



Trailhead Estate Planning

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Signal Mountain, TN 37377
(423) 228-7029
trailheadep.com

Estate Planning Questionnaire

Instructions: These questions pertain to the people named below for whom we are planning. We ask a lot of questions because we need a lot of information about you for our planning for you.

If a question is inapplicable to you, note "N/A" and skip to the next applicable question.

If you are unsure how to answer a question, have concerns, or need assistance, please contact us.

Note: The initial consultation to discuss your estate planning needs is **NOT a free consultation**. However, **completion of at least the first 7 pages** (as applicable) and submission of this form at least one calendar week prior to your initial appointment will entitle you to a **discount of up to one hour** of the consultation time.

Date _____ How did you hear about us? _____

1. Personal Information.

	Spouse 1 (i.e. you/one of you)	Spouse 2 (i.e. your spouse/fiancée)
Title (e.g., Dr.)		
Full Legal Name		
Preferred First and Last Name		
Address		
County		
D/O/B	Age:	Age:
Phone		
SSN		
*NOTE: Never email your SSN unless secured and encrypted.		
Email		
U.S. Citizen	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Veteran (for info on VA Aid & Attendance)	<input type="checkbox"/> No <input type="checkbox"/> Yes, Branch: Active Duty: <input type="checkbox"/> No <input type="checkbox"/> Yes Dates of service: Rank & Discharge:	<input type="checkbox"/> No <input type="checkbox"/> Yes, Branch: Active Duty: <input type="checkbox"/> No <input type="checkbox"/> Yes Dates of service: Rank & Discharge:

Marriage Information: Date and place of marriage _____

2. Children.

(Attach additional sheets if necessary.)

<p>Name _____</p> <p>Child of: _____</p> <p>D/O/B _____ Age _____</p> <p>Predeceased? D/O/D _____</p> <p>Address _____</p> <p>Email _____</p> <p>Telephone _____</p> <p>Spouse _____</p> <p>Children (and ages) _____</p> <p>Financial Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Marital Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Medical Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Benefits received? SSI / SSDI / Medicaid Other _____</p>	<p>Name _____</p> <p>Child of: _____</p> <p>D/O/B _____ Age _____</p> <p>Predeceased? D/O/D _____</p> <p>Address _____</p> <p>Email _____</p> <p>Telephone _____</p> <p>Spouse _____</p> <p>Children (and ages) _____</p> <p>Financial Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Marital Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Medical Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Benefits received? SSI / SSDI / Medicaid Other _____</p>
<p>Name _____</p> <p>Child of: _____</p> <p>D/O/B _____ Age _____</p> <p>Predeceased? D/O/D _____</p> <p>Address _____</p> <p>Email _____</p> <p>Telephone _____</p> <p>Spouse _____</p> <p>Children (and ages) _____</p> <p>Financial Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Marital Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Medical Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Benefits received? SSI / SSDI / Medicaid Other _____</p>	<p>Name _____</p> <p>Child of: _____</p> <p>D/O/B _____ Age _____</p> <p>Predeceased? D/O/D _____</p> <p>Address _____</p> <p>Email _____</p> <p>Telephone _____</p> <p>Spouse _____</p> <p>Children (and ages) _____</p> <p>Financial Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Marital Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Medical Trouble? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Benefits received? SSI / SSDI / Medicaid Other _____</p>

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)? ☐ No | ☐ Yes. Who? _____

3. Advisors.

Do you have the following advisors? (Attach additional pages if necessary.)

Accountant? <input type="checkbox"/> No <input type="checkbox"/> Yes. Who? _____ Company _____ Phone/email _____ When was the last time you reviewed your books/tax situation? _____ When was the last time you and your accountant talked? _____ How happy are you with the service you are getting? _____
Financial Advisor/Planner? <input type="checkbox"/> No <input type="checkbox"/> Yes. Who? _____ Company _____ Phone/email _____ When was the last time you and your financial advisor/planner reviewed your investments, portfolio, risk tolerance, and goals? _____ When was the last time you and your financial advisor/planner talked? _____ How happy are you with the service you are getting? _____
Life Insurance Agent? <input type="checkbox"/> No <input type="checkbox"/> Yes. Who? _____ Company _____ Phone/email _____ When was the last time you reviewed your life insurance portfolio, policy performance, risk analysis, and goals? _____ When was the last time you and your insurance agent talked? _____ How happy are you with the service you are getting? _____
Home/Auto Insurance Agent? <input type="checkbox"/> No <input type="checkbox"/> Yes. Who? _____ Company _____ Phone/email _____ When was the last time you reviewed your insurance portfolio, policy performance, risk analysis, and goals? _____ When was the last time you and your insurance agent talked? _____ How happy are you with the service you are getting? _____

Do your advisors know about what your other advisors are doing for you? _____

4. Resources.

A. Monthly Income.

(Pre-withholding numbers preferred.)

Type	Spouse 1	Source/Notes	Spouse 2	Source/Notes
Wages				
Rental				
Social Security				
Pension				
Other				
Total				

A. Business Interests.**(Attach additional pages if necessary.)**

These are your **interests in the businesses you own**. This is for businesses you are involved in beyond mere ownership of stock in a publicly traded company.

Business Name		Business Name	
Type (e.g., LLC)		Type (e.g., LLC)	
Share owned		Share owned	
Value of shares		Value of shares	
Other owners		Other owners	
Business Name		Business Name	
Type (e.g., LLC)		Type (e.g., LLC)	
Share owned		Share owned	
Value of shares		Value of shares	
Other owners		Other owners	

NOTE: Please attach a copy of the articles of incorporation, operating agreement/bylaws, and other business formation documents for further discussion.

B. Real Property.**(Attach additional sheets as necessary.)**

Primary Residence		Other Real Property	
Property Address		Property Address	
Names as on Deed		Names as on Deed	
Date Acquired		Date Acquired	
Purchase Price		Purchase Price	
Current Value		Current Value	
Tax-Appraised Value		Tax-Appraised Value	
Mortgage Company		Mortgage Company	
Mortgage Balance		Mortgage Balance	
Other Real Property		Other Real Property	
Property Address		Property Address	
Names as on Deed		Names as on Deed	
Date Acquired		Date Acquired	
Purchase Price		Purchase Price	
Current Value		Current Value	
Tax-Appraised Value		Tax-Appraised Value	
Mortgage Company		Mortgage Company	
Mortgage Balance		Mortgage Balance	

C. Qualified Accounts.

(Attach additional pages if necessary.)

These are your retirement plans, such as **IRAs, 401(k)s, 403(b)s**, and the like.

Type (e.g., 401(k) IRA)		Type (e.g., 401(k) IRA)	
Managing Company		Managing Company	
Value (to hundreds)		Value (to hundreds)	
Owner (e.g., Sp1 name)		Owner (e.g., Sp1 name)	
Primary beneficiary		Primary beneficiary	
Contingent beneficiary(ies)		Contingent beneficiary(ies)	
Type (e.g., 401(k) IRA)		Type (e.g., 401(k) IRA)	
Managing Company		Managing Company	
Value (to hundreds)		Value (to hundreds)	
Owner (e.g., Sp1 name)		Owner (e.g., Sp1 name)	
Primary beneficiary		Primary beneficiary	
Contingent beneficiary(ies)		Contingent beneficiary(ies)	

D. Non-Qualified Investments and Accounts.

(Attach additional pages if necessary.)

These are your **bank accounts, CD's, annuities, stocks, bonds, mutual funds, money market accounts**, and the like. **NOTE:** TOD/POD means "Transfer on Death" or "Payable on Death."

Type (e.g., savings)		Type (e.g., savings)	
Company (i.e., where)		Company (i.e., where)	
Value (to hundreds)		Value (to hundreds)	
Owner and type (e.g., Sp1/Sp2 jointly)		Owner and type (e.g., Sp1/Sp2 jointly)	
TOD/POD?		TOD/POD?	
Type (e.g., savings)		Type (e.g., savings)	
Company (i.e., where)		Company (i.e., where)	
Value (to hundreds)		Value (to hundreds)	
Owner and type (e.g., Sp1/Sp2 jointly)		Owner and type (e.g., Sp1/Sp2 jointly)	
TOD/POD?		TOD/POD?	
Type (e.g., savings)		Type (e.g., savings)	
Company (i.e., where)		Company (i.e., where)	
Value (to hundreds)		Value (to hundreds)	
Owner and type (e.g., Sp1/Sp2 jointly)		Owner and type (e.g., Sp1/Sp2 jointly)	
TOD/POD?		TOD/POD?	

E. Life Insurance.**(Attach additional pages if necessary.)**

Type (e.g., whole, group, term 20y from MM/DD/YY)		Type (e.g., whole, group, term 20y from MM/DD/YY)	
Issuing Company		Issuing Company	
Owner (e.g., Spl name)		Owner (e.g., Spl name)	
Insured		Insured	
Death Benefit (face value)		Death Benefit (face value)	
Cash surrender value		Cash surrender value	
Loans against (if any)		Loans against (if any)	
Primary Beneficiary		Primary Beneficiary	
Contingent beneficiary(ies)		Contingent beneficiary(ies)	
Type (e.g., whole, group, term 20y from MM/DD/YY)		Type (e.g., whole, group, term 20y from MM/DD/YY)	
Issuing Company		Issuing Company	
Owner (e.g., Spl name)		Owner (e.g., Spl name)	
Insured		Insured	
Death Benefit (face value)		Death Benefit (face value)	
Cash surrender value		Cash surrender value	
Loans against (if any)		Loans against (if any)	
Primary Beneficiary		Primary Beneficiary	
Contingent beneficiary(ies)		Contingent beneficiary(ies)	

F. Personal Property.**(Attach additional pages if necessary.)**

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins and stamps, guns, etc.)

Personal Property (Item)	Value	Current Owner

G. Money You Owe (non-mortgage debt).**(Attach additional pages if necessary.)**

Debt Type	Who owes the debt?	Creditor's Name	Amount Owed
		Total	

5. Gifts and Transfers.

Have you made any sizable gifts or transfers, greater than \$1,500.00? ☐ No | ☐ Yes

If yes, please provide details for each gift or transfer here or on a separate page.

6. Information About Your Health.

Spouse 1 (i.e. you/one of you)	Spouse 2
1. If any, what medical or health problems do you currently have?	1. If any, what medical or health problems do you currently have?
2. If any, what medical problems have you had in the past?	2. If any, what medical problems have you had in the past?

7. Other “Big Picture” Concerns.

Are either of you in a high risk (liability) profession? ☐ No | ☐ Yes

Are either of you worried about other potential creditors? ☐ No | ☐ Yes

Are either of you worried about the costs of long-term care? ☐ No | ☐ Yes

Are you worried about gift and estate taxes? ☐ No | ☐ Yes

Are you worried about capital gains taxes? ☐ No | ☐ Yes

Do you want to keep your estate plan out of the public record at your death? ☐ No | ☐ Yes

Are you worried about the costs of probate administration at your death? ☐ No | ☐ Yes

Are you worried about shielding a child’s inheritance until he/she can handle it? ☐ No | ☐ Yes

8. Estate Planning.

Mark in the box that applies. **Please bring the existing documents with you to our meeting.**

Do you have any of the following documents?	Spouse 1 (i.e. you / one of you)	If so, when was it made?	Spouse 2	If so, when was it made?
Power of Attorney	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Health Care Power of Attorney	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Living Will	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Will	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Revocable Living Trust	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Irrevocable Trust	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Beneficiary of a trust made by another	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	

Note The following sections are to be completed for each of you. Please read all the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.)

We will discuss what tools match your “big picture” goals with your choices listed below.

Attorney Notes:

Descendant POAppt? ☐GPOA | ☐LPOA | ☐None Adopted? ☐Any | ☐Minors
Revoke prior DGPOA? ☐No | ☐Yes TProt? ☐No | ☐Yes
QF Tax summary? ☐No | ☐Yes Keep? ☐TEP | ☐Client

A. Spouse 1:

i. Specific Bequests.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

ii. Division of Estate.

Rank to at least the 3rd level of priority how you want the rest of your property to be divided on your death **and in what percentages**. Leave a line blank if you do not want that distribution. **Example:** “All to spouse, else equally to children with grandchildren taking a predeceased child’s share” would be “#1 100% spouse; #2 100% children; #3 100% grandchildren, dividing their parent’s share.”

If you give two groups the same rank, that indicates you wish to split the property between the groups at that rank level. **Example:** “If the #1 ranked beneficiary predeceases, split between Friend A and Church X” would be “#2 50% Friend A; #2 50% Church X.”

We'll talk about **how** your beneficiaries receive this property at our meeting.

#___ ___% to my spouse.

#___ ___% to my children, divided equally.

#___ ___% to my spouse’s children, divided equally.

#___ ___% to my grandchildren, dividing their parent’s share.

#___ ___% to all my grandchildren, divided equally, regardless of family size.

#___ ___% to friends and family named below.

#___ ___% to charities/causes named below.

#___ ___% in a different manner than the above options.

Names/Notes for above	
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iii. Fiduciaries to carry out estate plan.

(Attach additional sheets if necessary.)

Rank whom you want to serve as your executor. If you want two people to serve at the same time, rank them at the same level. **Co-executors must serve jointly**, and therefore it is not recommended to have more than two co-executors serving at a time.

# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Rank whom you want to serve as guardian of minor children, if needed. If you want two or more people to serve at the same time, rank them at the same level. **Co-guardians' decisions will be by majority**, so more than two may serve at a time, but too many guardians will make administration difficult.

# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Rank whom you want to serve as trustee, if needed. If you want two or more people to serve at the same time, rank them at the same level. **Co-trustees may serve jointly, by majority or independently, as you indicate below.** Joint (Jt.) co-trustees must ALL agree, so too many may make administration unworkable. Majority (Maj.) rule avoids lone dissenter paralysis but should have an odd number of co-trustees to prevent deadlock. Independent (Ind.) co-trustees are the most flexible due to their independence, but they must communicate well to avoid confusion and cancelling each other out.

# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

iv. Decision Making.

Legal and Financial.

Decision makers. If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? **Please list and rank the individuals you trust to take care of your legal, business, personal, and financial affairs.** If you want more than one agent (“attorney-in-fact”), please indicate whether these co-agents are serving jointly (**Jt.**), by majority (**Maj.**), or independently (**Ind.**). Again, too many individuals named at the same time can make administration difficult.

#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Do you want these people (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?

☐ No | ☐ Yes | ☐ Don't know.

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my attorney-in-fact to make the right decision.

☐ My restrictions are: _____

Health Care.

Decision makers. If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? **Please list and rank the individuals you trust to be your health care advocate.** If you want more than one advocate, please indicate whether these co-agents are serving jointly (**Jt.**), by majority (**Maj.**), or independently (**Ind.**). Again, too many individuals named at the same time can make administration difficult.

#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Quality of Life. Which of the following conditions would you be willing to live with if you had adequate comfort care and pain management?

<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	Permanent unconsciousness. You are totally unaware of people or your surroundings and have little chance of ever waking.
<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	Permanent confusion. You are unable to remember, understand, or make decisions, and you do not recognize loved ones or have a clear conversation with them.
<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	Dependent in all activities of daily living. You are no longer able to communicate clearly or move and are completely dependent on others for feeding, bathing, dressing, and walking with no chance to recover through rehabilitation or other treatment.
<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	End-Stage Illness. You have an illness that reached its final stages despite full treatment, and you are no longer able to communicate your wishes.

If and **only if** your quality of life becomes **unacceptable** under one of the scenarios above, do you want any of the following treatments?

<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	CPR (Cardiopulmonary Resuscitation). Attempt to cause your heart to beat again and restore breathing when you have an unacceptable quality of life condition.
<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	Life Support. Continuous use of equipment to help the lungs, heart, kidneys, or other organs continue to function when you have an unacceptable quality of life condition.
<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	Treatment of New Conditions. Use of surgery, antibiotics or other treatments to address a new condition, but which will not help the main unacceptable quality of life condition.
<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	Tube Feeding/IV fluids. Use of tubes to deliver food/nutrition and water to your stomach or a vein when you have an unacceptable quality of life condition.

Do you wish hospice if medically appropriate? ☐ No | ☐ Yes. Notes: _____

When health care decisions must be made on your behalf, do you have any religious beliefs that need to be taken into account? ☐ No | ☐ Yes. What preferences? _____

Do you wish <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> No preference <input type="checkbox"/> Other:
Do you have a prepaid funeral or burial? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you discussed your final arrangements with any family, your religious/spiritual advisor or funeral director? <input type="checkbox"/> No <input type="checkbox"/> Yes. Details:

Do you want to be an organ donor? ☐ No | ☐ Yes | ☐ Don't know.

Do you want to meet a guide (a/k/a “death doula”) to work with you on other items such as personal property memoranda and letters to family, as well as comprehensive final arrangement options (e.g., church service options and resting place options)? ☐ No | ☐ Yes.

Attorney Notes:

Descendant POAppt? ☐GPOA | ☐LPOA | ☐None Adopted? ☐Any | ☐Minors
Revoke prior DGPOA? ☐No | ☐Yes TProt? ☐No | ☐Yes
QF Tax summary? ☐No | ☐Yes Keep? ☐TEP | ☐Client

B. Spouse 2:

i. Specific Bequests.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

ii. Division of Estate.

Rank to at least the 3rd level of priority how you want the rest of your property to be divided on your death **and in what percentages**. Leave a line blank if you do not want that distribution. **Example:** "All to spouse, else equally to children with grandchildren taking a predeceased child's share" would be "#1 100% spouse; #2 100% children; #3 100% grandchildren, dividing their parent's share."

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#___ ___% to my spouse.

#___ ___% to my children, divided equally.

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#___ ___% to all my grandchildren, divided equally, regardless of family size.

#___ ___% to friends and family named below.

#___ ___% to charities/causes named below.

#___ ___% in a different manner than the above options.

Names/Notes for above	
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iii. Fiduciaries to carry out estate plan.

(Attach additional sheets if necessary.)

Rank whom you want to serve as your executor. If you want two people to serve at the same time, rank them at the same level. **Co-executors must serve jointly**, and therefore it is not recommended to have more than two co-executors serving at a time.

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Rank whom you want to serve as guardian of minor children, if needed. If you want two or more people to serve at the same time, rank them at the same level. **Co-guardians' decisions will be by majority**, so more than two may serve at a time, but too many guardians will make administration difficult.

# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
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# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Rank whom you want to serve as trustee, if needed. If you want two or more people to serve at the same time, rank them at the same level. **Co-trustees may serve jointly, by majority or independently, as you indicate below.** Joint (Jt.) co-trustees must ALL agree, so too many may make administration unworkable. Majority (Maj.) rule avoids lone dissenter paralysis but should have an odd number of co-trustees to prevent deadlock. Independent (Ind.) co-trustees are the most flexible due to their independence, but they must communicate well to avoid confusion and cancelling each other out.

# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
# ____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

iv. Decision Making.

Legal and Financial.

Decision makers. If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? **Please list and rank the individuals you trust to take care of your legal, business, personal, and financial affairs.** If you want more than one agent (“attorney-in-fact”), please indicate whether these co-agents are serving jointly (**Jt.**), by majority (**Maj.**), or independently (**Ind.**). Again, too many individuals named at the same time can make administration difficult.

#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Do you want these people (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?

☐ No | ☐ Yes | ☐ Don't know.

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my attorney-in-fact to make the right decision.

☐ My restrictions are: _____

Health Care.

Decision makers. If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? **Please list and rank the individuals you trust to be your health care advocate.** If you want more than one advocate, please indicate whether these co-agents are serving jointly (**Jt.**), by majority (**Maj.**), or independently (**Ind.**). Again, too many individuals named at the same time can make administration difficult.

#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____
#____ <input type="checkbox"/> Jt. <input type="checkbox"/> Maj. <input type="checkbox"/> Ind.	Name: _____ Relationship: _____	Address: _____	Ph: _____ Em: _____

Quality of Life. Which of the following conditions would you be willing to live with if you had adequate comfort care and pain management?

<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	Permanent unconsciousness. You are totally unaware of people or your surroundings and have little chance of ever waking.
<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	Permanent confusion. You are unable to remember, understand, or make decisions, and you do not recognize loved ones or have a clear conversation with them.
<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	Dependent in all activities of daily living. You are no longer able to communicate clearly or move and are completely dependent on others for feeding, bathing, dressing, and walking with no chance to recover through rehabilitation or other treatment.
<input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable	End-Stage Illness. You have an illness that reached its final stages despite full treatment, and you are no longer able to communicate your wishes.

If and **only if** your quality of life becomes **unacceptable** under one of the scenarios above, do you want any of the following treatments?

<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	CPR (Cardiopulmonary Resuscitation). Attempt to cause your heart to beat again and restore breathing when you have an unacceptable quality of life condition.
<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	Life Support. Continuous use of equipment to help the lungs, heart, kidneys, or other organs continue to function when you have an unacceptable quality of life condition.
<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	Treatment of New Conditions. Use of surgery, antibiotics or other treatments to address a new condition, but which will not help the main unacceptable quality of life condition.
<input type="checkbox"/> May Use <input type="checkbox"/> Do Not Use	Tube Feeding/IV fluids. Use of tubes to deliver food/nutrition and water to your stomach or a vein when you have an unacceptable quality of life condition.

Do you wish hospice if medically appropriate? ☐ No | ☐ Yes. Notes: _____

When health care decisions must be made on your behalf, do you have any religious beliefs that need to be taken into account? ☐ No | ☐ Yes. What preferences? _____

Do you wish <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> No preference <input type="checkbox"/> Other:
Do you have a prepaid funeral or burial? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you discussed your final arrangements with any family, your religious/spiritual advisor or funeral director? <input type="checkbox"/> No <input type="checkbox"/> Yes. Details:

Do you want to be an organ donor? ☐ No | ☐ Yes | ☐ Don't know.

Do you want to meet a guide (a/k/a “death doula”) to work with you on other items such as personal property memoranda and letters to family, as well as comprehensive final arrangement options (e.g., church service options and resting place options)? ☐ No | ☐ Yes.