



ESTATE PLANNING WORKBOOK (MARRIED)

Please complete this Workbook to the best of your ability. Your answers to the questions asked herein will allow us to provide you with the most appropriate counsel and care. If you have a question about any of the information requested, or are unsure how to answer any question asked herein, please leave it blank and we can review it with you at your appointment.

A. PERSONAL INFORMATION

HUSBAND

Full Legal Name _____ Nickname: _____
(print name as shown on your checks and other financial accounts)

Email Address _____

Cell Number _____ Home Number _____

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security No. _____

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

WIFE

Full Legal Name _____ Nickname: _____
(print name as shown on your checks and other financial accounts)

Email Address _____

Cell Number _____ Home Number _____

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security No. _____

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

B. FAMILY

1. CHILDREN (if applicable)

Child's Name	Address (including zip code)	Date of Birth

Does the Husband have any children by a previous marriage? Yes No
 If so, who? _____

Does the Wife have any children by a previous marriage? Yes No
 If so, who? _____

Are all of your children in good health? Yes No

Are any of your children blind or disabled? Yes No

Are any of your children receiving SSI or other form of government entitlement? Yes No

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

Child is receiving: Medicaid Medicare Veterans Disability Benefit

Do any of your family members have any problems with:

- Drug Addiction? Yes No
- Alcoholism? Yes No
- Spendthrift? Yes No
- Marital Difficulty? Yes No
- Financial Difficulty? Yes No

2. GRANDCHILDREN

Grandchild's Name	Address (including zip code)	Date of Birth

Do you wish to treat all of your grandchildren equally? Yes No

If not, why? _____

Do you want to leave your grandchildren a specific bequest or percentage distribution upon the death of either of you? Yes No

If so, how much do you want to leave your grandchildren? _____

Are any of your grandchildren disabled? Yes No

Are any of your grandchildren receiving SSI or other form of government entitlement? Yes No

Grandchild is receiving: Medicaid Medicare Veterans Disability Benefit

At what age do you want distributions to your grandchildren? _____

(You might decide to distribute funds to adult grandchildren immediately, or you may decide to hold the assets in trust for your grandchildren until they reach certain ages. For example, you may want your grandchildren to receive 1/3 of their share at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35, or any other age/ages that make sense to you.)

3. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than your spouse, children, grandchildren, i.e., charity or other person?

Yes No

If yes, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

C. FINANCIAL SUMMARY - Please bring spreadsheet of your financial assets or fill out the information requested below and bring most recent statements, if possible.

		<u>ASSETS</u>		<u>LIABILITIES</u>
	Husband	Wife	Joint	
Bank Accounts	\$ _____	\$ _____	\$ _____	\$ _____
Real Estate (residence) <i>[bring copy of deed, if possible]</i>	\$ _____	\$ _____	\$ _____	\$ _____
Real Estate (other) <i>[bring copies of all deeds, if possible]</i>	\$ _____	\$ _____	\$ _____	\$ _____
Non-Retirement Investments <i>(Brokerage Accounts, Stock, Mutual Fund, CDs, etc.)</i>	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
Non-Retirement Account Annuities	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
Retirement Account Assets <i>(IRAs, 401(k), 403(b), etc.)</i>	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
	\$ _____	\$ _____	\$ _____	\$ _____
Business Interests <i>[if any]</i>	\$ _____	\$ _____	\$ _____	\$ _____
Anticipated Inheritance <i>[if any]</i>	\$ _____	\$ _____	\$ _____	\$ _____
Life Insurance	\$ _____	\$ _____	\$ _____	\$ _____
TOTALS	\$ _____	\$ _____	\$ _____	\$ _____

Personal Residence:

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

(2) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

D. LAST WILL AND TESTAMENT

DISPOSITIVE INTENTIONS - SPOUSE AND CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children? Yes No

Do you wish to treat all of your children equally? Yes No

If not, why? _____

EXECUTOR

Whom do you want to serve as your Executor?

(Husband)

First Choice: ___ Spouse ___ Other _____

Second Choice _____

Third Choice _____

(Wife)

First Choice: ___ Spouse ___ Other _____

Second Choice _____

Third Choice _____

TRUSTEE

If a Trust is established whom do you want to serve as your Trustee?

(Husband)

First Choice _____

Second Choice _____

(Wife)

First Choice _____

Second Choice _____

GUARDIAN

If you have **minor** or **disabled** child/children, whom do you want to act as Guardian?

First Choice _____

Second Choice _____

E. POWER OF ATTORNEY

Do either of you currently have a Power of Attorney? Yes No

(Husband)

First Choice _____
(Name) (Address)

Second Choice _____
(Name) (Address)

(Wife)

First Choice _____
(Name) (Address)

Second Choice _____
(Name) (Address)

F. LIVING WILL

(Husband)

Do you want a Living Will? Yes No

Do you want your Living Will to provide for withdrawal of artificial food and fluid? Yes No

Do you want to donate your eyes or organs? Yes No

Whom do you want to make your medical decisions?

First Choice _____
(Name) (Address)

Second Choice _____
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?

Yes No

If yes, with whom? _____

(Wife)

Do you want a Living Will? Yes No

Do you want your Living Will to provide for withdrawal of artificial food and fluid? Yes No

Do you want to donate your eyes or organs? Yes No

Whom do you want to make your medical decisions?

First Choice _____
(Name) (Address)

Second Choice _____
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?

Yes No

If yes, with whom? _____

G. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain _____

H. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Have you visited our Website? Yes No

I. CERTIFICATION

The undersigned hereby represents to Fendrick Morgan that the information contained in this intake form is accurate and complete. The undersigned is aware that the law firm will rely on this information and further understands that the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:
