



CONFIDENTIAL

ESTATE PLANNING QUESTIONNAIRE

Date: _____

GENERAL INFORMATION

CLIENT 1:

Full name			
Any other name(s) used			
Civil Status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed/er	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Cohabiting Unmarried Couple
Date of Birth		Social Security #	
Place of Birth		Country of Citizenship	<input type="checkbox"/> U.S. <input type="checkbox"/> Other:
Telephone Number		Email Address	
Permanent Residence	Street Address	City	State Zip
Own or Rent? (select one)	<input type="checkbox"/> Own <input type="checkbox"/> Rent	Lived here since (date)	

CLIENT 2 (SPOUSE/PARTNER OF CLIENT 1):

Full name			
Any other name(s) used			
Civil Status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed/er	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Registered Domestic Partner <input type="checkbox"/> Cohabiting Unmarried Couple
Date of Birth		Social Security #	
Place of Birth		Country of Citizenship	<input type="checkbox"/> U.S. <input type="checkbox"/> Other:
Telephone Number		Email Address	
Residence (if different)	Street Address	City	State Zip
Own or Rent? (select one)	<input type="checkbox"/> Own <input type="checkbox"/> Rent	Lived here since (date)	
Date of Marriage		Place of Marriage	

PRIOR MARRIAGE(S)

CLIENT 1:

Former Spouse Name			
Date of Marriage		Place of Marriage	
Reason for Marriage's End	<input type="checkbox"/> Divorce; date of judgment papers:		<input type="checkbox"/> Death; date on death certificate:

CLIENT 2:

Former Spouse			
Date of Marriage		Place of Marriage	
Reason for Marriage's End	<input type="checkbox"/> Divorce; date of judgment papers:		<input type="checkbox"/> Death; date on death certificate:

CHILDREN AND OTHER RELATIVES

LIVING CHILDREN AND GRANDCHILDREN

Please list the children of your current marriage first, followed by any children of your prior marriage(s). If you need more space, please print out as many copies of the following page as needed.

#

Full Name				
Address (if not with you)	Street Address	City	State	Zip
Date of Birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Relation to Client 1	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption		
Relation to Client 2	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption		
Name of Other Parent				
Name of Spouse				
Name(s) of Children				
Special Needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, nature of disability:			
Additional Information				

If you have additional Living Children and Grandchildren, please make as many copies of this page as needed.

#

Full Name			
Address (if not with you)	Street Address	City	State Zip
Date of Birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Client 1	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Relation to Client 2	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Name of Other Parent			
Name of Spouse			
Name(s) of Children			
Special Needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, nature of disability:		
Additional Information			

#

Full Name			
Address (if not living with)	Street Address	City	State Zip
Date of Birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Client 1	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Relation to Client 2	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Name of Other Parent			
Name of Spouse			
Name(s) of Children			
Special Needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, nature of disability:		
Additional Information			

DECEASED CHILDREN

If you need additional space, please make as many copies of this page as needed.

#

Full Name			
Date of Death		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Client 1	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Relation to Client 2	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Name / Status of Spouse	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Address of Spouse	Street Address	City	State Zip
Name(s) of Children	Full Name	Date of Birth	
	Full Name	Date of Birth	
Additional Information			

#

Full Name			
Date of Death		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Client 1	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Relation to Client 2	<input type="checkbox"/> Biological Child <input type="checkbox"/> Adopted <input type="checkbox"/> Step-Child	Date of Adoption	
Name / Status of Spouse	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Address of Spouse	Street Address	City	State Zip
Name(s) of Children	Full Name	Date of Birth	
	Full Name	Date of Birth	
Additional Information			

PEOPLE RAISED BY CLIENT(S)

Are there people you and/or your spouse have raised as children who are not legally your children? (Note: An adopted child is legally your child.) If so, please list them and make as many copies of this page as needed.

#

Full Name				
Address	Street Address	City	State	Zip
Date of Birth		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Legal Relationship				
Additional Information				

For purposes of your Will and/or Trust, do you wish this person to be considered your child?

Yes No

#

Full Name				
Address	Street Address	City	State	Zip
Date of Birth		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Legal Relationship				
Additional Information				

For purposes of your Will and/or Trust, do you wish this person to be considered your child?

Yes No

#

Full Name				
Address	Street Address	City	State	Zip
Date of Birth		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Legal Relationship				
Additional Information				

For purposes of your Will and/or Trust, do you wish this person to be considered your child?

Yes No

EXECUTOR(S)

In order of preference, please list the full name(s), relationship(s) and address(es) of your Executor(s).

Your spouse first? Yes No Then:

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				
#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				
#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

TRUSTEE(S)

In order of preference, please list the full name(s), relationship(s) and address(es) of your Trustee(s).

Same as Executor(s)? Yes No If no, then:

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				
#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				
#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

GUARDIAN(S) OF MINOR CHILD(REN)

In order of preference, please list the full name(s), relationship(s) and address(es) of the Guardian(s) of any Minor Child(ren).

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

DURABLE POWER OF ATTORNEY - ASSET MANAGEMENT

In order of preference, please list the full name(s), relationship(s) and address(es) of your Agent(s) for your General Durable Power of Attorney (asset management if you are incapacitated).

Same as Executor(s)? Yes No If no, then:

Spouse first? Yes No Then:

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

DURABLE POWER OF ATTORNEY - HEALTH CARE

In order of preference, please list the full name(s), relationship(s) and address(es) of your Agent(s) for your General Durable Power of Attorney (health care management if you are incapacitated).

Same as Executor(s)? Yes No If no, then:

Spouse first? Yes No Then:

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

#	Full Name				
	Address	Street Address	City	State	Zip
	Relationship				

HEALTH / SPECIAL NEEDS

Do either you or your spouse/partner have health concerns? Yes No

If yes, please explain: _____

Do any of your children have special needs you would like to address in your estate plan? Yes No

If yes, please explain: _____

DISINHERITANCE

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

If yes, please list their full name(s), relationship(s) to you, and address(es). You may provide a brief explanation if you like.

#

Full Name				
Address	Street Address	City	State	Zip
Relationship				
Explanation				

#

Full Name				
Address	Street Address	City	State	Zip
Relationship				
Explanation				

#

Full Name				
Address	Street Address	City	State	Zip
Relationship				
Explanation				

DISTRIBUTION OF PROPERTY ON DEATH - GENERAL

What is your desired disposition of your property on your death and/or your spouse's/partner's death?

If married:

All to your spouse on death? Yes No

To your children in equal shares on your Spouse's death? Yes No

If not married:

To your children in equal shares? Yes No

If neither of the above distribution methods apply, to whom do you wish to leave your property, and in what proportions? Please list full names, addresses, and proportions on the following page.

DISTRIBUTION OF PROPERTY ON DEATH - SPECIFIC

To whom do you wish to leave your property, and in what proportions? Please list full names, addresses, and proportions (i.e. 50%, 1/3, etc.).

#	Full Name				
	Address	Street Address	City	State	Zip
	Proportion				
	Additional Information				

#	Full Name				
	Address	Street Address	City	State	Zip
	Proportion				
	Additional Information				

#	Full Name				
	Address	Street Address	City	State	Zip
	Proportion				
	Additional Information				

CHILDREN'S AGES AND SHARES FOR DISTRIBUTIONS

When should your child(ren) receive their distributions?

Outright on your death? Yes No

Outright on your spouse's/partner's death? Yes No

If not outright, please provide age(s) of distribution and the fractional or percentage interest of each child's share to be distributed at the specified age(s):

#	Child's Name		
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Age	Fractional or % Interest of Share
_____	_____
_____	_____
_____	_____

CHILDREN'S AGES AND SHARES FOR DISTRIBUTIONS (CONTINUED)

#	Child's Name		
		Age	Fractional or % Interest of Share
		_____	_____
		_____	_____
		_____	_____

#	Child's Name		
		Age	Fractional or % Interest of Share
		_____	_____
		_____	_____
		_____	_____

If a child/children of yours predecease you:

Would you like their issue (your grandchildren) to receive their distribution? Yes No

If yes, at same ages listed above? Yes No

SIMULTANEOUS DEATH

Desired disposition of estate in the event client, spouse/partner and issue die simultaneously:

- EXAMPLES:
1. Your heirs (determined by California law)
 2. Specified named individuals (other than your heirs, generally)
 3. A specific charity (i.e. Red Cross, Boys Town, Girl Scouts)

1. _____

2. _____

3. _____

SPECIFIC BEQUESTS

Please list specific bequests you wish to make, if any, indicating what and to whom. In the event the individual or organization does not survive, please specify if the gift will be distributed to that individual's issue, to someone else, or if the gift will lapse and become a part of the residue of your

1. _____

2. _____

3. _____

4. _____

SAFETY DEPOSIT BOXES

#	Name of Bank				
	Address of Bank	Street Address	City	State	Zip
	Full Name(s) of Person(s) Entitled to Access				

#	Name of Bank				
	Address of Bank	Street Address	City	State	Zip
	Full Name(s) of Person(s) Entitled to Access				

KEY ADVISORS

Lawyer (other than this office):

Name				
Address	Street Address	City	State	Zip
Telephone			Fax	
Email Address				

Accountant:

Name				
Address	Street Address	City	State	Zip
Telephone			Fax	
Email Address				

Stockbrokers/Investment Advisors:

Name of Contact				
Address	Street Address	City	State	Zip
Institution				
Telephone			Fax	
Email Address				

Trust Officer (Primary Banker):

Name of Contact				
Address	Street Address	City	State	Zip
Institution				
Telephone			Fax	
Email Address				

KEY ADVISORS (CONTINUED)

Insurance Agents:

Name of Contact				
Address	Street Address	City	State	Zip
Company				
Telephone		Fax		
Email Address				
Type of Coverage				

Name of Contact				
Address	Street Address	City	State	Zip
Company				
Telephone		Fax		
Email Address				
Type of Coverage				

Pension Plan Administrator:

Name of Plan				
Address of Plan	Street Address	City	State	Zip
Name of Contact				
Telephone		Fax		
Email Address				

Doctor:

Name				
Address	Street Address	City	State	Zip
Telephone		Fax		