

ESTATE PLANNING WORKSHEET

Information provided is held in complete confidence, and is used for the sole purpose of analyzing estate planning needs and designing estate planning documents. Preparation of this worksheet is not mandatory prior to the initial appointment with us, but if we are able to review the completed worksheet prior to your appointment, more information and value will be received during the 30-minute complimentary initial consultation.

WE OFFER A FREE NO OBLIGATION, 30-MINUTE CONSULTATION

During the initial appointment, we will determine your specific estate planning needs and goals. The potential cost of probate and tax which would occur with your current plan will be analyzed, and methods of reducing costs and accomplishing goals will be discussed. An exact quote on fees for estate planning will be provided before you decide to authorize completion of your estate plan.

JONES & KINDELAN, LLP ATTORNEYS AT LAW

12526 HIGH BLUFF DRIVE, SUITE 300, SAN DIEGO, CALIFORNIA 92130
TEL: (858) 259-8221 FAX (858) 259-0380
www.jandklaw.net

J. WILEY JONES
wjones@jandklaw.net

ELISE KINDELAN
ekindelan@jandklaw.net

NORTH COUNTY OFFICE
1933 VALLEY ROAD
OCEANSIDE, CALIFORNIA 92056
TEL: (760) 231-5190
FAX (760) 231-5191

PERSONAL INFORMATION

If you are single, please fill out the information for Client #1 only.

For those who are married, its up to you to decide which of you is Client #1 and Client #2.

Unmarried couples may fill out this worksheet just as a married couple would, but please insert your correct marital status as it significantly affects application of tax rules.

CLIENT #1

Name: Be sure to print your name exactly as it appears on your photo ID

Other Names: Please list any aliases, or any variations of your name, that you use regularly

(**Example:** Tom Smith instead of Thomas James Smith)

What type of photo ID do you normally use? (check applicable box)

Please remember to bring this ID with you to your signing appointment.

- | | |
|--|---|
| <input type="checkbox"/> California Driver's License | <input type="checkbox"/> California ID Card |
| <input type="checkbox"/> Out of State Driver's License | <input type="checkbox"/> Out of State ID Card |
| <input type="checkbox"/> U.S. Passport | <input type="checkbox"/> Military/Student ID |
| <input type="checkbox"/> Other _____ | |

Date of Birth _____ / _____ / _____ SSN _____ - _____ - _____

Home Phone (_____) _____ - _____ Alternate Phone (_____) _____ - _____

Home Address _____

Email Address _____

Marital Status:

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Married | <input type="checkbox"/> Registered Domestic Partner | <input type="checkbox"/> Unmarried Partner |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Single/Widowed |

CLIENT #2

Name: Be sure to print your name exactly as it appears on your photo ID

Other Names: Please list any aliases, or any variations of your name, that you use regularly

(Example: Tom Smith instead of Thomas James Smith)

What type of photo ID do you normally use? (check applicable box)

Please remember to bring your ID with you to your signing appointment

- | | |
|--|---|
| <input type="checkbox"/> California Driver's License | <input type="checkbox"/> California ID Card |
| <input type="checkbox"/> Out of State Driver's License | <input type="checkbox"/> Out of State ID Card |
| <input type="checkbox"/> U.S. Passport | <input type="checkbox"/> Military/Student ID |
| <input type="checkbox"/> Other _____ | |

Date of Birth _____ / _____ / _____ SSN _____ - _____ - _____

Home Phone (_____) _____ - _____ Alternate Phone (_____) _____ - _____

Home Address _____

Email Address _____

Marital Status:

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Married | <input type="checkbox"/> Registered Domestic Partner | <input type="checkbox"/> Unmarried Partner |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Single/Widowed |

Relationship of Client #1 to Client #2

- | | |
|---|---|
| <input type="checkbox"/> Married | <input type="checkbox"/> California Registered Domestic Partner |
| <input type="checkbox"/> Unmarried Partners | |

If married, give date and location of marriage _____

CHILDREN

List all of your children, including children from previous marriages, if any.

CLIENT #1

NAME	ADDRESS	DOB	LIVING/DECEASED

If any of the above children are predeceased, list their children (if any)

NAME	ADDRESS	DOB	LIVING/DECEASED

CLIENT #2 (If different than above)

NAME	ADDRESS	DOB	LIVING/DECEASED

If any of the above children are predeceased, list their children (if any)

NAME	ADDRESS	DOB	LIVING/DECEASED

Are any of the above children adopted? If so, please list

OTHER BENEFICIARIES

Please list all other Beneficiaries of your estate plan.
For example: grandchildren, nieces/nephews, siblings, friends, charitable organizations, etc.

CLIENT #1

NAME	ADDRESS	RELATIONSHIP

CLIENT #2 (If different than above)

NAME	ADDRESS	RELATIONSHIP

PLAN OF DISTRIBUTION

1. **SPECIFIC GIFTS.** Do you wish to make a special gift to a particular person, such as a piece of jewelry to a particular child? Would you like to make charitable gifts, such as a gift of money to a house of worship or to a non-profit charity? You may attach an additional page if necessary.

CLIENT #1

ITEM (describe in detail)	BENEFICIARY	ALTERNATE BENEFICIARY (optional)

CLIENT #2

ITEM (describe in detail)	BENEFICIARY	ALTERNATE BENEFICIARY (optional)

2. **REMAINING ASSET DISTRIBUTION.** Briefly describe what you would want to do with any assets remaining after specific gifts are distributed. Don't worry about tax planning or other considerations in answering this question. We will consider those details later if needed.

All to spouse, then equally between children, and if a child didn't survive, the deceased child's children would take the share of the deceased child.

All to spouse, then equally between surviving children.

All to spouse, then _____

As follows _____

YOUNG BENEFICIARIES

1. AGE OF ULTIMATE DISTRIBUTION TO YOUNG BENEFICIARIES. If you do establish a trust to allow the successor trustee to manage assets for a beneficiary or beneficiaries, then it is necessary for you to decide when the beneficiaries will be mature enough to manage assets on their own. You may want to give each beneficiary his or her share at the time the beneficiary reaches a particular age. You may consider splitting the distribution, such as 1/2 at age 25 and the balance at age 30 (or 1/3 at 21, 1/3 at 25, and 1/3 at 35). You may use any age or combination of ages that you choose.

2. INSTRUCTIONS TO SUCCESSOR TRUSTEE. Use of assets for young beneficiaries: During the time that the successor trustee is managing assets for the beneficiaries, the successor trustee will need guidelines. You may select one of the following options or write your own.

At the time of death, trust assets go into individual equal shares, one for each young beneficiary. The successor trustee has the discretion to use the assets in the share of the beneficiary as he/she feels fit. When a beneficiary reaches the ages specified in paragraph 1, the remaining assets in his/her share are distributed.

At the time of death, trust assets go into individual equal shares, one for each young beneficiary. The successor trustee may use the assets in the share for the beneficiary only for the following purposes. When a beneficiary reaches the ages specified in paragraph 1, the remaining assets in his/her share are distributed.

(**Example:** tuition, room and board at a university, tuition only at a university or community college, general education and living expenses, down payment on a house, etc.)

Other instructions to successor trustee regarding the use of assets held in trust for young beneficiaries.

APPOINTMENTS

1. **SUCCESSOR TRUSTEE.** If you choose to avoid probate of your estate by executing a living trust during your lifetime, a successor trustee should be named. The successor trustee would be responsible for managing your assets if you were unable to manage them yourself. In the case of a joint trust, the successor trustee would act only if neither you nor your spouse were able to manage assets due to incompetence. The successor trustee would distribute assets to beneficiaries after your death, or in a joint trust, when neither you nor your spouse survives. If you leave minor children or beneficiaries with disabilities, the trust would continue and the successor trustee would manage the assets on behalf of those beneficiaries. It is a good idea to name an alternate successor trustee to act if your first choice cannot serve.

SUCCESSOR TRUSTEE _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

ALTERNATE SUCCESSOR TRUSTEE _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

2. **PERSONAL REPRESENTATIVE.** This is the person you would like to act as the personal representative of your will in the event that a probate is necessary. You may appoint anyone, although it is usually either the successor trustee or your spouse if you are married. It is a good idea to name an alternate representative to act if your first choice cannot serve.

CLIENT #1

PERSONAL REPRESENTATIVE _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

ALTERNATE REPRESENTATIVE _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

CLIENT #2

PERSONAL REPRESENTATIVE _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

ALTERNATE REPRESENTATIVE _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

3. GUARDIAN. If you have minor children (under 18) or a beneficiary with special needs, you may need to appoint a guardian. The guardian is responsible for the day-to-day care of the child. It is a good idea to name an alternate guardian to act if your first choice cannot serve.

GUARDIAN _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

ALTERNATE GUARDIAN _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

4. TRUST NAME. If you have a specific name you would like for your trust, list it here. You may choose anything you like for the trust name.

TRUST _____

HEALTH CARE AND END OF LIFE DECISIONS (AHCD)

The Advance Health Care Directive (“AHCD”) is an extremely important document. If an individual does not have an AHCD, and is in a situation where he/she cannot communicate with medical personnel, the medical personnel are required to make their own decisions regarding that individual’s health care. This issue becomes critical when questions arise regarding pain relief and artificial life support.

You may give specific instructions to your appointed health care agent regarding your wishes for your health care (such as pain relief and life support) and after-life issues (such as funeral and burial arrangements). These instructions are optional, however it is ideal if you give your health care agent guidance. Your health care agent will have the power to override the recommendations of medical personnel and the wishes of other friends and relatives.

This is a worksheet only. Feel free to write notes on this worksheet if the choices given do not exactly match your wishes. We will incorporate your individual and unique wishes on the final version of your AHCD.

1. APPOINTMENT OF HEALTH CARE AGENT. This is the person who would make medical decisions on your behalf, including decisions regarding medical consents, life support, and nursing home admission, if you were unable to make these decisions yourself. It is a good idea to name a secondary health care agent to act if your first choice cannot serve.

CLIENT #1

HEALTH CARE AGENT _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

CELL PHONE NUMBER (_____) _____ - _____

ALTERNATE HEALTH CARE AGENT _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

CELL PHONE NUMBER (_____) _____ - _____

CLIENT #2

HEALTH CARE AGENT _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

CELL PHONE NUMBER (_____) _____ - _____

ALTERNATE HEALTH CARE AGENT _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

CELL PHONE NUMBER (_____) _____ - _____

2. HEALTH CARE DECISIONS. Give instructions to your appointed health care agent regarding your wishes for your health care (such as pain relief and life support) and after-life issues (such as funeral and burial arrangements).

CLIENT #1

A. Pain Relief (check applicable box)

- As much pain relief medication as needed, even if it may cause medical side effects.
- As little pain relief medication as possible
- Other Pain Relief Instructions: _____

(**Example:** I do not wish to be provided with treatment for alleviation of pain or discomfort, except under certain circumstances. I therefore direct that my primary physician must be consulted before any such treatment is provided.)

B. Life Support (check applicable box)

- Choice Not To Prolong Life - I do not want my life to be prolonged if:
 - I have an incurable and irreversible condition that will result in my death within a relatively short time, or
 - I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
 - The likely risks and burdens of treatment would outweigh the expected benefits.
- Choice To Prolong Life - I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.
- Other Wishes. If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions given above, you may do so here:

(**Example:** If I should have an incurable injury, disease, or illness certified by two (2) physicians to be a terminal condition, and if the application of life sustaining procedures would serve only to artificially prolong the moment of my death, whether or not life sustaining procedures are utilized, then my agent may direct that all life sustaining treatment be withheld or removed. For the purposes of this document, "terminal condition" refers to a condition that is reasonably expected to result in my death within six (6) months regardless of the treatment I may receive. If I am in an irreversible coma and have been for at least ninety (90) days, which two (2) physicians have diagnosed as irreversible (i.e. if there is no reasonable possibility that I will regain consciousness), then my agent may direct that

all life sustaining treatment be removed or withheld. For the purposes of this document, "irreversible coma" refers to a permanent loss of consciousness from which there is no reasonable possibility that I will return to a cognitive and sapient life, and shall include but not be limited to a persistent vegetative state. Regarding the decision to withhold or withdraw life-sustaining treatment, I desire that my agent act after allowing a reasonable period of time for observation and diagnosis.)

C. Organ Donation. Upon my death (check applicable box)

- I do not authorize any organ donations
- I give any needed organs, tissues, or parts
- I give the following organs, tissues, or parts only:

My gift is for the following purposes. Strike any of the options that you do not want: • Transplant • Research • Therapy • Education

D. Burial and Funeral

Burial Arrangements. After my death (check applicable box)

My body shall be buried in _____ cemetery, located in

My body shall be cremated and the ashes shall be _____

My body shall be donated to _____

Other (specify) _____

Funeral Service. I instruct my agent to carry out funeral services in the following manner:

Specific Comments, Wishes, and Thoughts regarding Funeral and Burial Arrangements:

E. Primary Physician. If you have a specific physician that you would like for your health care agent to hire and consult with regarding your care, write their contact information here:

PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

CLIENT #2

A. Pain Relief (check applicable box)

As much pain relief medication as needed

As little pain relief medication as possible

Other Pain Relief Instructions: _____

(**Example:** I do not wish to be provided with treatment for alleviation of pain or discomfort, except under certain circumstances. I therefore direct that my primary physician must be consulted before any such treatment is provided.)

B. Life Support (check applicable box)

Choice Not To Prolong Life - I do not want my life to be prolonged if:

I have an incurable and irreversible condition that will result in my death within a relatively short time, or

I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or

The likely risks and burdens of treatment would outweigh the expected benefits.

Choice To Prolong Life - I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

Other Wishes. If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here:

(Example: If I should have an incurable injury, disease, or illness certified by two (2) physicians to be a terminal condition, and if the application of life sustaining procedures would serve only to artificially prolong the moment of my death, whether or not life sustaining procedures are utilized, then my agent may direct that all life sustaining treatment be withheld or removed. For the purposes of this document, “terminal condition” refers to a condition that is reasonably expected to result in my death within six (6) months regardless of the treatment I may receive. If I am in an irreversible coma and have been for at least ninety (90) days, which two (2) physicians have diagnosed as irreversible (i.e. if there is no reasonable possibility that I will regain consciousness), then my agent may direct that all life sustaining treatment be removed or withheld. For the purposes of this document, “irreversible coma” refers to a permanent loss of consciousness from which there is no reasonable possibility that I will return to a cognitive and sapient life, and shall include but not be limited to a persistent vegetative state. Regarding the decision to withhold or withdraw life-sustaining treatment, I desire that my agent act after allowing a reasonable period of time for observation and diagnosis.)

C. Organ Donation. Upon my death (check applicable box)

- I do not authorize any organ donations
- I give any needed organs, tissues, or parts
- I give the following organs, tissues, or parts only:

My gift is for the following purposes. Strike any of the options that you do not want: • Transplant • Research • Therapy • Education

D. Burial and Funeral

Burial Arrangements. After my death (check applicable box)

- My body shall be buried in _____ cemetery, located in _____
 - My body shall be cremated and the ashes shall be _____
 - My body shall be donated to _____
-

Other (specify) _____

Funeral Service. I instruct my agent to carry out funeral services in the following manner:

Specific Comments, Wishes, and Thoughts regarding Funeral and Burial Arrangements:

E. Primary Physician. If you have a specific physician that you would like for your health care agent to hire and consult with regarding your care, write their contact information here:

PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER (_____) _____ - _____

3. ADDITIONAL HEALTH CARE NOTES. You may use this space to list any questions you have regarding the healthcare documents, or write in any wishes that are not covered by the above options:

ASSET/LIABILITY INFORMATION

Please list your specific asset/liability information in the appropriate category below.
 (Examples for "Title In Which Held" are: joint, joint with third party, sole and separate, etc)
 You may attach an additional page if necessary.

TYPE OF ASSET	TITLE IN WHICH HELD	CURRENT VALUE
---------------	---------------------	---------------

REAL ESTATE

Include type of property (residential, agricultural, commercial, etc.) and address or description.

Personal Residence:		
Other:		

LIQUID ASSETS

Include Account Number and where held

Cash on Hand:		
Government and Publicly Traded Securities:		
Unlisted Securities (Not Publicly Traded):		
Money Market Accounts:		

Brokerage Accounts:		
Equity in Business: <input type="checkbox"/> Sole Prop. <input type="checkbox"/> Partnership		
Notes and Loans Receivable:		
Checking Accounts:		

Savings Accounts:		
Certificates of Deposit:		
Automobiles:		
Other Personal Property:		
Annuities:	Owner	Beneficiary
IRA's:		
401K:		
Pension/Profit Sharing:		
Life Insurance:		Cash Value Death Benefit

QUESTIONNAIRE

	CLIENT #1	CLIENT #2
1. Are you a U.S. citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you presently have a will?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you presently have a trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Were there any previous marriages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are any of your children not from your current marriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do any of your children or beneficiaries have disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you own a farm or business?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. If yes, do any of your children work in the business with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. If yes, do the children working in the business have an ownership interest in the business?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have gift tax returns ever been filed to report gifts made? If yes, please bring copies of the returns to your appointment.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you own a long-term care insurance policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you hold everything jointly with your spouse, or is some property separate? (Except IRAs, pensions, etc)	<input type="checkbox"/> All joint	<input type="checkbox"/> Some separate
13. Have you entered into any agreements with your spouse (such as a prenuptial or community property agreement)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe briefly _____		

ADDITIONAL QUESTIONS

1. NET WORTH. What is the approximate total value of your estate? Add the value of all property owned by yourself (and your spouse if you are married) including real estate, personal property, bank accounts, stocks, bonds, IRAs, and anything else you own (except death benefits on life insurance).

Client #1 _____ Client #2 _____

What is the value of death benefits on life insurance?

Client #1 _____ Client #2 _____

What is the approximate total amount of your outstanding liabilities?

Client #1 _____ Client #2 _____

2. MOTIVATION. What is your motivation for estate planning? (check all applicable boxes)

- Business Planning Probate Avoidance Guardianship for Minor Children
 Federal estate planning tax Other _____

3. FINANCIAL ADVISOR. If you have a Financial Advisor, give name and contact info.

Name _____

Phone Number (_____) _____ - _____

4. CERTIFIED PUBLIC ACCOUNTANT. If you have a CPA, give name and contact info.

Name _____

Phone Number (_____) _____ - _____

5. HOW SOON WOULD YOU LIKE TO COMPLETE PLANNING? Is there a specific deadline, such as an upcoming trip, surgery, etc.?

6. NOTES AND QUESTIONS. Please note anything else that may be of importance in planning your estate, or any questions you may have. You may attach an additional sheet if necessary.
