



ESTATE PLANNING QUESTIONNAIRE

General Information:

Legal Name		Date of Birth	Date of Marriage		
Email Address		Social Security Number			
Spouse's Legal Name		Date of Birth	Place of Marriage		
Spouse's Email Address		Social Security Number			
Home Address		City	State/Zip Code		
Home Phone ()	Cell Phone ()	Spouses' Cell Phone ()	Fax Number ()		
Employer		Spouse's Employer			
Business Address & Telephone Number		Spouse's Business Address & Telephone Number			
Health – Self:		<input type="checkbox"/> excellent	<input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> distressed
Spouse:		<input type="checkbox"/> excellent	<input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> distressed

Family Information:

Children:			
Name and address	Date of Birth	Relationship:	Special Needs?

Grandchildren:			
Name and address	Date of Birth	Relationship:	Special Needs?

Dispositive Intentions:

Spouse and Children:	
Do you wish to provide primarily for your spouse and secondarily for your children?	<input type="checkbox"/> YES <input type="checkbox"/> No
Do you want to distribute any part of your estate prior to your spouse's death?	<input type="checkbox"/> YES <input type="checkbox"/> No
Please explain _____	
Do you wish to treat all of your children equally? If not, why not?	<input type="checkbox"/> YES <input type="checkbox"/> No
After your spouse's death, at what age do you want distribution to your children? _____ For example, you may select an outright distribution, a certain age, periodic intervals (1/3 at age 25, 1/3 at age 30 and 1/3 at age 35) or lifetime trusts	

Grandchildren/Others:	
Do you want to leave a specific amount of money or a percentage of your estate to grandchildren or others?	<input type="checkbox"/> YES <input type="checkbox"/> No
What amount or percentage and to whom? _____	
Do you wish to treat all of your grandchildren equally? If not, why not?	<input type="checkbox"/> YES <input type="checkbox"/> No
At what age do you want distribution to your grandchildren/others? _____ For example, you may select an outright distribution, a certain age, periodic intervals (1/3 at age 25, 1/3 at age 30 and 1/3 at age 35) or lifetime trusts	

Others Beneficiaries:			
Do you want your will to benefit anyone other than Children, Grandchildren or a charity? <input type="checkbox"/> YES <input type="checkbox"/> No			
If yes, please list:			
Name of beneficiary	Address of beneficiary	Relationship	Amount or Percent

Charities:		
Do you want to leave a specific amount of money or other assets to any charity? <input type="checkbox"/> YES <input type="checkbox"/> No		
If yes, please list:		
Name of charity	Address of charity	Dollar amount

Fiduciary Appointments		
EXECUTOR	Name	Address
Client:		
Primary Executor		
Alternate Executor (if primary cannot serve)		
Spouse:		
Primary Executor		
Alternate Executor (if primary cannot serve)		
TRUSTEE	Name	Address
Client:		
Primary trustee		
Alternate trustee (if primary cannot serve)		
Spouse:		
Primary trustee		
Alternate trustee (if primary cannot serve)		

Guardian:
If you have minor or disabled children, whom do you want to act as guardian?
First choice: _____ Second choice: _____

Living Will and Durable Power of Attorney for Health Care Decisions:

CLIENT:

Do you want your living will to provide for withdrawal of artificial food and fluid? YES No

Do you want to donate your eyes or organs? YES No

Do you want your health care agent to consult with any other person prior to acting? YES No

If yes, whom? _____

Who would make your health care decisions if you cannot: _____

Street address _____

City _____ State _____ Zip _____

Name of proposed alternate if that person cannot serve: _____

Street address _____

City _____ State _____ Zip _____

What is the name and address of your primary care physician? _____

Street Address _____

City _____ State _____ Zip _____

SPOUSE:

Do you want your living will to provide for withdrawal of artificial food and fluid? YES No

Do you want to donate your eyes or organs? YES No

Do you want your health care agent to consult with any other person prior to acting? YES No

If yes, whom? _____

Who would make your health care decisions if you cannot: _____

Street address _____

City _____ State _____ Zip _____

Name of proposed alternate if that person cannot serve: _____

Street address _____

City _____ State _____ Zip _____

What is the name and address of your primary care physician? _____

Street Address _____

City _____ State _____ Zip _____

General Durable Power of Attorney: (Makes financial decisions when you are unable)

CLIENT:

Name of proposed financial agent: _____

Street address _____

City _____ State _____ Zip _____

Name of proposed alternate financial agent: _____

Street address _____

City _____ State _____ Zip _____

SPOUSE:

Name of proposed financial agent: _____

Street address _____

City _____ State _____ Zip _____

Name of proposed alternate financial agent: _____

Street address _____

City _____ State _____ Zip _____

Miscellaneous:

Do you have any other legal issues which I should be aware of? YES No

If yes, explain _____

What is the location of your important papers? _____

Do you have a safe deposit box? YES No

if yes, please indicate the name and address of the location _____

Have you ever made gifts to any one person in excess of \$10,000 in any one calendar year? YES No

Have you ever filed a federal gift tax return? YES No

Assets:

		Fair Market Value & Ownership		
Real estate:	Address or location:	Self	Spouse	JTWROS
Residence				
Vacation Property				
Rental Property				
Oil, gas & Minerals				
Other real Estate				
Stocks (please attach list)				
Bonds (please attach list)				
Notes (please attach list)				
Business Assets/family business/ Private corporation (please attach most recent Form k-1 or financial statements)				
Cash and Savings				
Certificates of Deposit				
Money Market (please attach list)				
Mutual Funds (please attach list)				
Annuities				
Life Insurance (Complete Life Insurance Section)				
Retirement Plans (Complete Retirement Plan Section)				
Personal Property (insured amount)				
Automobiles				
TOTAL ASSETS				

Liabilities:

Liabilities	Self	Spouse	Joint
Loans			
Mortgages			
Other			
Total Liabilities			

Life Insurance:

Company	Owner	Amount of Death Benefit			Beneficiaries	Type
		Self	Spouse	Second-to-Die		
					Primary	<input type="checkbox"/> Term
					Secondary	<input type="checkbox"/> Whole
						<input type="checkbox"/> Variable
					Primary	<input type="checkbox"/> Term
					Secondary	<input type="checkbox"/> Whole
						<input type="checkbox"/> Variable
					Primary	<input type="checkbox"/> Term
					Secondary	<input type="checkbox"/> Whole
						<input type="checkbox"/> Variable
Total Amount (also put in Assets section)						

Retirement Plans:

Type of Plan	Plan Sponsor	Value		Beneficiaries
		Self	Spouse	
Money Purchase				Primary
				Secondary
Profit Sharing Plan				Primary
				Secondary
401(k) Savings				Primary
				Secondary
IRA				Primary
				Secondary
Total Value (also put in Assets section)				
		Current Accrued Monthly Benefit	Projected Monthly Benefit at Age 65	Benefit Option
Pension Plan				<input type="checkbox"/> Life Annuity <input type="checkbox"/> Joint Life Annuity
Spouse's Pension Plan				<input type="checkbox"/> Life Annuity <input type="checkbox"/> Joint Life Annuity

Other Information:

Prospective Inheritances		
	Source	Anticipated Value
Self		
Spouse		

Business Arrangements and Governing Documents		
	Self	Spouse
Stock Purchase Agreement		
Buy-Sell Agreement		
Employment Agreement		
Stock Options		
Split Dollar Agreement		

Continuing Obligations		
	Self	Spouse
Property Settlement Agreement		
Divorce Decree		
Premarital Agreement		
Other (explain)		

Referred by:			
Name			
Address			
City	State	Zip code	Telephone ()

Certification:

The undersigned hereby represents to Law Office of Jennifer L. Stultz, LLC, and its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of client(s) or client representative:
