



ESTATE PLANNING QUESTIONNAIRE (SINGLE)

This form is extremely important. Your accuracy and completeness in responding will help represent you. Please bring this completed information packet, including each of the attached schedules, to your initial consultation.

Date: _____ File No.: _____

A. CLIENT DATA

CLIENT

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone Number: _____

Business Phone Number: _____ E-mail Address: _____

Date of Birth: _____ Social Security Number: _____

U.S. Citizen? Yes No Veteran? Yes No

If not a Veteran, was your former spouse a Veteran? Yes No

If yes, please list branch and dates of service: _____

B. MARITAL INFORMATION (if previously married)

Date of Marriage: _____

Place of Marriage: _____

City: _____

State or Province: _____

Country: _____

Name of former spouse: _____

Marriage terminated by: Death Divorce Annulment

C. LONG TERM CARE INSURANCE

Do you have Long Term Care Insurance? Yes No

If yes, please provide a copy of the policy.

D. CHILDREN (if applicable, include adult and minor children, as well as any who have predeceased you)

NAME OF CHILD: _____

Male Female Married Single

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ E-mail Address: _____

Relationship to Client: Natural child Adopted Stepchild Child born out of wedlock Deceased

NAME OF CHILD: _____

Male Female Married Single

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ E-mail Address: _____

Relationship to Client: Natural child Adopted Stepchild Child born out of wedlock Deceased

NAME OF CHILD: _____

Male Female Married Single

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ E-mail Address: _____

Relationship to Client: Natural child Adopted Stepchild Child born out of wedlock Deceased

NAME OF CHILD: _____

Male Female Married Single

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ E-mail Address: _____

Relationship to Client: Natural child Adopted Stepchild Child born out of wedlock Deceased

Please check this box and attach a separate page to list additional children.

CHILDREN (continued)

Are all of your children in good health?

- Yes No

Are any of your children blind?

- Yes No

Are any of your children disabled?

- Yes No

Are any of your children receiving Supplemental Security Income or SSDI?

- Yes No

If yes, how much is the child's monthly payment?

\$ _____

Are any of your children receiving Medicaid or Medicare?

- Medicaid Medicare

Do any of your children have any problems with:

Serious physical or mental illness?

- Yes No

Drug Addiction?

- Yes No

Alcoholism?

- Yes No

Debt problems/ bankruptcy?

- Yes No

Marital Difficulty?

- Yes No

If you answered yes above, please list the name and reason for listing that child.

Do any of your children owe you money, or have you made gifts to one or more of your children that you wish to treat as an advancement of their inheritance? If yes, please provide information:

F. GRANDCHILDREN (if applicable)

NAME OF GRANDCHILD: _____

Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____

Name(s) of Grandchild's Parent(s): _____

Is this grandchild a direct descendant (natural or adopted) child of your child? Yes No

NAME OF GRANDCHILD: _____

Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____

Name(s) of Grandchild's Parent(s): _____

Is this grandchild a direct descendant (natural or adopted) child of your child? Yes No

NAME OF GRANDCHILD: _____

Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____

Name(s) of Grandchild's Parent(s): _____

Is this grandchild a direct descendant (natural or adopted) child of your child? Yes No

NAME OF GRANDCHILD: _____

Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____

Name(s) of Grandchild's Parent(s): _____

Is this grandchild a direct descendant (natural or adopted) child of your child? Yes No

Please check this box and attach a separate page to list additional grandchildren.

GRANDCHILDREN (continued)

Are all of your grandchildren in good health?

Yes No

Are any of your grandchildren blind?

Yes No

Are any of your grandchildren disabled?

Yes No

Are any of your grandchildren receiving Supplemental Security Income or SSDI?

Yes No

If yes, how much is the grandchild's monthly payment?

\$ _____

Do any of your grandchildren have any problems with:

Serious physical or mental illness?

Yes No

Drug Addiction?

Yes No

Alcoholism?

Yes No

Debt problems/ bankruptcy?

Yes No

Marital Difficulty?

Yes No

Are the grandchildren receiving Medicaid or Medicare?

Medicaid Medicare

If you answered yes above, please list the name and reason for listing that grandchild.

G. MISCELLANEOUS

1. Do you have any legal issues I should be aware of? Yes No

If yes, please explain: _____

2. Where do you store your important papers? _____

3. Do you have a Safe Deposit Box? Yes No

If yes, please indicate the name and address of the bank: _____

4. Have you prepaid your burial and funeral arrangements? Yes No

If yes, please provide copies of your cemetery deed and funeral contract.

5. Are there any difficult family dynamics that could impact your planning? Yes No

If yes, please provide information: _____

6. Are you a contributor to a 529 Plan? Yes No

If yes, please attach a statement of the 529 account.

7. Does anyone in your immediate or extended family have special need issues (including any spouses of your children)? Yes No

If yes, name and relationship of disabled family member: _____

H. REFERRAL

Who referred you to our office?

Name: _____

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

Have you visited our website at www.TSummersLegal.com? Yes No

Do you have any ideas for improving our website? If so, please discuss: _____

I. CERTIFICATION

The undersigned hereby represents to Summers Legal, PA that the information contained in this questionnaire (including the attached schedules) is accurate and complete, and that the undersigned understands that the law firm will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Summers Legal, PA may not be appropriate.

Signature of Client or Client Representative

Date

FOR INTERNAL USE ONLY	
EP _____	_____
Current: _____	_____
Proposed: _____	_____
CP _____	_____
APP _____	_____

SCHEDULE ONE: ASSETS AND RESOURCES

A. REAL ESTATE

(Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way <i>(Sample)</i>	\$ xxx,xxx.xx	\$ xxx,xxx.xx	\$ xx,xxx.xx	Joint tenant
\$ _____	\$ _____	\$ _____	\$ _____	_____
\$ _____	\$ _____	\$ _____	\$ _____	_____
\$ _____	\$ _____	\$ _____	\$ _____	_____
\$ _____	\$ _____	\$ _____	\$ _____	_____

B. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)

(Please provide copies of most recent statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. <i>(Sample)</i>	xxx-xxxx	Savings	\$ xx,xxx.xx	Jointly w/ son
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____

C. SECURITIES (Bonds, Marketable Securities, etc.)

(Please provide copies of most recent statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. <i>(Sample)</i>	Common <i>(or Preferred)</i>	xx Shares	\$ x,xxx.xx	\$ x,xxx.xx	Sole owner
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____

D. RETIREMENT ACCOUNTS (IRAs, Annuities, Keoghs, etc.)

(Please provide copies of most recent statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker <i>(Sample)</i>	xxx-xxxx	Client	Spouse	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

E. LIFE INSURANCE (Whole Life, Term, Endowment, etc.)

(Please provide copies of most recent statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Apple Ins. Co. <i>(Sample)</i>	xxx-xxxx	Client	Son/Daughter	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

F. PERSONAL PROPERTY

	Market Value and Item	How Title Held
Home Furnishings:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Jewelry , Furs, etc.:	\$ _____	_____
Other :	\$ _____	_____
Other :	\$ _____	_____

G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of any Trust in which you have an interest, or the person who is the source of the inheritance and what you expect to receive. Please provide a copy of the Will or Trust which creates the interest, if available. If not, please advise if and how we may obtain a copy.

H. BUSINESS INTERESTS

If client has an ownership in any business (whether sole proprietorship, corporation or partnership), please provide additional information regarding the nature of the interest and value of the business interest. If there are business documents (such as Buy-Sell Agreements, Stock Certificates, etc.) please provide copies.

I. MISCELLANEOUS

If client has any property interests not described above, please explain the nature of the interests and the estimated value of each.

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SCHEDULE 2. – SELECTING BENEFICIARIES

Please note we will spend time during our first meeting completing Schedule 2 and Schedule 3. However, you may want to review your existing documents (if any) and the following choices of beneficiaries and fiduciaries in preparation for our meeting.

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. Are there certain items of personal property that should pass to designated individuals? Are there specific charities or individuals that you intend to leave a gift? Are some selected beneficiaries going to require a Trustee to manage their fund on their behalf?

A. First-choice beneficiaries: Children Other

B. Second-choice beneficiaries: Children Other

C. Third-choice beneficiaries: Children Other

D. Any specific disposition of your residence?

E. Any specific gifts of special articles, such as art or jewelry?

F. Any specific disposition of other household and/or personal effects?

G. Other information you think is important to your estate planning:

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SCHEDULE 3. – SELECTING FIDUCIARIES

(Please provide names, addresses and phone numbers if chosen person is not a child or spouse.)

POSITION _____ **CLIENT** _____

WILL SELECTIONS:

Executor or Co-Executors _____

1st Successor(s) _____

2nd Successor(s) _____

Trustee or Co-Trustees _____

Guardian(s) for minor of disabled
Children _____

FINANCIAL GENERAL POWER OF ATTORNEY:

Agent or Co-Agents _____

1st Successor(s) _____

2nd Successor(s) _____

If more than one Agent is selected, may either Agent act alone, independently of the other Agent, or must all Co-Agents act together?

Yes, my Co-Agents may act independently of each other. No, each task must be undertaken jointly by all Co-Agents

HEALTH CARE POWER OF ATTORNEY & LIVING WILL:

Agent or Co-Agents _____

1st Successor(s) _____

2nd Successor(s) _____

If more than one Agent is selected, may either Agent act alone, independently of the other Agent, or must all Co-Agents act together?

Yes, my Co-Agents may act independently of each other. No, each task must be undertaken jointly by all Co-Agents

RESET FIELDS

SAVE

SEND VIA EMAIL

PRINT