



**LIVING TRUST INFORMATION QUESTIONNAIRE**

Trust name:

Your Trust name can be named anything, as long as it has Family Trust or Revocable Trust at the end. Ex: (First Name)(Last Name) Revocable Trust.

Referred By: \_\_\_\_\_

Date of Marriage:

If unmarried, please only complete the information for Client#1 \_\_\_\_\_

Client#1's Name:	<u>Name as it appears on your driver's license, ID card or passport</u>		
U.S. Citizen? Yes      No			
Other Names Used by Client#1:			
Address:			
Telephone:	Home:	Work/Cell	
Email Address:			
Date of Birth:			
Business/Employment:			
Prior Marriage? Yes      No	<u>Name of Ex-Spouse</u>	<u>Type of Termination:</u>	<u>Date of Termination:</u>
Unexpired License? Yes      No			

Client#2's Name:	<u>Name as it appears on your driver's license, ID card or passport</u>		
U.S. Citizen? Yes      No			
Other Names Used by Client#2:			
Address:			
Telephone:	Home:	Work/Cell	
Email Address:			
Date of Birth:			
Business/Employment:			
Prior Marriage? Yes      No	<u>Name of Ex-Spouse</u>	<u>Type of Termination:</u>	<u>Date of Termination:</u>
Unexpired License? Yes      No			

## FAMILY INFORMATION

Please list the names & address information of all living children. **Please include Step-Children from a previous/ current marriage and exclude Grand-Children.**

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

<b>Childs Name:</b>		
<b>Date of Birth:</b>		<b>Male      Female</b>
<b>Childs Street Address:</b>		<b>Legally Adopted?</b> <b>Yes      No</b>
<b>City, State, Zip Code:</b>		<b>Biological Mom?</b> <b>Yes      No</b>
<b>Telephone:</b>		<b>Biological Dad?</b> <b>Yes      No</b>

Please list deceased children, if any, and whether their own children survived them.

<u>Name</u>	<u>Date of Birth</u>	<u>Date of Death</u>	<u>Number of Deceased Child's Children</u>

## GUARDIANSHIP OF MINORS

Name and contact information of the person(s) that you want to raise a child that is under 18, if both spouses die: (if applicable).

<b>Name(s):</b>	
<b>Street Address:</b>	
<b>City, State, Zip Code:</b>	
<b>Telephone:</b>	
<b>Special Instructions:</b>	
<b>Stipend to Guardian for care of minor children? Yes      No</b>	
<b>If Yes, how much?</b>	

**ALTERNATE:** Name and contact information of the person(s) that you want to raise a child that is under 18, if both spouses die: (if applicable).

<b>Name(s):</b>	
<b>Street Address:</b>	
<b>City, State, Zip Code:</b>	
<b>Telephone:</b>	
<b>Special Instructions:</b>	
<b>Stipend to Guardian for care of minor children? Yes      No</b>	
<b>If Yes, how much?</b>	

## CHOICE OF SUCCESSOR TRUSTEES/EXECUTORS

You will be the initial trustee of your trust. If one of you passes away, the surviving spouse will be the sole trustee. The successor and/or alternate trustees you name below will only become trustee(s) if neither of you are able to do so. For successor trustee choices, it is usually best to select named beneficiaries, family members, or long-time close friends. You should list at least choices for successor trustee in case your first choice is unavailable for some reason. The people you name here will have no power, control, or authority over you or your financial affairs while you are alive and have sufficient capacity to handle your own affairs. There is no need to repeat an address if you have already written it once on this Questionnaire.

### Successor Trustee Choice #1

Name/Relationship:	
Street Address, City, State & Zip:	
Telephone Number:	
Trustee Compensation? Y      N	
If Yes, how much?	

### Alternative Successor Trustee Choice #2

Do you want Co-Trustees? Yes      No

Name/Relationship:	
Street Address, City, State & Zip:	
Telephone Number:	
Trustee Compensation? Y      N	
If Yes, how much?	

### Alternative Successor Trustee Choice #3

Name/Relationship:	
Street Address, City, State & Zip:	
Telephone Number:	
Trustee Compensation? Y      N	
If Yes, how much?	

## BENEFICIARIES

Beneficiaries are those people to whom you wish to pass your estate upon your death. It is important to know that beneficiaries can be changed anytime you like by amending your living trust. You may specify a set percentage of our estate to each beneficiary, or you may choose to let your estate pass to your beneficiaries in equal shares. If you choose to specify percentages, please be sure the total equals 100%. If you check the “equal share” box you do not need to fill in the percentages. If you will be naming more beneficiaries, please make additional copies of this page.

**Beneficiaries (Check Here \_\_\_\_\_ if all beneficiaries are to receive equal shares)**

<b>Name:</b>	
<b>Relationship:</b>	
<b>Street Address:</b>	
<b>City, State, ZipCode:</b>	
<b>Telephone:</b>	

**If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?**  
 Yes    No  
**Age for issue to receive?**  
**Do you want assets passing down to your beneficiaries to be held in a trust until a specific age? Yes    No**  
 If Yes, what age?                      Share %

<b>Name:</b>	
<b>Relationship:</b>	
<b>Street Address:</b>	
<b>City, State, ZipCode:</b>	
<b>Telephone:</b>	

**If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?**  
 Yes    No  
**Age for issue to receive?**  
**Do you want assets passing down to your beneficiaries to be held in a trust until a specific age? Yes    No**  
 If Yes, what age?                      Share %

<b>Name:</b>	
<b>Relationship:</b>	
<b>Street Address:</b>	
<b>City, State, ZipCode:</b>	
<b>Telephone:</b>	

**If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?**  
 Yes    No  
**Age for issue to receive?**  
**Do you want assets passing down to your beneficiaries to be held in a trust until a specific age? Yes    No**  
 If Yes, what age?                      Share %

<b>Name:</b>	
<b>Relationship:</b>	
<b>Street Address:</b>	
<b>City, State, Zipcode:</b>	
<b>Telephone:</b>	

**If a beneficiary predeceases you, do you want their share to go to their children (Known as issue and/or grandchildren)?**  
 Yes    No  
**Age for issue to receive?**  
**Do you want assets passing down to your beneficiaries**  
**Yes    No**  
 If Yes, what age?                      Share%

**Please state any specific concerns (not already addressed) that you have regarding the distribution of your estate plan, including disinheritance of individuals and alternative beneficiaries:**

## ADDITIONAL IMPORTANT INFORMATION

YES

NO

1. Do any of your beneficiaries have a learning disability, Special educational, medical or physical needs?
2. Do you have any relatives (other than children) who depend on you for all or part of their support?
3. Do you think any of your beneficiaries have special problems with spouses, drugs, alcohol or handling money?
4. Do you wish to disinherit any of your children, grandchildren, or any close relative?
5. Do you have an existing prenuptial or postnuptial agreement?
6. Do you have existing Wills?
7. Do you have existing Trusts?
8. Do you want any assets to pass to your children before the second spouse's death? It is common in blended families.
9. Special Gifts? Please list:

## POWER OF ATTORNEY CHOICES

Durable Power of Attorney is for assets and business affairs. Its purpose is to authorize someone to handle your day-to-day business affairs should you become incapacitated. Power of Attorneys are designed to be "springing". This means that they only become valid if you become incapacitated or unable to handle your own affairs. **Your spouse will automatically be your first choice and any other choice MUST BE 18 YEARS OR OLDER.**

On what your choice is below **are only in case your spouse is not available or unable to act.** Each spouse's choices can be different, if desired. Please note, that you have the choice of "Upon Incapacity Only" or "Effective Immediately." In choosing "Upon Incapacity Only," this would be **determined by your primary physician** that you no longer have the ability to make your own healthcare decisions. In choosing "effective immediately," the agents/choices you've selected will be authorized to act on your behalf effective immediately.

Would you like your spouse to be your first choice? YES      NO

**UPON INCAPACITY ONLY  
EFFECTIVE IMMEDIATELY**

**Power of Attorney 1st Choice: (If spouse is unavailable)**

Client #1 Choice

Client #2 Choice

Name:		
Relationship:		
Street Address:		
City, State, ZipCode:		
Telephone:		

**Power of Attorney 2nd Choice :**

Client # 1 Choice

Client # 2 Choice

Name:		
Relationship:		
Street Address:		
City, State, Zipcode:		
Telephone:		

**Power of Attorney 3rd Choice:**

Client #1 Choice

Client #2 Choice

Name:		
Relationship:		
Street Address:		
City, State, Zipcode:		
Telephone:		

**For Client #1:**

Would you like either of your choices listed above to be Co-agents? YES      NO  
If yes, which ones?

**For Client #2:**

Would you like either of your choices listed above to be Co-agents? YES      NO  
If yes, which ones?



## Advanced Health Care Directive

Advanced Health Care Directive (also known as a Durable Power of Attorney for health issues) is when you're incapacitated and you're unable to make Medical decisions. Same as Power of Attorney, Advanced Health Care Directive are designed to also be "springing". This means that they only become valid if you become incapacitated or unable to handle your own affairs. **Your spouse will automatically be your first choice and any other choice MUST BE 18 YEARS OR OLDER.** The selections you list below are only in case your spouse is not available or unable to act. Each spouse's choices can be different, if desired.

There is an option on if you would like your Advanced Health Care Directive to be "Effective Immediately" or "Upon Incapacity Upon". In choosing "Upon Incapacity Only," this would be **determined by your primary physician** that you no longer have the ability to make your own healthcare decisions. In choosing "effective immediately," the agents/choices you've selected below will be authorized to act on your behalf effective immediately

Would you like your spouse to be your first choice? YES      NO      UPON INCAPACITY ONLY  
EFFECTIVE IMMEDIATELY

Advanced Health Care Directive Choice # 1(if spouse is unavailable )

Client # 1 Choice

Client #2 Choice

<b>Name:</b>		
<b>Relationship:</b>		
<b>Street Address:</b>		
<b>City, State, ZipCode:</b>		
<b>Telephone:</b>		

Advanced Health Care Directive Choice #2

Client #1 Choice

Client #2 Choice

<b>Name:</b>		
<b>Relationship:</b>		
<b>Street Address:</b>		
<b>City, State, ZipCode:</b>		
<b>Telephone:</b>		

Advanced Health Care Directive Choice #3

Client #1 Choice

Client #2 Choice

<b>Name:</b>		
<b>Relationship:</b>		
<b>Street Address:</b>		
<b>City, State, ZipCode:</b>		
<b>Telephone:</b>		

**For Client #1:**

Would you like either of your choices listed above to be Co-agents? YES      NO  
If yes, which ones?

**For Client #2**

Would you like either of your choices listed above to be Co-Agents? YES      NO  
If yes, which ones?

## END OF LIFE DECISIONS

### End-Of-Life Decisions for Client#1:

The choices below represent a summary of instructions to your agent for health-care decisions.

1. Please check the box of the statement that best states your desires:

I want to live as long as possible; therefore, I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

I do not want life-sustaining treatment to be provided or continued: (a) if I am in an irreversible coma or persistent vegetative state; or (b) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (c) under any other circumstances in which the burdens of treatment outweigh the expected benefits.

2. Life Support?

YES

NO

For how long? \_\_\_\_\_

3. Please select only 1 option regarding how you would like CPR to be administered:

CPR to be administered **AT ALL TIMES** regardless of condition.

CPR to be administered at all times **UNLESS** you are in an irreversible coma or in a vegetative state or in hospice care.

CPR to **NOT** be administered at **ANY** and **ALL** times.

4. Organ Donation? YES NO Limit Use of Organs? YES NO

Please explain: \_\_\_\_\_

### End-Of-Life Decisions for Client#2:

The choices below represent a summary of instructions to your agent for health-care decisio

I want to live as long as possible; therefore, I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

I do not want life-sustaining treatment to be provided or continued: (a) if I am in an irreversible coma or persistent vegetative state; or (b) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (c) under any other circumstances in which the burdens of treatment outweigh the expected benefits.

2. Life Support?

YES

NO

For how long? \_\_\_\_\_

3. Please select only 1 option regarding how you would like CPR to be administered:

CPR to be administered **AT ALL TIMES** regardless of condition.

CPR to be administered at all times **UNLESS** you are in an irreversible coma or in a vegetative state or in hospice care.

CPR to **NOT** be administered at **ANY** and **ALL** times.

4. Organ Donation? YES NO Limit Use of Organs? YES NO

Please Explain: \_\_\_\_\_

### **Nursing Care Facility: (Does not mean you're going there)**

Continue Religious Activities? YES NO

Which Church/Temple/Synagogue or Religion: \_\_\_\_\_

Enjoy outdoors? YES NO

**BURIAL WISHES**

**Client#1:**

At my death, I wish to be:            Cremated            Buried            No Preference

If cremation, I would like my ashes disposed as follows:

If buried, I would like my remains interred as follows:

I have already made arrangements at:

Funeral            Memorial            Celebration of Life            No Preference

**Client#2:**

At my death, I wish to be:            Cremated            Buried            No Preference

If cremation, I would like my ashes disposed as follows:

If buried, I would like my remains interred as follows:

I have already made arrangements at:

Funeral            Memorial            Celebration of Life            No Preference

## SCHEDULE OF ASSETS

As an attachment to your Living Trust, you need to make a list of your assets you intend to place in the trust. The schedule of assets should sufficiently identify the asset, but should not state values. For example, on bank accounts you would list the name of the bank and the account number, but you would not list how much money is in the account.

### Real Estate Owned

Main Property:	Address, City, State:
Additional Property #1:	Address, City, State:
Additional Property #2:	Address, City, State:
Additional Property #3:	Address, City, State:
Additional Property #4:	Address, City, State:

### Bank Accounts

Please give the last 4 Digits of your Account #'s

Bank Name/Type:	Account Number(s):
Who's account?	JOINT      SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT      SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT      SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT      SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT      SEPARATE

Bank Name/Type:	Account Number(s):
Who's account?	JOINT      SEPARATE

Securities Owned (stocks, bonds, Mutual funds) Please give the last 4 digits of your account #  
 Client #1 Client #2

Broker's Name: Account Type: Account#		Broker's Name: Account Type: Account#	
Broker's Name: Account Type: Account #		Broker's Name: Account Type: Account #	
Broker's Name: Account Type: Account #		Broker's Name: Account Type: Account #	

Retirement Plans (IRA, 401K, Deferred Compensation) Please give the last 4 digits of your account #

Client #1

Client #2

Account Name: Account Type: Account #:		Account Name: Account Type: Account #:	
Account Name: Account Type: Account #:		Account Name: Account Type: Account #:	
Account Name: Account Type: Account #:		Account Name: Account Type: Account #:	

Life Insurance (Please give the last 4 digits of your account #)

Client #1

Client #2

Account Name: Account Type: Account #:		Account Name: Account Type: Account #:	
Account Name: Account Type: Account #:		Account Name: Account Type: Account #:	
Account Name: Account Type: Account #:		Account Name: Account Type: Account #:	

**Safe Deposit Box:**

<b>Location:</b>	<b>Box Number:</b>
<b>Location:</b>	<b>Box Number:</b>

**Other Assets (Own a business? Collectors Vehicles? Notes or Loans Owed to You?)**


I am signing this under penalty of perjury that I have provided all information known to me to my attorney and hold my attorney innocent of any excluded information I have not provided to her

Date: \_\_\_\_\_

\_\_\_\_\_  
*Client #1 signature*

\_\_\_\_\_  
*Client #2 signature*

\_\_\_\_\_  
Client #1 printed name:

\_\_\_\_\_  
Client #2 printed name: