

The Law Offices of Nancy M. Rice
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ESTATE PLANNING QUESTIONNAIRE

HUSBAND'S NAME:

First MI Last

Also Known As (if any) Date of Birth

SOCIAL SECURITY #

WIFE'S NAME:

First MI Last

Also Known As (if any) Date of Birth

SOCIAL SECURITY #

HOME ADDRESS:

HOME TELEPHONE:

HUSBAND'S OCCUPATION:

EMPLOYER'S NAME:

ADDRESS:

WORK TELEPHONE:

WIFE'S OCCUPATION:

EMPLOYER'S NAME:

ADDRESS:

WORK TELEPHONE:

DATE OF MARRIAGE: _____

HAVE YOU ENTERED ANY PRENUPTIAL, POSTNUPTIAL OR PROPERTY SETTLEMENT AGREEMENT WITH YOUR SPOUSE REGARDING DIVISION OF PROPERTY UPON DIVORCE OR DEATH? Yes ___ No ___

IS THIS HUSBAND'S FIRST MARRIAGE? Yes ___ No ___

If no, please list date(s) and method of termination (death, divorce, annulment) of prior marriages including name(s) of former spouse(s): _____

IS THIS WIFE'S FIRST MARRIAGE? Yes ___ No ___

If no, please list date(s) and method of termination (death, divorce, annulment) of prior marriages including name(s) of former spouse(s): _____

IF DIVORCED, indicate whether you entered any property settlement agreements with a former spouse:

ARE YOU BOTH UNITED STATES CITIZENS? Yes ___ No ___

If no, please indicate which spouse is not a U.S. and country of citizenship: _____

ARE YOU BOTH IN GOOD HEALTH? Yes ___ No ___

If no, please indicate the diagnosis of your ailment(s): _____

PLEASE INDICATE IF EITHER OF YOU HAVE HAD RECENT HOSPITALIZATIONS: Yes ___ No ___

DO EITHER OF YOU HAVE LONG TERM CARE INSURANCE? Yes ___ No ___

If yes, please indicate from which company, what the monthly or daily benefit is and the terms: _____

DO EITHER OF YOU HAVE HEALTH INSURANCE THAT SUPPLEMENTS MEDICARE ("Medigap")?

Yes ___ No ___

If yes, please indicate which company: _____

ARE EITHER OF YOU A VETERAN OF THE UNITED STATES ARMED FORCES? Yes ___ No ___

HOW WERE YOU REFERRED TO OUR FIRM? _____

WHAT TYPE OF SERVICE ARE YOU INTERESTED IN US PROVIDING FOR YOU?

- Estate Planning: Will, Trust, Power of Attorney, Living Will
- Estate or Trust Administration
- Medicaid Planning
- Estate Litigation: Will Contests, etc.
- Guardianship

PLEASE LIST NAME, ADDRESS AND TELEPHONE NUMBER OF THE FOLLOWING:

Family/Corporate Attorney	_____
Accountant	_____
Financial Planner/Broker	_____
Banker	_____
Insurance Agent	_____
	Homeowners _____
	Auto _____
	Life _____

Name: _____

Date: _____

Assets:

ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	√ if None	HUSBAND	WIFE	JOINT	LIABILITIES
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD's					
Residence					
Other Real Estate					
(State: _____)					
(State: _____)					
Time Share Interests					
Business Interests					
(Name: _____)					
(Name: _____)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS					

Name: _____

Date: _____

Assets:

ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	√ if None	OWNER	INSURED/ ANNUITANT	BENEFICIARY	VALUE/ DEATH BENEFIT
QUALIFIED FUNDS					
IRA's (including rollovers)					
401(K's)					
401(B's)					
TIAA/CREF					
Savings Plans					
Qualified Annuities					
NON-QUALIFIED ANNUITIES OR IRA's					
LIFE INSURANCE					
TOTALS					

DO YOU HAVE A POWER OF APPOINTMENT IN A TRUST CREATED BY ANOTHER PERSON OR IN ANOTHER PERSON'S ESTATE? Yes No

Name: _____

Date: _____

Assets:

MONTHLY INCOME		
	HUSBAND	WIFE
Net Salary or Wages	\$	\$
Social Security	\$	\$
Pension	\$	\$
Other Income	\$	\$
TOTAL INCOME	\$	\$

GIFTS		
<p>Gifts made in excess of \$7,282.00 <u>per month</u> to someone other than your spouse within the past 36 month (including transfers of real estate (e.g., adding a child's name to a Deed):</p>		
RECIPIENT	DATE	AMOUNT
		\$
		\$
		\$
		\$
		\$
		\$

ANTICIPATED MONTHLY NURSING HOME EXPENSE (if applicable)	
Name of Nursing Home/Assisted Living Facility	
Date of Admission	
Average Monthly Bill	\$