



Heather Lynn Law, APC

ESTATE PLANNING ATTORNEY

LIVING TRUST INFORMATION QUESTIONNAIRE

Trust name: _____

Your Trust name can be named anything, as long as it has Family Trust, Revocable Trust, and Living Trust at the end. Ex: (First Name)(Last Name) Revocable Trust.

Referred By: _____

Meetings to be in:

English

Spanish

Date of Marriage:

If unmarried, please only complete the information for Client#1

Client#1's Name:	<u>Name as it appears on your driver's license, ID card or passport</u>		
U.S. Citizen? Yes No			
Other Names Used by Client#1:			
Address:			
Telephone:	Home:	Work/Cell	
Email Address:			
Date of Birth:			
Business/Employment:			
Prior Marriage? Yes No	<u>Name of Ex-Spouse</u>	<u>Type of Termination:</u>	<u>Date of Termination:</u>
Unexpired License? Yes No			

Client#2's Name:	<u>Name as it appears on your driver's license, ID card or passport</u>		
U.S. Citizen? Yes No			
Other Names Used by Client#2:			
Address:			
Telephone:	Home:	Work/Cell	
Email Address:			
Date of Birth:			
Business/Employment:			
Prior Marriage? Yes No	<u>Name of Ex-Spouse</u>	<u>Type of Termination:</u>	<u>Date of Termination:</u>
Unexpired License? Yes No			

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FAMILY INFORMATION

Please list the names & address information of all living children. **Please include Step-Children from a previous/ current marriage and exclude Grand-Children.**

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Childs Name:		
Date of Birth:		Male Female
Childs Street Address:		Legally Adopted? Yes No
City, State, Zip Code:		Biological Mom? Yes No
Telephone:		Biological Dad? Yes No

Please list deceased children, if any, and whether their own children survived them.

<u>Name</u>	<u>Date of Birth</u>	<u>Date of Death</u>	<u>Number of Deceased Child's Children</u>

GUARDIANSHIP OF MINORS

Name and contact information of the person(s) that you want to raise a child that is under 18, if both spouses die: (if applicable).

Name(s):	
Street Address:	
City, State, Zip Code:	
Telephone:	
Special Instructions:	
Stipend to Guardian for care of minor children? Yes No	
If Yes, how much?	

ALTERNATE: Name and contact information of the person(s) that you want to raise a child that is under 18, if both spouses die: (if applicable).

Name(s):	
Street Address:	
City, State, Zip Code:	
Telephone:	
Special Instructions:	
Stipend to Guardian for care of minor children? Yes No	
If Yes, how much?	

CHOICE OF SUCCESSOR TRUSTEES/EXECUTORS

You will be the initial trustee of your trust. If one of you passes away, the surviving spouse will be the sole trustee. The successor and/or alternate trustees you name below will only become trustee(s) if neither of you are able to do so. For successor trustee choices, it is usually best to select named beneficiaries, family members, or long-time close friends. You should list at least choices for successor trustee in case your first choice is unavailable for some reason. The people you name here will have no power, control, or authority over you or your financial affairs while you are alive and have sufficient capacity to handle your own affairs. There is no need to repeat an address if you have already written it once on this Questionnaire.

Successor Trustee Choice #1

Name/Relationship:	
Street Address, City, State & Zip:	
Telephone Number:	
Trustee Compensation? Y N	
If Yes, how much?	

Alternative Successor Trustee Choice #2

Do you want Co-Trustees? Yes No

Name/Relationship:	
Street Address, City, State & Zip:	
Telephone Number:	
Trustee Compensation? Y N	
If Yes, how much?	

Alternative Successor Trustee Choice #3

Name/Relationship:	
Street Address, City, State & Zip:	
Telephone Number:	
Trustee Compensation? Y N	
If Yes, how much?	

BENEFICIARIES

Beneficiaries are those people to whom you wish to pass your estate upon your death. It is important to know that beneficiaries can be changed anytime you like by amending your living trust. You may specify a set percentage of our estate to each beneficiary, or you may choose to let your estate pass to your beneficiaries in equal shares. If you choose to specify percentages, please be sure the total equals 100%. If you check the "equal share" box you do not need to fill in the percentages. If you will be naming more beneficiaries, please make additional copies of this page.

Beneficiaries (Check Here _____ if all beneficiaries are to receive equal shares)

Name:	
Relationship:	
Street Address:	
City, State, ZipCode:	
Telephone:	

If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?

Yes No

Age for issue to receive?

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

If Yes, what age? Share %

Name:	
Relationship:	
Street Address:	
City, State, ZipCode:	
Telephone:	

If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?

Yes No

Age for issue to receive?

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

If Yes, what age? Share %

Name:	
Relationship:	
Street Address:	
City, State, ZipCode:	
Telephone:	

If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?

Yes No

Age for issue to receive?

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

If Yes, what age? Share %

Name:	
Relationship:	
Street Address:	
City, State, Zipcode:	
Telephone:	

If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?

Yes No

Age for issue to receive?

Do you want assets passing down to your beneficiaries Yes No

If Yes, what age? Share%

Please state any specific concerns (not already addressed) that you have regarding the distribution of your estate plan, including disinheritance of individuals and alternative beneficiaries:

ADDITIONAL IMPORTANT INFORMATION

YES

NO

1. Do any of your beneficiaries have a learning disability, Special educational, medical or physical needs?
2. Do you have any relatives (other than children) who depend on you for all or part of their support?
3. Do you think any of your beneficiaries have special problems with spouses, drugs, alcohol or handling money?
4. Do you wish to disinherit any of your children, grandchildren, or any close relative?
5. Do you have an existing prenuptial or postnuptial agreement?
6. Do you have existing Wills?
7. Do you have existing Trusts?
8. Do you want any assets to pass to your children before the second spouse's death? It is common in blended families.
9. Pets? List care and further instruction below:
10. Special Gifts? Please list below as well:

[illegible]

POWER OF ATTORNEY CHOICES

Durable Power of Attorney is for assets and business affairs. Its purpose is to authorize someone to handle your day-to-day business affairs should you become incapacitated. Power of Attorneys are designed to be "springing". This means that they only become valid if you become incapacitated or unable to handle your own affairs. **Your spouse will automatically be your first choice and any other choice MUST BE 18 YEARS OR OLDER.**

On what your choice is below **are only in case your spouse is not available or unable to act.** Each spouse's choices can be different, if desired. Please note, that you have the choice of "Upon Incapacity Only" or "Effective Immediately." In choosing "Upon Incapacity Only," this would be **determined by your primary physician** that you no longer have the ability to make your own healthcare decisions. In choosing "effective immediately," the agents/choices you've selected will be authorized to act on your behalf effective immediately.

Would you like your spouse to be your first choice? YES NO

UPON INCAPACITY ONLY
EFFECTIVE IMMEDIATELY

Power of Attorney 1st Choice: (If spouse is unavailable)

choice:

choice:

Name:		
Relationship:		
Street Address:		
City, State, ZipCode:		
Telephone:		

Power of Attorney 2nd Choice :

choice:

choice:

Name:		
Relationship:		
Street Address:		
City, State, Zipcode:		
Telephone:		

Power of Attorney 3rd Choice:

choice:

choice:

Name:		
Relationship:		
Street Address:		
City, State, Zipcode:		
Telephone:		

For _____

Would you like either of your choices

listed above to be Co-agents? YES If NO

yes, which ones? _____

For _____

Would you like either of your choices

listed above to be Co-agents? YES NO

If yes, which ones? _____

Advanced Health Care Directive

Advanced Health Care Directive (also known as a Durable Power of Attorney for health issues) is when you're incapacitated and you're unable to make Medical decisions. Same as Power of Attorney, Advanced Health Care Directive are designed to also be "springing". This means that they only become valid if you become incapacitated or unable to handle your own affairs. **Your spouse will automatically be your first choice and any other choice MUST BE 18 YEARS OR OLDER.** The selections you list below are only in case your spouse is not available or unable to act. Each spouse's choices can be different, if desired.

There is an option on if you would like your Advanced Health Care Directive to be "Effective Immediately" or "Upon Incapacity Upon". In choosing "Upon Incapacity Only," this would be **determined by your primary physician** that you no longer have the ability to make your own healthcare decisions. In choosing "effective immediately," the agents/choices you've selected below will be authorized to act on your behalf effective immediately

Would you like your spouse to be your first choice? YES NO UPON INCAPACITY ONLY
Advanced Health Care Directive Choice # 1(if spouse is unavailable) EFFECTIVE IMMEDIATELY

	choice:	choice:
Name:		
Relationship:		
Street Address:		
City, State, ZipCode:		
Telephone:		

Advanced Health Care Directive Choice #2

	choice:	choice:
Name:		
Relationship:		
Street Address:		
City, State, ZipCode:		
Telephone:		

Advanced Health Care Directive Choice #3

	choice:	choice:
Name:		
Relationship:		
Street Address:		
City, State, ZipCode:		
Telephone:		

For _____
Would you like either of your choices
listed above to be Co-agents? YES If NO
yes, which ones? _____

For _____
Would you like either of your choices listed
above to be Co-Agents? YES NO
If yes, which ones? _____

END OF LIFE DECISIONS

End-Of-Life Decisions for _____

The choices below represent a summary of instructions to your agent for health-care decisions.

1. Please check the box of the statement that best states your desires:

I want to live as long as possible; therefore, I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

I do not want life-sustaining treatment to be provided or continued: (a) if I am in an irreversible coma or persistent vegetative state; or (b) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (c) under any other circumstances in which the burdens of treatment outweigh the expected benefits.

2. Life Support?

YES

NO

For how long? _____

3. Please select only 1 option regarding how you would like CPR to be administered:

CPR to be administered **AT ALL TIMES** regardless of condition.

CPR to be administered at all times **UNLESS** you are in an irreversible coma or in a vegetative state or in hospice care.

CPR to **NOT** be administered at **ANY** and **ALL** times.

4. Organ Donation? YES NO Limit Use of Organs? YES NO

Please explain: _____

End-Of-Life Decisions for _____:

1. The choices below represent a summary of instructions to your agent for health-care decision

I want to live as long as possible; therefore, I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

I do not want life-sustaining treatment to be provided or continued: (a) if I am in an irreversible coma or persistent vegetative state; or (b) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (c) under any other circumstances in which the burdens of treatment outweigh the expected benefits.

2. Life Support?

YES

NO

For how long? _____

3. Please select only 1 option regarding how you would like CPR to be administered:

CPR to be administered **AT ALL TIMES** regardless of condition.

CPR to be administered at all times **UNLESS** you are in an irreversible coma or in a vegetative state or in hospice care.

CPR to **NOT** be administered at **ANY** and **ALL** times.

4. Organ Donation? YES NO Limit Use of Organs? YES NO

Please Explain: _____

Nursing Care Facility: (Does not mean you're going there)

Continue Religious Activities? YES NO

Which Church/Temple/Synagogue or Religion: _____

Enjoy outdoors? YES NO

BURIAL WISHES

Burial Wishes for _____ :

At my death, I wish to be: Cremated Buried No Preference

If cremation, I would like my ashes disposed as follows:

If buried, I would like my remains interred as follows:

I have already made arrangements at:

Funeral

Memorial

Celebration of Life

No Preference

Burial Wishes for _____ :

At my death, I wish to be: Cremated Buried No Preference

If cremation, I would like my ashes disposed as follows:

If buried, I would like my remains interred as follows:

I have already made arrangements at:

Funeral

Memorial

Celebration of Life

No Preference

SCHEDULE OF ASSETS

As an attachment to your Living Trust, you need to make a list of your assets you intend to place in the trust. The schedule of assets should sufficiently identify the asset, but should not state values. For example, on bank accounts you would list the name of the bank and the account number, but you would not list how much money is in the account.

Real Estate Owned

Main Property:	Address, City, State:
Additional Property #1:	Address, City, State:
Additional Property #2:	Address, City, State:
Additional Property #3:	Address, City, State:
Additional Property #4:	Address, City, State:

Are any of the properties listed above on Native American Land? YES NO
If yes, which one?

Bank Accounts

Please give the last 4 Digits of your Account #'s

Bank Name/Type:	Account Number(s):
Who's account?	JOINT SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT SEPARATE

Securities Owned (stocks, bonds, Mutual funds) Please give the last 4 digits of your account #

Client #1		Client #2	
Broker's Name:		Broker's Name:	
Account Type:		Account Type:	
Account#		Account#	
Broker's Name:		Broker's Name:	
Account Type:		Account Type:	
Account #		Account #	
Broker's Name:		Broker's Name:	
Account Type:		Account Type:	
Account #		Account #	

Retirement Plans (IRA, 401K, Deferred Compensation)

Please give the last 4 digits of your account #

Client #1		Client #2	
Account Name:		Account Name:	
Account Type:		Account Type:	
Account #:		Account #:	
Account Name:		Account Name:	
Account Type:		Account Type:	
Account #:		Account #:	
Account Name:		Account Name:	
Account Type:		Account Type:	
Account #:		Account #:	

Life Insurance (Please give the last 4 digits of your account #)

Client #1		Client #2	
Account Name:		Account Name:	
Account Type:		Account Type:	
Account #:		Account #:	
Account Name:		Account Name:	
Account Type:		Account Type:	
Account #:		Account #:	
Account Name:		Account Name:	
Account Type:		Account Type:	
Account #:		Account #:	

Safe Deposit Box:

Location:	Box Number:
Location:	Box Number:

Other Assets (Own a business? Collectors Vehicles? Notes or Loans Owed to You?)

Additional Information**Tax Professional**

- | | | |
|---|-----|----|
| 1. Do you have a Tax Professional? | YES | NO |
| 2. Do you have any concerns about Tax Reduction? | YES | NO |
| 3. Would you like to speak with one of our vetted tax strategist? | YES | NO |

Insurance Professional

- | | | |
|---|-----|----|
| 1. Do you have an Insurance Professional? | YES | NO |
|---|-----|----|

Please provide the following information:

Name: _____

City: _____

Phone: _____

Email: _____

2. At what level are you satisfied with their work?

Very Satisfied

Somewhat Satisfied

Unsatisfied

Financial Advisor

- | | | |
|---|-------|----|
| 1. Do you have a Financial Advisor? | YES | NO |
| 2. Do you have a complete and updated financial plan? | YES | NO |
| 3. Would you like a complimentary financial plan? | YES | NO |
| 4. Do you have any other professionals you'd like listed? | _____ | |

Peace of Mind Plan

Are you interested in setting up a Peace of Mind Plan?	YES	NO
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I am signing this under penalty of perjury that I have provided all information known to me to my attorney and hold my attorney innocent of any excluded information I have not provided to her

Date: _____

*Client #1 signature*_____
*Client #2 signature*_____
Client #1 printed name:_____
Client #2 printed name: