



**LAW OFFICES OF RICHARD SAX**  
**ESTATE PLANNING QUESTIONNAIRE**



Your name: \_\_\_\_\_ aka \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ aka \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Are you a U.S. citizen? Yes \_\_\_\_\_ No \_\_\_\_\_ Is your spouse a citizen? Yes \_\_\_\_\_ No \_\_\_\_\_

Marital status: Married \_\_\_\_\_ Unmarried \_\_\_\_\_ Date of marriage: \_\_\_\_\_

Any previous marriages (indicate number for each): Yourself \_\_\_\_\_ Your Spouse \_\_\_\_\_

Name(s) of former spouse(s); date of termination of each previous marriage; reason for termination (death/dissolution):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRESUMED BENEFICIARIES:**

Any living children of your current marriage?

NAME/ADDRESS: SEX: DOB: NICKNAME:

Any deceased children of your current marriage?

NAME/ADDRESS: SEX: DOB: NICKNAME:



Buy-sell agreement or restriction on transfer of shares?

PARTNERSHIPS:

NAME:      LOCATION:      TYPE OF PARTNERSHIP:      VALUE:      COST:      TITLE:

Buy-sell agreement or restriction on transfer of shares?

STOCKS AND BONDS:

COMPANY OR BROKERAGE NAME (# of shares):      ACCOUNT #:      TITLE:

\*\*\*\*\*Certificates and copies of monthly statements\*\*\*\*\*

MUTUAL FUNDS:

NAME OF FUND:      ACCOUNT #:      TITLE:

\*\*\*\*\*Certificates, and copies of last monthly statement\*\*\*\*\*

TREASURY BONDS, ETC:

TYPE:      ACCOUNT #:      TITLE:

\*\*\*\*\*Certificates, and copies of last monthly statement\*\*\*\*\*



VEHICLES:

ASSET:

VALUE:

COST:

TITLE:

MISCELLANEOUS ASSETS (Antiques, Coin Collections, etc.):

ASSET:

VALUE:

COST:

TITLE:

Any IRA's? \_\_\_\_\_ Any Annuities? \_\_\_\_\_

Any Marital Settlement Agreements/ Pre-Marital Agreements?

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NOTES

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FIDUCIARIES (Trustees/Executors/Guardians/Attorneys-in-Fact/Health Care Agents)

Persons whom you wish to name as trustees of your living trust, executors of your will(s), guardians (of minor children or pets), and holders of your powers of attorney for property management and for health care.

FULL NAMES OF TRUSTEES:    ADDRESS:                    PHONE:                    RELATIONSHIP:

FULL NAMES OF EXECUTORS: ADDRESS:                    PHONE:                    RELATIONSHIP:

FULLS NAMES OF GUARDIANS: ADDRESS:                    PHONE:                    RELATIONSHIP:

**(NOTE: PLEASE LET US KNOW IF THESE ARE ALL THE SAME DESIRED PERSONS  
WHEN TRUST IS FOR A COUPLE)**

HEALTH CARE AGENTS (AHCD):  
FULL NAME:                    ADDRESS:                    PHONE:                    RELATIONSHIP:

FINANCIAL CARE AGENTS (DPOA):  
FULL NAME:                    ADDRESS:                    PHONE:                    RELATIONSHIP:

ASSET TO BE DISTRIBUTED IN AN UNEQUAL WAY:  
BENEFICIARY(ies) (and percentages, if applicable):

OUTRIGHT OR IN TRUST?

DISTRIBUTION OF BALANCE OF YOUR ESTATE:

\_\_\_\_\_ Distribution in equal shares to your children; if any are deceased, his or her share to be distributed to his or her issue by right of representation OR

\_\_\_\_\_ Distribution to your children (or other beneficiaries) in specific percentages:

NAME OF BENEFICIARY:

PERCENTAGE:

TRUST FOR ANY MINOR BENEFICIARIES?

If so, distribution in how many stages? \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3

Age(s) of distribution for minor trusts:

Stage 1 \_\_\_\_\_ Stage 2 (if any) \_\_\_\_\_ Stage 3 (if any) \_\_\_\_\_

\_\_\_\_\_ CHECK HERE IF SPOUSES HAVE DIFFERING BEQUESTS AND NOTE DIFFERENCES BELOW:

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For married couples, indicate any gifts to someone other than spouse at either spouse's death prior to death of surviving spouse:

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Other Distribution Provisions

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Any children or relatives to be excluded as a beneficiary? \_\_\_\_\_ YES      \_\_\_\_\_ NO  
Do you expect the Estate to be contested?                      \_\_\_\_\_ YES      \_\_\_\_\_ NO  
Do you want a "no contest" clause?                              \_\_\_\_\_ YES      \_\_\_\_\_ NO

COMMENTS:

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MISCELLANEOUS QUESTIONS:

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PRIMARY MEDICAL DOCTOR:

NAME:                      ADDRESS:

FUNERAL ARRANGEMENTS:

PREPAID BURIAL PLAN?  YES     NO

WHERE:

PLEASE WRITE YES OR NO:

Cremation                       Die at home                       Medical or Scientific Purposes  
 Buried                       With Military Honors                       Organ Donation  
 Authorize Autopsy

Religious Preferences?     YES     NO    DENOMINATION: \_\_\_\_\_

Do any of your children or others dependent on you have special needs due to mental or physical disabilities?     YES     NO

Comments:

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Are you supporting any persons other than your spouse or children (such as parents, brothers or sisters, etc.)?     YES     NO

Comments:

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If you are SINGLE, WITHOUT CHILDREN, whom would you want to receive your estate?

NAME(S):            RELATIONSHIP TO YOU:    ADDRESS:                            PERCENTAGE:

If one of the persons you named does not survive you, do you want such person's share to go to his/her children, if he/she has any?         YES     NO    PERCENTAGE: \_\_\_\_\_

How long must someone survive you to be able to receive a benefit from the trust? \_\_\_\_\_

Do you want to have pain relief, even if it were to hasten your death?

YES     NO

Do you want to be on life support if you are terminal?

YES     NO

Do you have any pets to be cared for?

YES     NO

NOTES: