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ESTATE PLANNING INFO SHEET

Personal Information:

Full Legal Name: _____

Nickname/Aliases: _____

Spouse's Full Legal Name: _____

Spouse's Nickname/Aliases: _____

If Widowed, Date of Spouse's/Partner's Death: _____

Your Birthplace:	City:	State:
Spouse's Birthplace:	City:	State:

Are you a U.S. Citizen?	YES	NO	Is your Spouse?	YES	NO
Are you a Veteran?	YES	NO	Is your Spouse?	YES	NO

Primary Home Address:

City:	State:	Zip code:	County:
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Your Social Security Number:	
Spouse's Social Security Number:	

Home Phone:	Cell Phone:	Work Phone:
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Email: _____

Your Employer:	Occupation:
Spouse's Employer:	Occupation:

Have you ever worked for the government?	YES	NO
Has your spouse ever worked for the government?	YES	NO

Are you currently married?	YES	NO
If yes, date of Marriage:		
Place of Marriage:	City:	State: Country:
Have you been married previously?	YES	NO
Has your spouse been married previously?	YES	NO

Your Children:

Please provide the following information for all your children (living and deceased):

Full Legal Name:	Child of:	Birth Date:	Married to:	City/State:

Did you legally adopt any of your children	YES	NO
Have any of your children predeceased you?	YES	NO

If yes, please list their names: _____

Your Grandchildren:

Please provide the following information for all your grandchildren and great-grandchildren:

Full Legal Name:	Child of:	Birth Date:	Married to:	City/State:

Other Beneficiaries:

Please provide the following information for all other intended beneficiaries under your will:

Full Legal Name:	Child of:	Birth Date:	Married to:	City/State:

Your Executor:

Who do you want to handle your estate/financial affairs upon your death? Please list in order of priority.

NAME:	RELATIONSHIP:

Your Trustee (If Applicable):

Do you wish to create a Trust for a minor or other beneficiary?	YES	NO
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If Yes, who do you want to be the Trustee for any Trusts created under your will? Please list in order of priority.

NAME:	RELATIONSHIP:

Disinheriting (If Applicable):

Do you have any relatives whom you specifically do not want to receive anything from your estate?

NAME:	RELATIONSHIP:

Disabilities:

Does anyone in your family, or any of your other beneficiaries, have any special needs due to physical or mental disability?

NAME:	RELATIONSHIP:	DISABILITY:

Beneficiaries

Please briefly describe how you would like your property to be distributed after your death. (We will discuss this in greater detail at your conference)

Guardian for Minor Children

If you have minor children (Under 18 years of age) and you and your spouse become unable to take care of them, or you and your spouse are deceased, who would you want to be Legal Guardians of your children? Please provide at least two (2) people (full legal names), their addresses, and their home and/or cell phone numbers.

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

Visitation Rights

Do you wish for any person(s) other than your chosen Guardian(s) to have access and visitation rights with your children? If yes, please list such person(s)'s full legal name(s):

Financial Power of Attorney

Who do you want to handle your financial affairs if you become incapacitated? Please provide at least two (2) people (full legal names), their addresses, and their home and/or cell phone numbers.

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

Health Care Power of Attorney

If you become incapacitated and unable to make health care decisions for yourself, who do you want to make health care decisions for you? Please provide at least two (2) people (full legal names), their addresses, and their home and/or cell phone numbers.

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

NAME:	ADDRESS:
PHONE (H):	PHONE (C):

Certain Powers of Health Care Agents

With respect to **Life-Prolonging Measures**, if you are incapacitated and you have an incurable or irreversible condition that will result in death within a relatively short period of time you direct your above-named Health Care Agent to: (Choose one of the following options)

<input type="checkbox"/>	Have Discretion to determine whether to provide life-prolonging treatment
<input type="checkbox"/>	Withhold or Withdraw life-prolonging treatment
<input type="checkbox"/>	Direct for my life to be prolonged to the greatest extent possible

With respect to **Life-Prolonging Measures**, if you are incapacitated and you are unconscious, and to a high degree of medical certainty, you will not regain consciousness, you direct your above-named Health Care Agent to: (Choose one of the following options)

<input type="checkbox"/>	Have Discretion to determine whether to provide life-prolonging treatment
<input type="checkbox"/>	Withhold or Withdraw life-prolonging treatment
<input type="checkbox"/>	Direct for my life to be prolonged to the greatest extent possible

With respect to **Life-Prolonging Measures**, if you are incapacitated and you suffer from advanced dementia or other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible, you direct your above-named Health Care Agent to: (Choose one of the following options)

<input type="checkbox"/>	Have Discretion to determine whether to provide life-prolonging treatment
<input type="checkbox"/>	Withhold or Withdraw life-prolonging treatment
<input type="checkbox"/>	Direct for my life to be prolonged to the greatest extent possible

Choose any and all of the following powers that you grant your chosen Health Care Agent:

	He/She may authorize an autopsy
	He/She may consent to the donation of all or any of your tissue or organs for transplantation or therapy
	He/She may donate your body for anatomical study
	He/She may direct the disposition of your remains

Already Existing Will/Trust

Do you presently have a Will?	YES	NO
If Yes, what year was it created?		

**If Yes, please bring a copy of such will with you to your conference.

Do you presently have a Trust?	YES	NO
If Yes, what year was it created?		
If Yes, is the Trust Revocable or Non- Revocable?	Revocable	Non-Revocable

**If Yes, please bring a copy of the Trust creating documents to your conference.

Do you anticipate receiving an inheritance?	YES	NO
Are you the Beneficiary, Trustee, or Settlor of any Trust?	YES	NO

Safe Deposit Box

Do you have a safe deposit box?	YES	NO
Bank/Branch:		

Other Professionals

If applicable, please provide the names of your CPA and/or Financial Planner

Financial Summary

If Married, do you or your spouse have property owned separately?	YES	NO
If Yes, what is the value of your separately owned property?		
If Yes, what is the value of your Spouse's separately owned property?		

If married, do you and your spouse jointly own property?	YES	NO
If Yes, what is the value of the jointly owned property?		
What is your annual income?		
Spouse's annual income?		

Do you own a home or any other real estate?

Address	City/State	Approximate Value	Mortgage

Do you own any vehicles, boats, etc.?

Description	Approximate Value	Amount Owned

Do you have any checking or savings accounts?

Name of Bank	Owner(s)	Name of Beneficiary (If Applicable)

Do you own any IRA, 401K, 403b, TSP, or Pension Plans?

Company	Account Number	Beneficiary or Beneficiaries	Approximate Value

Do you own any Life Insurance Policies and/or Annuities?

Company	Policy Number	Beneficiary or Beneficiaries	Death Benefit

Do you personally own any Stocks or Bonds?

Company	Owner	Number or Shares	Tax (Cost) Basis	Fair Market Value

Do you receive any government financial benefits such as Welfare, Medicaid, Medicare, or Social Security?

Program	Approximate Value

Do you have any non-publicly traded business interests (such as partnerships, limited liability companies, closely held corporations, royalty rights, etc.)?

Entity Name	Ownership Interest	Is there a buy-sell agreement in effect?	Desired Distribution of Ownership Interest?

Funeral Arrangements

Do you have any special requests regarding funeral arrangements, burial plot plans, cremation, or the disposition of remains?

Gifts

Have you made any substantial gifts during your lifetime (Gifts of \$10,000 or greater in either cash or other assets)?

If Yes, please provide the approximate value of the gift and a brief description of whether it was made through cash or some other asset:

Other information

Is there any other information that has not already discussed above that you feel is necessary to bring to our attention in your estate planning process? (The more information we are provided, the better we can achieve your goals as a client)

CONFIDENTIAL

In order for our firm to properly advise you in preparing your estate plan, please take time to fill out this questionnaire to the best of your knowledge. All information provided will be maintained in a strictly confidential manner in accordance with the law. We understand that you may not know exact amounts or every detail of every asset, but we ask that you estimate values as accurately as you can. If extra space is needed for you to provide all information you think is necessary, please attach additional sheets.

Communication is essential for formulating any estate plan. As such, please do not hesitate to contact us with any questions you have.

In addition, below is a checklist of items that, if applicable, we ask that you bring to your conference. Bringing these items with you would be beneficial for our office to provide the best estate plan legally possible to achieve your goals.

Checklist

_____ Any will already in existence.

_____ Any Trust creating documents for an already existing trust.

_____ Any Financial Power of Attorney documents already in existence.

_____ Any Health Care Power of Attorney documents already in existence.