

Estate Planning Questionnaire



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Please bring this form with you to your initial meeting. All information provided herein is considered CONFIDENTIAL INFORMATION by LEGACY LAW GROUP, LLC and will not be shared with anyone outside of our office without your permission. Please call us if you have any questions.

Date Completed: _____

Please Print

First Name _____ Middle _____ Last _____

Name Used to Sign Legal Documents (please print) _____

Nickname _____ Social Security Number _____ - _____ - _____

Home address _____ City _____ State/ZIP _____

County of Residence _____ U.S. Citizen: Yes No

Home telephone _____ Cell phone _____

Birth date ____ / ____ / ____ Age _____ Email _____

Employer _____ Position _____ Business Telephone _____

Marital Status: Single Married, Date: _____ Divorced, Date: _____

Widowed, Date: _____ Deceased Spouse's Name: _____

Spouse Name _____ Middle _____ Last _____

Name Used to Sign Legal Documents (please print) _____

Nickname _____ Social Security Number _____ - _____ - _____

Birth date ____ / ____ / ____ Age _____ Email _____

Employer _____ Position _____ Business Telephone _____

Cell phone _____ U.S. Citizen: Yes No

Military Service

Husband: Branch _____ Length of Service _____

Wife: Branch _____ Length of Service _____

Referred By: _____ **Located in:** _____

CHILDREN'S INFORMATION

Child # 1 Age _____ Child of: Client Only Client & Spouse Spouse Only

First Name _____ Middle _____ Last _____

Male Female Nickname _____

Home address _____

City _____ State _____ Zip _____

Home telephone _____ Cell phone _____

Birth date _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employer _____ Occupation _____

Child's Special Needs: Medical Financial Educational

Marital Status of the Child: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Does this child have children?

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child # 2 Age _____ Child of: Client Only Client & Spouse Spouse Only

First Name _____ Middle _____ Last _____

Male Female Nickname _____

Home address _____

City _____ State _____ Zip _____

Home telephone _____ Cell phone _____

Birth date _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employer _____ Occupation _____

Child's Special Needs: Medical Financial Educational

Marital Status of the Child: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Does this child have children?

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child # 3 Age _____ Child of: Client Only Client & Spouse Spouse Only

First Name _____ Middle _____ Last _____

Male Female Nickname _____

Home address _____

City _____ State _____ Zip _____

Home telephone _____ Cell phone _____

Birth date _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employer _____ Occupation _____

Child's Special Needs: Medical Financial Educational

Marital Status of the Child: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Does this child have children?

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child # 4 Age _____ Child of: Client Only Client & Spouse Spouse Only

First Name _____ Middle _____ Last _____

Male Female Nickname _____

Home address _____

City _____ State _____ Zip _____

Home telephone _____ Cell phone _____

Birth date _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employer _____ Occupation _____

Child's Special Needs: Medical Financial Educational

Marital Status of the Child: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Does this child have children?

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child # 5 Age _____ Child of: Client Only Client & Spouse Spouse Only

First Name _____ Middle _____ Last _____

Male Female Nickname _____

Home address _____

City _____ State _____ Zip _____

Home telephone _____ Cell phone _____

Birth date _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employer _____ Occupation _____

Child's Special Needs: Medical Financial Educational

Marital Status of the Child: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Does this child have children?

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child # 6 Age _____ Child of: Client Only Client & Spouse Spouse Only

First Name _____ Middle _____ Last _____

Male Female Nickname _____

Home address _____

City _____ State _____ Zip _____

Home telephone _____ Cell phone _____

Birth date _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employer _____ Occupation _____

Child's Special Needs: Medical Financial Educational

Marital Status of the Child: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Does this child have children?

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER DEPENDENTS

Are there any persons that are dependent upon you for their support?

Dependent # 1

Dependent's Full Legal Name _____

Relationship: _____

Birth date _____

Home address _____ City _____ State _____ Zip _____

Special Needs? Medical Educational Financial

Marital Status of this person: Married Divorced Widowed Single

If Married, Spouse's Name: _____

Dependent # 2

Dependent's Full Legal Name _____

Relationship: _____

Birth date _____

Home address _____ City _____ State _____ Zip _____

Special Needs? Medical Educational Financial

Marital Status of this person: Married Divorced Widowed Single

If Married, Spouse's Name: _____

PEOPLE WHO ADVISE YOU

Name & Company	Telephone
Insurance Agent _____	_____
Tax Advisor _____	_____
Family Attorney _____	_____
Business Attorney _____	_____
Financial Advisor _____	_____
Stock Broker _____	_____
Banker _____	_____
Other Advisor _____	_____

ADDITIONAL PERSONAL INFORMATION

Seasonal Address

Street Address _____

City _____ State _____ Zip _____

When are you usually there (what months)? _____

Other

- Are any of your parents living? Yes No

If yes,
Father of: _____ Name _____ Age _____

Mother of: _____ Name _____ Age _____

Father of: _____ Name _____ Age _____

Mother of: _____ Name _____ Age _____

- Please indicate any charitable, church, and/or community organizations in which you have strong personal involvement:

Name _____ Location _____

Name _____ Location _____

Name _____ Location _____

- Family Pets?

Name _____ Dog Cat Other: _____

Name _____ Dog Cat Other: _____

Name _____ Dog Cat Other: _____

NOMINATIONS FOR ESTATE PLAN

If you were incapacitated for any period of time, who would you choose to handle your *financial* affairs?

Financial Agents		You	Your Spouse
	Initial Choice		
	Back Up # 1		
	Back Up #2		

If you were incapacitated for any period of time, who would you choose to make *health care* decisions for you?

Health Care Agents*		You*	Your Spouse*
	Initial Choice		
	Back Up # 1		
	Back Up # 2		

*Ultimately, we will need the addresses and telephone numbers of the persons identified above. Please consider providing this information on a separate sheet as you complete this form.

Who would you want to assume the legal responsibility of *managing your assets* when you are no longer able to due to disability or when you are no longer living?

Disability Trustee/ Successor Trustee		You & Your Spouse	
	Initial Choice		
	Back Up # 1		
	Back Up # 2		

Who would you want to assume the legal responsibility of *distributing your estate* when you are no longer living?

Personal Representative		You	Your Spouse
	Initial Choice		
	Back Up # 1		
	Back Up # 2		

Who do you nominate to serve as *guardian* for your minor children (if any)?

Guardians		You & Your Spouse	
	Initial Choice		
	Back Up # 1		
	Back Up #2		

HIPAA (Health Insurance Portability and Accountability Act) is the medical privacy act that was passed to protect your healthcare information. Our HIPAA Authorization allows you to choose who you want to receive information regarding your health and medical status. Feel free to list as many names as you would like.

You: _____

Spouse: _____

ESTIMATED VALUE OF MY ESTATE

Please use estimated figures, round where necessary.
 Indicate whether individual or joint, Indicate owner(s).

Value

Company

Primary Home \$ _____

Other Real Estate (value & type of property) \$ _____

Business Interests (value and entity type) \$ _____

Checking/ Money Market \$ _____

Savings Accounts \$ _____

Certificates of Deposit \$ _____

Stocks/Bonds /Mutual Funds (non IRA) \$ _____

Annuities (non-IRA) \$ _____

Retirement: IRA/Pension/TSA /401k \$ _____

Life Insurance (Death Benefit & Cash Value) \$ _____

Circle one: Term Whole Life

Autos, Boats, RV's, etc. \$ _____

Personal Property (antiques, valuables) \$ _____

Collectible Loans or money due to you \$ _____

Expected Inheritance \$ _____

Total Assets: (add everything up) \$ _____

How much do you owe right now? \$ _____
 (Total mortgages, loans, etc.)

Approximate Net Worth: \$ _____
 (Total assets minus debt)

PLEASE USE THIS SPACE FOR ANY ADDITIONAL FAMILY
INFORMATION OR FOR ANY QUESTIONS YOU MAY HAVE: