

ESTATE PLANNING CHECKLIST

(Please Print)

Client: _____

Date of Birth: ___ / ___ / ___ U.S. Citizen? Yes No

Spouse (if any): _____

Date of Birth: ___ / ___ / ___ U.S. Citizen? Yes No

Home Address: _____

Phone No.: () _____ E-mail: _____

Phone No.: () _____ Spouse's Email: _____

Client's Employer: _____ Business Phone: () _____

Spouse's Employer: _____ Business Phone: () _____

If applicable, have client or spouse ever been married to someone else? Yes No

Children, if any: (attach an additional sheet for additional children)

1. Name: _____ D.O.B. ___ / ___ / ___

Address _____ Phone _____

Marital Status: _____ # of Children _____ Spouse's First Name _____

2. Name: _____ D.O.B. ___ / ___ / ___

Address _____ Phone _____

Marital Status: _____ # of Children _____ Spouse's First Name _____

3. Name: _____ D.O.B. ___ / ___ / ___

Address _____ Phone _____

Marital Status: _____ # of Children _____ Spouse's First Name _____

4. Name: _____ D.O.B. ___ / ___ / ___

Address _____ Phone _____

Marital Status: _____ # of Children _____ Spouse's First Name _____

Is client the parent of all of these children? Yes No Is spouse the parent of all of these children? Yes No

Do any members of your family have any special physical or mental challenges? Yes No

If you now support your parents or other relatives, or wish to make provisions for them in your estate plan, please provide their Names, addresses and phone numbers:

If you have minor children, please provide the Name, address, phone number and relationship of your first and second choices for guardian.

Please provide the Name, address, phone number and relationship of your first and second choice for your Personal Representative.

Please provide the Name, address, phone number and relationship of your first and second choice for your successor Trustee.

Please provide the Name, address, phone number and relationship of your first and second choice for your Durable Power of Attorney.

Please provide the Name, address, phone number and relationship of your first and second choice for your Patient Advocate Designation.

If all of the beneficiaries you have indicated above predecease you or perish with you, please provide the Name, City, State and relationship of those to whom you would leave your estate (final takers) and the percentages for each.

If you wish to make any charitable contributions, please indicate the charity and the amount or percentage you wish to donate.

CPA: _____

Insurance Professional: _____

Financial Planner: _____

ASSETS*

(List Approximate Fair Market Value in Column)
(Attach additional pages, if necessary)

Assets	Owned Jointly By Client and Spouse	Owned by Client Only	Owned by Spouse Only
Cash			
Bank Accounts			
Money Markets Accounts			
Residence (Net of Mortgage Amount)			
Other Real Estate			
Partnerships			
Stocks and Bonds			

Assets	Owned Jointly By Client and Spouse	Owned by Client Only	Owned by Spouse Only
Closely Held Business			
Pension and Profit Sharing Benefits			
IRA Accounts			
Automobiles			
*Life Insurance			
Expected Inheritance in future?			
Debts			

* Values for Life Insurance should be the face value of the policies.