LAW OFFICE OF BARBARA M. MARTIN, LLC

Attorneys at Law
292 Crocker Place
Haworth, New Jersey 07641

Barbara M. Martin*

tel. (973) 641-6353

*Admitted NJ Bar
Writer's Direct Email
bmartin@barbaramartinlaw.com

ESTATE PLANNING QUESTIONNAIRE
(MARRIED)

Date_____

Home Phone No._____ Business Phone No. _____

E-mail address_____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please complete this form and return to the undersigned.

A. PERSONAL DATA

(Spouse #1) Full Name_____

Birth Date_____

U.S. Citizen? _____ Yes _____No

Annual Income_____

(Spouse #2) Full Name _____

Address _____

City_____ State_____ Zip_____

Birth Date_____

U.S. Citizen: _____Yes _____No

Annual Income_____

B. REFERRAL

By whom were you referred to this office?
Name_____

C. CHILDREN (if applicable)

Name of Child_____ Gender: _____41

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ E-mail _____

Relationship to Spouse: ____Natural child ____ Adopted ____Stepchild
___Child born out of wedlock

Relationship to Spouse: _____Natural child ___Adopted _____Stepchild
_____Child born out of wedlock

Name of Child_____ Gender:_____ Male _____ Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ E-mail Address_____

Relationship to Spouse: ____Natural child ____ Adopted ____Stepchild
___Child born out of wedlock Relationship to Spouse: _____Natural child
___Adopted _____Stepchild
_____Child born out of wedlock

GRANDCHILDREN - if applicable

Name of Grandchild_____ Gender: _____

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

Relationship to Your Child: _____ Natural child _____ Adopted _____ Stepchild
_____ Child born out of wedlock

E. DISPOSITIVE INTENTIONS

1. SPOUSE AND CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children?

Yes _____ No _____

Do you wish to treat all of your children equally? _____ Yes _____ No

If not, why not?_____

Children's Testamentary Trust After your spouse's death, at what age do you want distribution to your children (e.g. a typical plan provides for 1/2 at age 30 and 1/2 at age 35, with earlier Trustee payments for education etc)?_____

_____

2. OTHER BENEFICIARIES

Do you want your Will or Trust to benefit anyone other than your spouse, children, grandchildren or a charity?

_____ Yes _____ No If so, please list:

Name of Beneficiary

Address of Beneficiary

Relationship

Dollar Amount

F. EXECUTOR

Whom do you want to serve as your Executor?

(Spouse) First Choice: _____

Second Choice_____

(Spouse) First Choice: _____

Other_____

Second Choice_____

G. TRUSTEE

Whom do you want to serve as your Trustee?

(Spouse) First
Choice_____

Second Choice_____

(Spouse) First
Choice_____
Second Choice_____

H. GUARDIAN

If you have **minor** or **disabled** child/children, whom do you want to act as Guardian? Name and address.

First Choice_____

Second Choice_____

Do any of your children have special needs, receive government services or is it anticipated that they will require services in the future? _____

If so, what do you anticipate their needs will be?

_____

_____

I. LIVING WILL

Spouse #1: Do you want your Living Will to provide for withdrawal of artificial food and fluid?

___ Yes _____ No

Do you want to donate your eyes or organs? Yes _____ No _____

Do you want your Health Care Agent to consult with any other person prior to acting? Yes ____ No ___

If yes, with
whom?_____

Name of Proposed Health Care Agent_____

Street Address_____

City_____ State_____ Zip_____

Name of Proposed Alternate Health Care Agent_____

Street Address_____

City_____ State_____ Zip_____

Spouse #2

Do you want your Living Will to provide for withdrawal of artificial food and fluid? Yes_____ No _____

Do you want to donate your eyes or organs? Yes _____ No _____

Do you want your Health Care Agent to consult with any other person prior to acting? Yes_____ No_____

If yes, with whom?

Name of Proposed Health Care Agent_____

Street Address_____

City_____ State_____ Zip_____

Name of Proposed Alternate Health Care Agent_____

Street Address_____

City_____ State_____ Zip_____

What are the names and addresses of each of your primary care physicians?

Full Name of Physician_____

Street Address_____

City_____ State_____ Zip_____

J. POWER OF ATTORNEY

Spouse #1: Name of Proposed Financial Agent_____

Street Address_____

City_____ State_____ Zip_____

Name of Proposed Alternate Financial Agent_____

Street Address_____

City_____ State_____ Zip_____

Spouse #2: Name of Proposed Financial

Agent_____

Street Address_____

City_____ State_____ Zip_____

Name of Proposed Alternate Financial Agent_____

Street Address_____

City_____ State_____ Zip_____

K. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? _____ Yes _____ No

If yes, please explain_____

_____

What is the location of your important papers?_____

Do you have a Safe Deposit Box? _____ Yes _____ No

If yes, please indicate the name and address of the
location_____

Have you ever made gifts to any one person in excess of $13,000 in any one calendar year?

_____ Yes _____ No

Have you ever filed a Federal Gift Tax Return? _____ Yes _____ No

Does any child or possible beneficiary have special needs or receive governmental benefits ___ Yes ___No

L. FINANCIAL SUMMARY

Personal Residence:

Tax Block #_____ Lot #_____ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1)Street_____ City_____ State_____ Zip_____

Tax Block #_____ Lot #_____ (Can be obtained from Tax Bill)

(2)Street_____ City_____ State_____ Zip_____

Tax Block #_____ Lot #_____ (Can be obtained from Tax Bill)

I. FINANCIAL SUMMARY

Do not put the account numbers. Simply, the name and the amount. We will review to ensure the beneficiaries are correct.

Name of account	amount	Beneficiary	
Checking			
Savings			
RESIDENCE			
OTHER REAL ESTATE			
Street Address:			
BROKERAGE ACCOUNT			
Life insurance			
401K			
Pensions			
CD's			
529			
IRA			
OTHER			

M. CERTIFICATION

The undersigned hereby represents to THE LAW OFFICE OF BARBARA M. MARTIN, LLC and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_____