

BENNETT TRUST & ESTATE ELDER LAW

ESTATE PLANNING QUESTIONNAIRE

Please complete this packet as thoroughly as possible, creating an estate plan that works will be based on the information you provide us. The information is imperative to allow the attorney to recommend an estate plan best suited to your individual needs.

- ◆ Answer each section as completely as possible
- ◆ Print legibly
- ◆ Check all appropriate boxes including ANo@ and ANone@ boxes
- ◆ If necessary, please call our office or consult with your financial advisor for assistance

**All information contained in this document is confidential
and protected by attorney-client privilege.**

CLIENT NAME _____ DATE OF BIRTH _____
SPOUSE _____ DATE OF BIRTH _____

PRESENT PLANNING

Are you making payments pursuant to a divorce or property settlement?

Self Spouse None Amount: \$ _____ To Whom: _____

Have you signed a pre-nuptial agreement? Self Spouse None Revocable Irrevocable

Do you currently have a Trust? Self Spouse None

Do you currently have a Will? Self Spouse None **Date last revised?** _____

Have you granted a Power of Attorney? Self Spouse None

Do you currently have a Health Care Proxy? Self Spouse None

Are you a beneficiary of an inheritance or trust? Self Spouse None
Source: _____

Do you currently have Long Term Care Insurance? Yes No

Provider/Agent: _____ Phone number: _____ Policy No.: _____
Daily Benefit Amount: \$ _____ Inflation Rider? Yes No _____%

Spouse (if applicable): Yes No

Provider/Agent: _____ Phone number: _____ Policy No.: _____
Daily Benefit Amount: \$ _____ Inflation Rider? Yes No _____%

Do you currently have Disability Insurance? Yes No

Provider/Agent: _____ Phone number: _____ Policy No.: _____
Daily Benefit Amount: \$ _____

Spouse (if applicable): Yes No

Provider/Agent: _____ Phone number: _____ Policy No.: _____
Daily Benefit Amount: \$ _____

Do you currently have Accidental Death Insurance? Yes No

Provider/Agent: _____ Phone number: _____ Policy No.: _____
Daily Benefit Amount: \$ _____

Spouse (if applicable): Yes No

Provider/Agent: _____ Phone number: _____ Policy No.: _____
Daily Benefit Amount: \$ _____

Do you foresee a time when someone may be dependent upon you? Self Spouse Child NA

Name/Reason: _____

Name/Reason: _____

What is presently your most important personal goal? _____

What is presently your most important financial goal? _____

What do you presently see as the major threat to your goals? _____

Have you considered or do you give to any charitable or religious organization? Yes No

Names: _____

HEALTH INFORMATION

(It is important for the Attorney to know your health status, to design an estate plan that works for you.)

What is your current health status? Good Concern Problem

Specific Concern/Problem: _____

When was your last physical examination? _____ Date: _____

Primary Physician: _____ Phone: _____

Office Address: _____

Spouse (if applicable):

What is your current health status? Good Concern Problem

Specific Concern/Problem: _____

When was your last physical examination? _____ Date: _____

Primary Physician: _____ Phone: _____

Office Address: _____

Comments:

PROPOSED EXECUTOR _____

ALTERNATE _____

TRUSTEE _____

ALTERNATE _____

Any specific bequests? yes no

What? _____

What? _____

What? _____

What? _____

To Whom? _____

To Whom? _____

To Whom? _____

To Whom? _____

PARENTS: (Complete the following if you intend to name them):

Name(s): _____ Phone: _____
Address: _____ Parent of you spouse
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

Name(s): _____ Phone: _____
Address: _____ Parent of you spouse
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

BROTHERS/SISTERS: (Complete the following if you intend to name them)

Name: _____ Sibling Of: you spouse
Address: _____
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

Name: _____ Sibling Of: you spouse
Address: _____
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

Name: _____ Sibling Of: you spouse
Address: _____
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

Name: _____ Sibling Of: you spouse
Address: _____
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

OTHER DEPENDENTS (friends or relatives you support):

Name: _____ Relationship to you: _____
Address: _____
Special Needs/Considerations: _____
Potential Problems/Hardships: _____

Name: _____ Relationship to you: _____
Address: _____
Special Needs/Considerations: _____
Potential Problems/Hardships: _____