " pre-need" services:

Additional statement of desires, special provisions, and limitations:

The duration of a Power of Attorney for Health Care is perpetual unless otherwise so stated. If this acceptable to you? Yes _____ No _____

4A. GENERAL POWER OF ATTORNEY WITH DURABLE PROVISION (If a marital estate plan, please complete 4B; if a single-person estate plan, ignore)

Attorney-in-Fact (If married, husband or wife):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

First Alternate Attorney-in-Fact:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Second Alternate Attorney-in-Fact:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

4B. GENERAL POWER OF ATTORNEY WITH DURABLE PROVISION

Attorney-in-Fact (If married, husband or wife):

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

First Alternate Attorney-in-Fact:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Second Alternate Attorney-in-Fact:

Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

5A. GENERAL AUTHORIZATION (If a marital estate plan, please complete 5B; if a single-person estate plan, ignore)

Please list the persons authorized to request, inspect, examine, and/or copy your records:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

5B. GENERAL AUTHORIZATION

Please list the persons authorized to request, inspect, examine, and/or copy your records:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____