

ESTATE PLANNING QUESTIONNAIRE

THE LAW OFFICE OF EILEEN GUERIN SWICKER

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PHONE:

FAX:

EMAIL:

This questionnaire is for informational purposes only and will be kept strictly confidential. If you choose not to use our services, it will not be shared with anyone else, except at your specific request. Please provide the requested information to the best of your ability. If you are not able to obtain all the requested information, complete as much as you can. If you obtain additional information after submitting this questionnaire, please keep your attorney informed. If additional space is required, please feel free to attach additional sheets. If an area of the questionnaire does not apply to you, please write N/A to mark the answer as not applicable.

PERSONAL INFORMATION

Legal Name: _____

Other Names used: _____

US citizen? Yes No. If no, what nationality: _____

Address: _____

County: _____ E-Mail: _____

Telephone: (home)_____ (work)_____ (cell)_____

Date of Birth: _____ Social Security No.: _____

Business/Employer: _____

Marital Status: Never married Divorced Widowed Married

If married, name of Spouse: _____

Date of Birth: _____ Social Security No.: _____

Business/Employer: _____

Telephone: (home)_____ (work)_____ (cell)_____

E-Mail: _____

US citizen? Yes No. If no, what nationality: _____

CHILDREN: None

Date of Birth

Spouse: _____

Spouse: _____

Spouse: _____

Spouse: _____

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| • Do any of your beneficiaries have a learning disability, special educational, medical or physical needs? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have any relatives (other than children) who depend on you for all or part of their support? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you think any of your beneficiaries have special problems with spouses, drugs, alcohol or handling money? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to disinherit any of your children, grandchildren or any other close relative? | <input type="checkbox"/> | <input type="checkbox"/> |
| • If a named beneficiary dies before you, do you want the assets to go to that beneficiary's descendants? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you want assets passing to your beneficiaries to be held in trust until a specific age or ages? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you expect to inherit substantial assets (\$100,000 +)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have an existing Will? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever executed a trust (either revocable or irrevocable)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever filed a Federal Gift Tax Return? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you made any gifts in excess of \$13,000 per person? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have an existing General Power of Attorney? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you currently hold any assets in Joint Tenancy with another person? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to make anatomical bequests (organ donor)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to have a "Living Will"? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have a General Power of Appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Are you acting as an executor for someone's estate? | <input type="checkbox"/> | <input type="checkbox"/> |

- Are you involved in any type of law suit?
- Are you acting as agent under a Power of attorney?
- Have you been named as a legal guardian for a child or an adult?
- Have you ever lived in a community property state (Arizona, California, Idaho, Louisiana, New Mexico, Texas, Washington State or Wisconsin)?

The name of the person(s) that you want to make financial decisions on your behalf if you are incapacitated:

- The name of the person(s) that you want to be the decision maker for your estate upon your death:

- The name of the person(s) that you want to raise a child who is under 18 (if applicable):

- In general, state how you want your estate distributed among your beneficiaries?

- State any specific concerns (not already mentioned) that you have regarding the distribution of your estate:

ESTIMATED* VALUE OF ESTATE

<u>TYPE OF ASSET:</u>	<u>ESTIMATED VALUE</u>
• REAL ESTATE: (fair market value, <u>less</u> loans)	\$ _____
• SECURITIES: (stocks, bonds, mutual funds)	\$ _____
• CASH TYPE ASSETS: (cash, annuities, notes due you)	\$ _____
• BUSINESS INTERESTS: (sole proprietorship, partnerships, closely held corporation, etc.)	\$ _____
• RETIREMENT PLANS: (IRA, annuity, 401k, etc.**)	\$ _____
• VEHICLES: (autos, RV, boat)	\$ _____
• PERSONAL PROPERTY: (jewelry, furniture, antiques)	\$ _____
TOTAL:	\$ _____

* Use best guess; this can be a ballpark estimate.

** Do not show benefits which will terminate at death (e.g., pension, social security, etc.).

Value of Life Insurance policies will be listed separately on the next page.

LIFE INSURANCE

(do not include accidental death policies)

- "Cash Value" use best estimate (term policies normally have no cash value)
- "Face Value" is the amount payable at death

<u>COMPANY</u>	<u>CASH VALUE</u>	<u>FACE VALUE</u>	<u>BENEFICIARY</u>
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____

HEALTH CARE PREFERENCES FOR HEALTH CARE POWER OF ATTORNEY AND LIVING WILL

Please respond to the questions listed below to develop guidance for your Health Care Agent. Those instructions will only apply to the **FOUR** situations described below:

Two doctors have determined that you are incapable of any form of meaningful communication regarding your medical condition and treatment. “Meaningful communication” can include non-verbal communication such as blinking the eyes, pressure by hand, tapping, etc.

Four Situations

1. You have been comatose for at least fifteen days, or in a persistent vegetative state for at least 90 days, and the condition is not reversible.
2. You have been diagnosed with a terminal illness, given less than six months to live, the condition is not reversible, and you are unable to communicate.
3. You are in the advanced stages of dementia.
4. You are incapable of day-to-day living without mechanical assistance because of an accident or illness that has rendered you in a state in which you are incapable of perceiving outside stimulus, you are incapable of responding to outside stimulus, and the condition is not reversible.

Agents

Please name three agents, in your preferred order. Please identify if two agents should act together in making decisions. Please discuss your choices with your spouse, and with the agent(s).

	SELF	SPOUSE
1.	_____ _____	_____ _____
2.	_____ _____	_____ _____
3.	_____ _____	_____ _____

Your answers to these questions should be based on the fact that you are not mentally competent, and are in one of the four conditions listed above. Your Agent will make decisions on your behalf only if that is the case. If you are suffering from a temporary condition, judged to be reversible based on then-available medical treatment, these questions do not apply.

Do you want pain relieving medication administered even if you could become addicted to the medication?

SELF YES NO

SPOUSE YES NO

Do you want unconventional or alternative pain relieving treatment, such as massage, acupuncture, or bio feed back?

SELF YES NO

SPOUSE YES NO

Do you want to be resuscitated if you go into cardiac arrest?

SELF YES NO

SPOUSE YES NO

Do you want artificial nutrition and/or hydration (feeding tubes)?

SELF YES NO

SPOUSE YES NO

Do you want antibiotics administered for secondary infections if the primary illness will result in your death?

SELF YES NO

SPOUSE YES NO

Do you want chemotherapy if it will not cure the cancer or alleviate pain of cancer?

SELF YES NO

SPOUSE YES NO

Do you want blood transfusions?

SELF YES NO

SPOUSE YES NO

If so, do you prefer that friends and family be your blood donors?

SELF YES NO

SPOUSE YES NO

Do you want home or hospice care for your last days rather than being taken to a hospital? This assumes that home or hospice care is not emotionally or financially burdensome for your family. SELF YES NO

SPOUSE YES NO

Do you want friends and family to visit you in your final days?

SELF YES NO

SPOUSE YES NO

Do you have a medical condition for which you take prescription medication? If so do you want it continued for comfort only?

SELF YES NO

SPOUSE YES NO

Is there anyone who would object to the health care decisions you have made, and so should be ignored and have no role in making your health care decisions?

SELF YES NO

SPOUSE YES NO

Do you want to make anatomical gifts?

SELF YES NO

SPOUSE YES NO

Although assisted suicide is not currently legal in Virginia, Maryland or the District of Columbia, do you want to allow your agent to transfer you to a jurisdiction where it is legal?

SELF YES NO

SPOUSE YES NO

If you are pregnant, and your doctor knows that, do you want life support until the child is born? You may specify that you want life support only if the pregnancy is beyond the first or second trimester.

SELF YES NO

SPOUSE YES NO