



CLIENT ESTATE PLAN QUESTIONNAIRE

CONFIDENTIALITY NOTE: As with all attorney-client communications, please note that any and all information you disclose to this office orally or in writing will be held in the strictest possible confidence and released to no one without your consent.

INSTRUCTIONS: Please fill out all that apply. Do not hesitate to contact me if you have any questions. I am also happy to answer all questions at our first meeting. Once you have completed the booklet, return it to me prior to our first meeting together with any prior wills, trusts, powers of attorney or health care proxy documents that I should review before meeting with you to discuss your estate. Attach additional sheets wherever necessary.

Personal Information

Individual #1

Individual #2

Full Name: _____

Full Name: _____

Other names used: _____

Other names used: _____

Social Security No.: _____

Social Security No.: _____

Date of Birth: _____ US Citizen? _____

Date of Birth: _____ US Citizen? _____

Street Address: _____

Street Address: _____

Home phone: _____

Home phone: _____

Business/Occupation: _____

Business/Occupation: _____

Business phone: _____

Business phone: _____

Cell phone: _____

Cell phone: _____

E-mail: _____

E-mail: _____

At what time of day and at what phone number do you prefer to be contacted? _____

Marital Status: _____ Marital Status: _____

Preferred term to refer to your relationship: "Spouse" "Partner" "Significant Other" "Life Partner"
 Other: _____

How were you referred to our Firm? _____

If applicable, date and place of marriage: _____

Prior Marriages of the Parties

Individual #1: Yes No If yes, name of prior spouse: _____

Marriage terminated by: Death Divorce Date: _____

Individual #2: Yes No If yes, name of prior spouse: _____

Marriage terminated by: Death Divorce Date: _____

Family Information

Child One

Legal Name: _____ Date of Birth: _____

Spouse's Name: _____

Home Address: _____

Grandchildren: _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Child Two

Legal Name: _____ Date of Birth: _____

Spouse's Name: _____

Home Address: _____

Grandchildren: _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Do any of your beneficiaries have a learning disability, or other special educational, medical or physical needs? Yes No

Do any of your relatives (other than your children) depend upon you for some or all of their financial support? Yes No

Do you think any of your beneficiaries have special problems with spouses, drugs, alcohol, or handling money? Yes No

Do you wish to disinherit any of your children, grandchildren, or a close relative? Yes No

Do you/either of you expect to inherit substantial assets (\$100,000+) Yes No

Do you have any existing wills, trusts, or financial/health powers? Yes No

Should the survivor of you have the power to control distribution of the entire estate after the first death? Yes No

Do you want any assets/property to pass to any beneficiary before the second party's death? Yes No

If a beneficiary dies prior to the second person party's death, do you want the assets to go to that beneficiary's issue? Yes No

Do you want assets passing to your beneficiaries to be held in trust until a specific age or ages? Yes No

Asset Information

INSTRUCTIONS: Please list each asset you (and your spouse or partner) own, even if jointly held with another person or in trust. Please list, if you know, whether the property is held by (titled to) you *individually - jointly with spouse or partner - jointly with someone else*. You may use your best guess at the value of your personal and real property.

Please also begin to think about – and perhaps create a list of – those persons to whom you would like to grant, gift, or make the beneficiary of any specific personal property, real property, life insurance policy, etc.

(Real Estate)

Property One:

Address: _____

How titled: _____ Mortgage amount: _____

Year purchased: _____ Current value: _____

Purchase price: _____ Annual taxes: _____

Property Two:

Address: _____

How titled: _____ Mortgage amount: _____

Year purchased: _____ Current value: _____

Purchase price: _____ Annual taxes: _____

Insurance premium: _____

(Bank Accounts)

Name of Bank	How Titled	Type of Account	Present Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(IRAs, 401(k)s, or other retirement – please specify)

Owner	Name of Institution	Beneficiaries	Present Value
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Stocks, Bonds, Mutual Funds – please specify)

Name of Company	How Titled	Number Shares	Present Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Life Insurance)

Insured	Name of Company	Cash Surrender	Death Benefit	Beneficiaries
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Automobiles, Boats, Motor Homes, Etc.)

How Titled	Year/Make/Model	Loan Value	Present Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Other Assets or Items of Significant Personal Property)

How Titled	Description	Loan Value	Present Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Liabilities Information

Mortgage on Primary Residence: _____ Other Residence: _____

Loans on Automobiles, Boats, Other: _____

Student/Personal Loans: _____

Outstanding Balances on Credit Cards: _____

Other: _____

Income Information

Individual #1

Spouse/Partner #2

Wages: _____

Wages: _____

Social Security: _____

Social Security: _____

Pension: _____

Pension: _____

Other: _____

Other: _____

Other: _____

Other: _____

Personal Representatives

INSTRUCTIONS: Please consider the person(s) in your life who would be appropriate to serve as your personal representatives(s) in the following roles: (i) ***Executor*** of your estate; (ii) ***Guardian*** of any minor children or persons with special needs; (iii) ***Health Care Agent*** (person who can make medical decisions if you are incapacitated); and (iv) ***Attorney-in-Fact*** (person who can conduct financial transactions on your behalf).

Please pick both a primary representative and an alternate representative in the event that the primary representative is unable or unwilling to serve in his or her capacity.

Individual #1

Individual #2

(Executor)

Executor: _____

Executor: _____

Relation to you: _____

Relation to you: _____

Address: _____

Address: _____

Alternate Executor: _____

Alternate Executor: _____

Relation to you: _____

Relation to you: _____

Address: _____

Address: _____

(Guardian)

Guardian(s): _____

Guardian(s): _____

Relation to you: _____

Relation to you: _____

Address: _____

Address: _____

Alternate Guardian: _____

Alternate Guardian: _____

Relation to you: _____

Relation to you: _____

Address: _____

Address: _____

(Health Care Agent)

Health Care Agent: _____ Health Care Agent: _____

Relation to you: _____ Relation to you: _____

Address: _____ Address: _____

Tel: _____ Cell: _____ Tel: _____ Cell: _____

E-mail: _____ E-mail: _____

(Attorney-in-Fact, a.k.a Power of Attorney)

Attorney-in-Fact: _____ Attorney-in-Fact: _____

Relation to you: _____ Relation to you: _____

Address: _____ Address: _____

Living Will/Advanced Health Care Directive

INSTRUCTIONS: A living will is not legally enforceable by itself in Massachusetts, but can provide insight and instruction to your Health Care Agent, the person you have chosen to make medical decisions in the event that you are unable. Please initial on each of the lines that expresses your wishes under the circumstances described below. If you choose, these wishes can be incorporated into a living will instrument as part of your estate plan.

If there is no hope for my recovery and, in the opinion of my physician, there is no reasonable chance of recovery, and where I will die without life-sustaining treatment that only prolongs my dying process, I ask that my Health Care agent consider the following:

Ind. #1

Ind.#2

- | | | |
|-------|-------|---|
| _____ | _____ | If my heart stops, I do not want to be resuscitated (CPR). |
| _____ | _____ | If I stop breathing, I do not want to be on a breathing machine. |
| _____ | _____ | If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless necessary to keep me comfortable. |
| _____ | _____ | If I cannot eat, I do not want a tube inserted in my nose, mouth or surgically placed to give me food unless necessary to keep me comfortable. |
| _____ | _____ | If I have an infection, I do not want antibiotics administered to prolong my life without hope of cure unless necessary to keep me comfortable. |
| _____ | _____ | If possible, I wish to be an organ donor. |

***Thank you for your time and preparation.
I look forward to meeting with you.***