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ESTATE PLANNING QUESTIONNAIRE

Date: _____

Please fill out the following pages as completely as possible. Please use "N/A" to indicate "not applicable".

Wife A: _____

Wife B: _____

Social Security #: _____

Social Security #: _____

Date of Birth: _____

Date of Birth: _____

Are you a U.S. citizen? ___Y ___N

Are you a U.S. citizen? ___Y ___N

Other Citizenship: _____

Other Citizenship: _____

Wife A:

Have you ever been married? ___Y ___N
If yes, name of spouse or former spouse:

Wife B:

Have you ever been married? ___Y ___N
If yes, name of spouse or former spouse:

Date of Death of Spouse _____

Date of Death of Spouse _____

or

or

Decree of Dissolution: _____

Decree of Dissolution: _____

Names as you would like them to appear on the title of your trust (ie. Jane Doe & Nancy Roe Revocable Trust)

Residence Address:

Phone: _____

Fax: _____

E-mail(s): _____

Mailing Address (If different from Above)

WIFE A:

Place of Business: _____

Occupation: _____

Address: _____

Email/Phone: _____

WIFE B:

Place of Business: _____

Occupation: _____

Address: _____

Email/Phone: _____

Date and Place of Marriage: _____

GUARDIAN

If you have children under the age of 18, who would you appoint to act as guardian? The guardian will make decisions about the child's religion, education, medical care and where the child resides.

Name: _____ Relationship: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email address: _____

CHILDREN

(Attach extra pages if necessary)

1) Child's Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Social Security #: _____

Names of Parents: _____

2) Child's Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Social Security #: _____

Names of Parents: _____

3) Child's Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Social Security #: _____

Names of Parents: _____

HEALTH CARE INFORMATION

TREATING PHYSICIANS: Kaiser members, please include your Kaiser number.

Wife A's Physician: _____

Address: _____

Phone: _____

Wife B's Physician: _____

Address: _____

Phone: _____

Durable Power of Attorney for Health Care

If you were unable to make health care decisions for yourself (due to terminal illness, medication, or other crisis) and your partner was not available, whom would you appoint to make those decisions for you?

WIFE A

1. Name: _____

Relationship: _____

Address: _____

Phone #: Home _____ Work _____ Cell _____

Email: _____

2. Name: _____

Relationship: _____

Address: _____

Phone #: Home _____ Work _____ Cell _____

Email: _____

WIFE B

1. Name: _____

Relationship: _____

Address: _____

Phone #: Home _____ Work _____ Cell _____

Email: _____

2. Name: _____

Relationship: _____

Address: _____

Phone #: Home _____ Work _____ Cell _____

Email: _____

DETERMINATION OF INCOMPETENCE

Whom would you trust to determine that you had become incompetent to the extent that you could no longer carry out your usual business affairs, if your partner was unable to do so?

WIFE A

1. Name: _____

Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

2. Name: _____

Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

WIFE B

1. Name: _____

Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

2. Name: _____

Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

SUCCESSOR TRUSTEE

If your partner was not available, whom would you appoint as Successor Trustee to carry out your financial and business affairs? The Successor Trustee acts in three situations: 1) When you die, the Successor Trustee signs the assets over to your beneficiaries. 2) If you are incapacitated, the Successor Trustee handles all financial transactions for you, such as paying bills and investing. 3) If there are children under the age of 30 who are beneficiaries, the Successor Trustee invests trust assets and determines the appropriate distributions for their education, support and medical care.

1. Name: _____

Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

2. Name: _____

Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Please indicate who should receive the trust assets after the death of both partners. You may attach additional sheets if necessary.

1.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone
2.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone
3.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone
4.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone
5.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone
6.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone
7.	_____	_____
	Name	Relationship
	_____	_____
	Address	Phone

SAFETY DEPOSIT BOXES

1. Bank name and branch: _____

Bank address and phone: _____

Safety deposit box #: _____

Full name(s) of the individual(s) entitled to access: _____

2. Bank name and branch: _____

Bank address and phone: _____

Safety deposit box #: _____

Full name(s) of the individual(s) entitled to access: _____

3. Bank name and branch: _____

Bank address and phone: _____

Safety deposit box #: _____

Full name(s) of the individual(s) entitled to access: _____

CASH ACCOUNTS--BANK AND CREDIT UNION ACCOUNTS

For all cash accounts, please provide the information requested.

1. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

2. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

3. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

4. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

5. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

6. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

7. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

8. Name of Institution: _____

Branch & Address: _____

Phone Number: _____

Type of Account & Account #: _____

Name(s) on Account(s): _____

MUTUAL FUNDS

For all mutual funds, including UTMA Uniform Transfer to Minors accounts and 529 College Savings, please provide the information requested.

1. Custodial Institution: _____

Address: _____

Phone #: _____

Name of Fund: _____

Account #: _____

2. Custodial Institution: _____

Address: _____

Phone #: _____

Name of Fund: _____

Account #: _____

3. Custodial Institution: _____

Address: _____

Phone #: _____

Name of Fund: _____

Account #: _____

4. Custodial Institution: _____

Address: _____

Phone #: _____

Name of Fund: _____

Account #: _____

SECURITIES ACCOUNTS

For all securities accounts, please provide the information requested below. OR, you may send a copy of a recent monthly statement, which will contain all of the requested information.

1. Name of Brokerage: _____

Brokerage Address and Phone : _____

Account Number: _____

Your Account Representative: _____

2. Name of Brokerage: _____

Brokerage Address and Phone : _____

Account Number: _____

Your Account Representative: _____

3. Name of Brokerage: _____

Brokerage Address and Phone : _____

Account Number: _____

Your Account Representative: _____

4. Name of Brokerage: _____

Brokerage Address and Phone : _____

Account Number: _____

Your Account Representative: _____

STOCKS AND BONDS

For all stocks and bonds held by you outside of a brokerage account (i.e., you have the certificates), we need a copy of the front and back of each stock and/or bond.

1. Name and address of the transfer agent for the company that issued the stock or bond.

2. Name and address of the transfer agent for the company that issued the stock or bond.

3. Name and address of the transfer agent for the company that issued the stock or bond.

4. Name and address of the transfer agent for the company that issued the stock or bond.

5. Name and address of the transfer agent for the company that issued the stock or bond.

PARTNERSHIPS AND JOINT VENTURES

For all Partnerships in which you own an interest, please provide the information requested below.

1. Name of Partnership: _____

Name of Owner as it appears on Partnership records: _____

SELECT ONE: GENERAL PARTNER LIMITED PARTNER

Amount of Original Investment: _____

2. Name of Partnership: _____

Name of Owner as it appears on Partnership records: _____

SELECT ONE: GENERAL PARTNER LIMITED PARTNER

Amount of Original Investment: _____

3. Name of Partnership: _____

Name of Owner as it appears on Partnership records: _____

SELECT ONE: GENERAL PARTNER LIMITED PARTNER

Amount of Original Investment: _____

4. Name of Partnership: _____

Name of Owner as it appears on Partnership records: _____

SELECT ONE: GENERAL PARTNER LIMITED PARTNER

Amount of Original Investment: _____

INDIVIDUAL RETIREMENT ACCOUNTS

For each Individual Retirement Account (IRA) and/or Keogh accounts, please provide the requested information for your Individual Retirement Account (IRA) and / or Keogh accounts. OR, you may attach a copy of the most recent statement, which will contain all of the requested information.

1. Participant's Name: _____ Account # _____

SELECT ONE: TRADITIONAL IRA ROTH IRA KEOGH

Name and Address of Custodial Institution: _____

Phone Number: _____

Name of Primary Beneficiary: _____

Name of Contingent Beneficiary: _____

2. Participant's Name: _____ Account # _____

SELECT ONE: TRADITIONAL IRA ROTH IRA KEOGH

Name and Address of Custodial Institution: _____

Phone Number: _____

Name of Primary Beneficiary: _____

Name of Contingent Beneficiary: _____

3. Participant's Name: _____ Account # _____

SELECT ONE: TRADITIONAL IRA ROTH IRA KEOGH

Name and Address of Custodial Institution: _____

Phone Number: _____

Name of Primary Beneficiary: _____

Name of Contingent Beneficiary: _____

4. Participant's Name: _____ Account # _____

SELECT ONE: TRADITIONAL IRA ROTH IRA KEOGH

Name and Address of Custodial Institution: _____

Phone Number: _____

Name of Primary Beneficiary: _____

Name of Contingent Beneficiary: _____

5. Participant's Name: _____ Account # _____

SELECT ONE: TRADITIONAL IRA ROTH IRA KEOGH

Name and Address of Custodial Institution: _____

Phone Number: _____

Name of Primary Beneficiary: _____

Name of Contingent Beneficiary: _____

6. Participant's Name: _____ Account # _____

SELECT ONE: TRADITIONAL IRA ROTH IRA KEOGH

Name and Address of Custodial Institution: _____

Phone Number: _____

Name of Primary Beneficiary: _____

Name of Contingent Beneficiary: _____

LIFE INSURANCE / ANNUITY

For each life insurance and/or annuity policy you own, please provide the information requested, including the exact name of the owner. OR, you may provide a copy of the front page of your policy, which will contain all of the requested information.

1. Carrier's Name and Address: _____

Phone #: _____

Policy Number: _____ Face Value: _____

Owner of Policy: _____ Insured: _____

Primary Beneficiary: _____

Contingent Beneficiary: _____

SELECT ONE: Term Universal Life Whole Life Annuity

2. Carrier's Name and Address: _____

Phone #: _____

Policy Number: _____ Face Value: _____

Owner of Policy: _____ Insured: _____

Primary Beneficiary: _____

Contingent Beneficiary: _____

SELECT ONE: Term Universal Life Whole Life Annuity

3. Carrier's Name and Address: _____

Phone #: _____

Policy Number: _____ Face Value: _____

Owner of Policy: _____ Insured: _____

Primary Beneficiary: _____

Contingent Beneficiary: _____

SELECT ONE: Term Universal Life Whole Life Annuity

4. Carrier's Name and Address: _____

Phone #: _____

Policy Number: _____ Face Value: _____

Owner of Policy: _____ Insured: _____

Primary Beneficiary: _____

Contingent Beneficiary: _____

SELECT ONE: Term Universal Life Whole Life Annuity

5. Carrier's Name and Address: _____

Phone #: _____

Policy Number: _____ Face Value: _____

Owner of Policy: _____ Insured: _____

Primary Beneficiary: _____

Contingent Beneficiary: _____

SELECT ONE: Term Universal Life Whole Life Annuity

CORPORATE RETIREMENT PLANS

For all Corporate Retirement Plans (401(k), 403(b), pension plan, profit sharing plan, etc.) in which you participate, please provide the requested information. OR you may send a copy of the most recent annual statement, which will contain all of the requested information.

1. Participant's Name: _____

Name of Plan and Plan Number (if applicable): _____

Name & Address of Plan Administrator: _____

Phone Number: _____

Primary Beneficiary: _____

2. Participant's Name: _____

Name of Plan: _____

Name of Plan and Plan Number (if applicable): _____

Phone Number: _____

Primary Beneficiary: _____

3. Participant's Name: _____

Name of Plan: _____

Name of Plan and Plan Number (if applicable): _____

Phone Number: _____

Primary Beneficiary: _____

MISCELLANEOUS BUSINESS INTERESTS

Example: Sole proprietorship, Stock Options (Include Agreement), Airplane, Race Horse, Boat, and etc.

1.

2.

3.

4.

5.
