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ESTATE PLANNING INQUIRY FORMS

PART I - PERSONAL DATA

NAME of DECLARANT: _____

Alias Names (if any): _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Telephone: _____ **Cell:** _____

Email Address: _____

Date of Birth: _____

Place of Birth: _____

Driver's License Number: _____

Social Security Number: _____

Is Declarant a U.S. citizen? Yes: _____ **No:** _____

If naturalized U.S. citizen, Date and Place of Naturalization: _____

I wish to obtain and execute the following documents:

☐ **Part II: Last Will and Testament**

☐ **Part III: Durable Power of Attorney**

☐ **Part IV: Medical Power of Attorney**

☐ **Part V: HIPPA Release**

☐ **Part VI: Directive to the Physician**

Please complete the attached information worksheet for each of the documents you are requesting. **You should use full legal names.**

PART II - WILL

CHILDREN'S INFORMATION:

Name	Living?	Age	Birthdate	Married?	City/State of Residence
	Yes/No			Yes/No	
	Yes/No			Yes/No	
	Yes/No			Yes/No	
	Yes/No			Yes/No	
	Yes/No			Yes/No	
	Yes/No			Yes/No	

For each child, state the name of the child's other parent if not your present spouse. _____

OTHER DEPENDENTS, IF ANY:

Name: Age: Residence:

GRANDCHILDREN'S INFORMATION, IF ANY:

Name: Age: Birthdate: Names of parents:

Please list the names of your parents, brothers, and sisters, and state whether they are living, and if so, list their city and state of residence.

Name:	Relationship:	Living?	Residence:
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	

List, as well, the same information for your spouse's parents and siblings.

Name:	Relationship:	Living?	Residence:
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	

Please provide the following information regarding any former marriages, if any:

Name of former spouse: _____
Living? _____
Date of Death and/or Divorce: _____

Please provide the following information regarding your spouse's former marriages, if any:

Name of former spouse: _____
Living? _____
Date of Death and/or Divorce: _____

Do you presently have a Will? Yes: ___ No: ___ If so, what is the date on the Will? _____
Was it signed in Texas? Yes: ___ No: ___ If not, where? _____
_____
Amended Will or Codicil? Yes: ___ No: ___ Date: _____

Spouse presently has a Will? Yes: ___ No: ___ If so, what is the date on the Will? _____
Was it signed in Texas? Yes: ___ No: ___ If not, where? _____
_____
Amended Will or Codicil? Yes: ___ No: ___ Date: _____

Are you a beneficiary, trustee (singly or jointly), or creator of a trust? Yes: ___ No: ___ If so, what is the name and date of the trust? _____
_____

Is your spouse a beneficiary, trustee (singly or jointly), or creator of a trust? Yes: ___ No: ___ If so, what is the name and date of the trust? _____
_____

PART II-a
YOUR DISPOSITIVE PLAN

Describe in general terms how you wish to distribute your property under your will: _____

PART II-b
SPOUSE'S DISPOSITIVE PLAN

Describe in general terms how you wish to distribute your property under your will: _____

Describe in SPECIFIC terms how you wish to distribute any particular property under your will, *(i.e. gold watch from my grandfather to my son, John):* _____

If your children are beneficiaries of your property, do you want the property to be distributed to your children outright or in trust until a certain date?

If your grandchildren are beneficiaries of your property, do you want the property to be distributed to your grandchildren outright or in trust until a certain date?

Do you wish to include:

- ☐ **NO CONTEST CLAUSE**
- ☐ **FUNERAL ARRANGEMENTS**

PART II-c - YOUR DESIGNEES

EXECUTOR *(i.e., the person who will be responsible for probating your will, filing the estate tax return, if necessary, and distributing assets to the beneficiaries)*

Name of Executor: _____
1st Alternate Executor: _____
2nd Alternate Executor: _____
3rd Alternate Executor: _____

Complete the following section if your spouse is requesting different persons be named:

Name of Executor: _____
1st Alternate Executor: _____
2nd Alternate Executor: _____
3rd Alternate Executor: _____

TRUSTEE (i.e., the person who will be responsible for the long-term management of property for the surviving spouse, children or other beneficiaries)

Name of Trustee: _____
1st Alternate Trustee: _____
2nd Alternate Trustee: _____
3rd Alternate Trustee: _____

Complete the following section if your spouse is requesting different persons be named:

Name of Trustee: _____
1st Alternate Trustee: _____
2nd Alternate Trustee: _____
3rd Alternate Trustee: _____

GUARDIAN OF MINOR CHILDREN (i.e. the person who will take physical care of your minor children should both parents die)

Name of Guardian: _____
1st Alternate Guardian: _____
2nd Alternate Guardian: _____
3rd Alternate Guardian: _____

Complete the following section if your spouse is requesting different persons be named:

Name of Guardian: _____
1st Alternate Guardian: _____
2nd Alternate Guardian: _____
3rd Alternate Guardian: _____

PART III - DURABLE POWER OF ATTORNEY:

(*Complete this information for yourself and your spouse; Make copies of these pages, if necessary.)*

NAME of PERSONAL REPRESENTATIVE, for Durable Power of Attorney:: _____

_____

Street Address: _____
City: _____
State: _____
Zip Code: _____
Home #: _____
Cell #: _____
Work #: _____
Fax #: _____
E-mail: _____
Relationship to Declarant, if any: _____

NAME of ALTERNATE REPRESENTATIVE: _____

_____

Street Address: _____
City: _____
State: _____
Zip Code: _____
Home #: _____
Cell #: _____
Work #: _____
Fax #: _____
E-mail: _____
Relationship to Declarant, if any: _____

Do you wish this document to take effect:

- ☐ **IMMEDIATELY**
- ☐ **UPON CERTIFICATION OF INCAPACITY**

PART IV: MEDICAL POWER OF ATTORNEY

Complete this information for the person(s) to be named in the medical power of attorney with authority to act on behalf of the Declarant. If the Personal Representative and First Alternate are the same as set out above, you may complete on the information for the Second Alternate.

NAME of PERSONAL REPRESENTATIVE, for Durable Power of Attorney:: _____

Street Address: _____
City: _____
State: _____
Zip Code: _____
Home #: _____
Cell #: _____
Work #: _____
Fax #: _____
E-mail: _____
Relationship to Declarant, if any: _____

NAME of FIRST ALTERNATE REPRESENTATIVE: _____

Street Address: _____
City: _____
State: _____
Zip Code: _____
Home #: _____
Cell #: _____
Work #: _____
Fax #: _____
E-mail: _____
Relationship to Declarant, if any: _____

NAME of SECOND ALTERNATE REPRESENTATIVE: _____

Street Address: _____
City: _____
State: _____
Zip Code: _____
Home #: _____
Cell #: _____
Work #: _____
Fax #: _____
E-mail: _____
Relationship to Declarant, if any: _____

PART V - HIPAA RELEASE

Please provide the following information for each and every person that the Declarant is authorizing to have access to their medical condition should they be hospitalized, become incapacitated or need to act on behalf of the Declarant. Repeat for each person to be named.

NAME: ______________________________
Street Address: ______________________________
City: ______________________________
State: ______________________________
Zip Code: ______________________________
Home #: ______________________________
Cell #: ______________________________
Work #: ______________________________
Fax #: ______________________________
E-mail: ______________________________
Relationship to Declarant, if any: ______________________________

NAME: ______________________________
Street Address: ______________________________
City: ______________________________
State: ______________________________
Zip Code: ______________________________
Home #: ______________________________
Cell #: ______________________________
Work #: ______________________________
Fax #: ______________________________
E-mail: ______________________________
Relationship to Declarant, if any: ______________________________

NAME: ______________________________
Street Address: ______________________________
City: ______________________________
State: ______________________________
Zip Code: ______________________________
Home #: ______________________________
Cell #: ______________________________
Work #: ______________________________
Fax #: ______________________________
E-mail: ______________________________
Relationship to Declarant, if any: ______________________________

PART VI- DIRECTIVE TO THE PHYSICIAN

Please provide the following information for instructions you wish your physician(s) to follow if you are unable to make these decisions yourself.

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

CHOSE ONE:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

OR

____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

AND

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

OR

____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.) _____

_____

_____