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ESTATE PLANNING QUESTIONNAIRE

PERSONAL INFORMATION - Overview

Date: _____

Name: _____

Primary Residence: _____

Telephone: Home: _____ Office: _____ Cell: _____

Email: _____

Birthdate: _____ Birthplace: _____

Social Security Number: _____ Citizenship: _____

Secondary Residence: _____

Employer: _____

Net Worth: _____ Income from salary/wages: _____ Unearned income: _____

Health: Excellent Reasonably good Poor Serious Adverse Condition

Legally blind? Yes No Disabled? Yes No

FAMILY RELATIONSHIPS

Spouses/Domestic Partners

Marital Status/Name of spouse or domestic partner if applicable: _____

Date of Marriage: _____

Prenuptial Agreement?: _____

Names/Number of Children from this marriage:

Previous Marriage/Divorce

Provide name of former spouse, date of marriage, children of marriage and any existing prenuptial or antenuptial agreement:

Children

Provide the Name/Residence/Address/Age/Date of Birth/Social Security Number for each:

Grandchildren

Provide Name/Parent's Name/Age/Date of Birth:

Living Parents/Siblings

Provide Name/Age/Address:

Important Family Health Issues (e.g. special needs children/parents):

Important Family Issues of Note:

TESTAMENTARY WISHES

CLIENT'S DISPOSITIVE PROVISIONS

Cash Gifts (cash and cash-equivalent gifts)

Name of Recipient	Relationship	Amount

Gifts of Real Estate

Name of Recipient	Relationship	Description of Property

Gift of Tangible Property (autos/jewelry/art/etc.)

Name of Recipient	Relationship	Description of Property

Gift of Intangibles (stock/bonds/annuities/etc.)

Name of Recipient	Relationship	Description of Property

CLIENT'S RESIDUAL GIFTS (after specific gifts, above)

Spouse/Partner

Do you want to provide primarily for your Spouse/Partner (and then secondarily for children/descendants, if any)?

- Yes No Not Applicable

If Yes, would you prefer gift to Spouse/Partner to be given: Outright In a Trust

Children/Descendants

Prefer gift to children (if any) to be given: Outright In a Trust

Do you wish to treat children equally? Yes No

Prefer gift to grandchildren (if any) to be given: Outright In a Trust

Do you wish to treat grandchildren equally? Yes No

Other Beneficiaries

Specify gift to other beneficiary(ies):

LIFETIME GIFTS

Taxable Gifts: Have you made any substantial transfers, lifetime gifts not covered or in excess of the annual gift tax exclusion (now \$13,000)? If so, please indicate for each gift so made: the name of the recipient, the amount/nature of the gift, the date the gift was made and whether a gift tax return was filed and a gift tax paid.

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Generation Skipping Tax Gifts: Also, if you have made any gifts that skipped a generation (e.g. to grandchildren), do you know if they were subject to the generation skipping tax or were eligible for an exemption? Do you know if you have any available gift tax or generation skipping tax credit?

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PERSONAL REPRESENTATIVES

EXECUTOR

CLIENT'S EXECUTOR

Independent Executor Under Client's Will (will serve concurrently with Spouse if applicable)

Initial Name/Address
Successor (will serve on death/disability of initial executor)

TRUSTEES (if applicable)

CLIENT'S TRUSTEES

Trustees for Client (applicable if trusts being considered)

Initial Name/Address
Successor

GUARDIAN/CONSERVATOR

Guardians for minor children or incapacitated adults (if applicable)

Initial Name/Address
Successor

EXISTING ESTATE PLANS AND DOCUMENTS

The following documents as applicable should be available for review in connection with your estate plan:

Current wills	Employee Benefits Statements
Powers of Attorney	Divorce Decree/Separation Agreement
Living Will/Health Care Proxy	Business Agreements
Real Estate Deeds	Trust Documents
Tax Returns (income/gift/estate)	Loan Agreements
Citizenship Papers	Adoption Agreements
Veterans Discharge Certificates	Birth Certificates/Marriage certificates
Powers of Appointment you hold/trusts in which you are a beneficiary	Documentation concerning prior taxable gifts
Marriage Certificates	Cemetery Site Deeds

ASSETS AND LIABILITIES

		Ownership	Co-owner	Liabilities
	Description			
Cash/Liquid				
	Savings			
	Checking			
	Money Market			
	Other			
Real Estate (Address)				
	Primary			
	Secondary			
	Other			
Personal Property				
	Automobiles			
	Jewelry			
	Art or Other Collections			
	Boats			
	Other			
Intangibles				
	Bonds			
	Stock			
	Mutual Funds			
	Note & Mortgages Receivables			
	Future Inheritance			
	Interests in Trusts			
	Annuities			
	Other			
Retirement Benefits				
	IRAs			
	401K			
	Keogh Plan			
	SEP			
	Other			
Life Insurance	Cash Value of all policies			

OTHER PLANNING ISSUES

Want to benefit Charity?	Y / N
Ownership in farm or ranch?	Y / N
Ownership in Closely held business?	Y / N
Own stock is SubChapter S corporation?	Y / N
Ownership in a Medical, Dental or Veterinarian Practice?	Y / N
Own a valuable collection? (e.g., art, stamp collections)	Y / N
Own interest in gas/oil?	Y / N
Own a Primary Residence?	Y / N
Own a Secondary Residence?	Y / N
Own other significant interests in real estate?	Y / N

MISCELLANEOUS

Safe Deposit Box: Do you have a safe-deposit box? Yes No

Location of safe-deposit box: _____

Location of important papers: _____

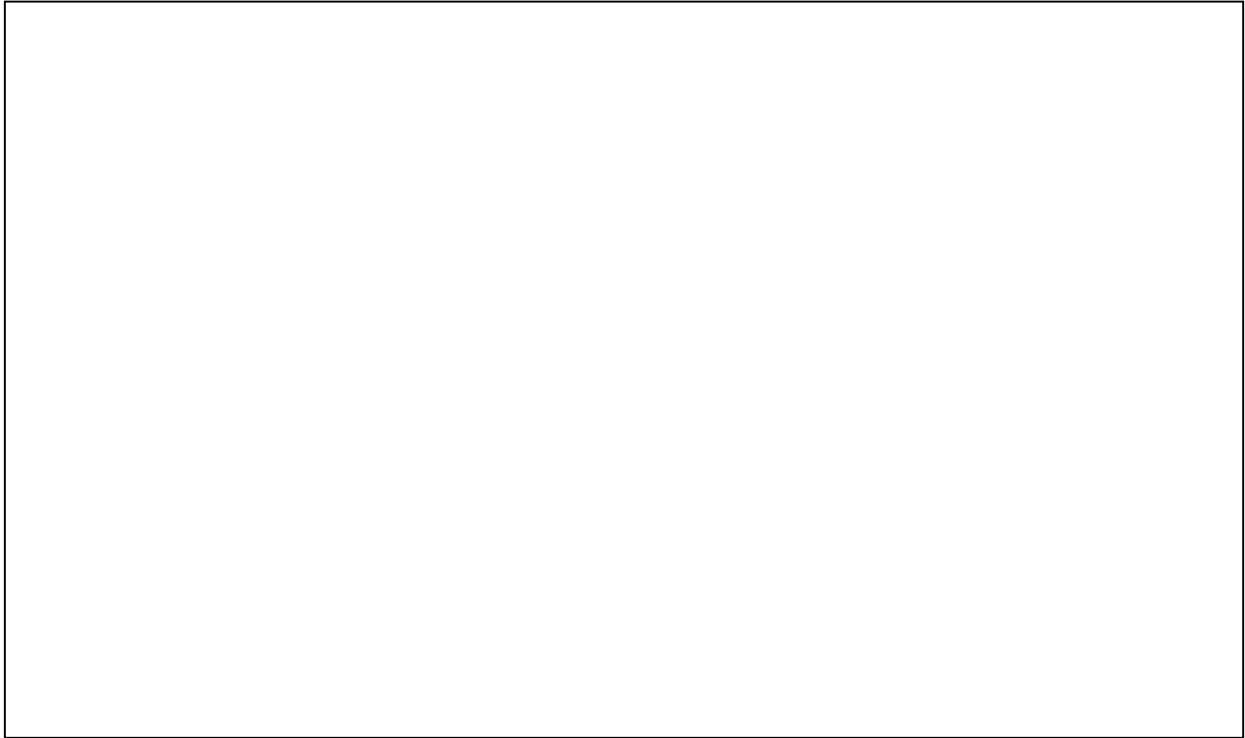
Grantor Trusts: Do you have any grantor trusts? Provide info re: same.

Life Insurance Trusts: Do you have any irrevocable life insurance trusts? Provide policy and trust information.

Burial Wishes: _____

Advisors: Name/contact information for accountant, investment advisor, insurance broker or other advisors who have input into your estate planning:

Anything Else? Is there any other information which you feel is important for me to know that may have a bearing on your estate plan?

A large, empty rectangular box with a thin black border, intended for the user to provide additional information relevant to their estate plan.

CLIENT'S HEALTH CARE DIRECTIVES

Do you have a current Living Will? Yes No If yes, date: _____

Do you have a current Health Care Directive (also called Health Care Power of Attorneys or Health Care Proxies)? Yes No If yes, date: _____

In preparing a Living Will or Health Care Directive, how would you want to provide for continued nutrition/hydration (food/water) if your death was imminent?

Do you wish to become an organ donor? Yes No

Primary Health Care Agent(s)

Name	Address	City	State	Zip	Phone

Alternate Health Care Agent(s)

Name	Address	City	State	Zip	Phone

Name of Primary Care Physician

Name	Address	City	State	Zip	Phone

CLIENT'S DURABLE POWER OF ATTORNEY

Primary Agent(s)

Name	Address	City	State	Zip	Phone

Alternate Agent(s)

Name	Address	City	State	Zip	Phone