

THE LAW OFFICE OF BARBARA M. MARTIN LLC

*Attorney 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

Date _____

File Number

Home Phone No. _____

Business Phone No.

E-mail address _____

Fax

No. _____

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

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Birth Date _____

U.S. Citizen? _____ Yes _____ No

Annual Income _____

B. CHILDREN (if applicable)

Name of Child _____ Gender: Male Female
Street Address _____
City _____ State _____ Zip _____
Home Phone Number _____ Work Phone Number _____
Date of Birth _____
E-mail Address _____

Name of Child _____ Gender: Male Female
Street Address _____
City _____ State _____ Zip _____
Home Phone Number _____ Work Phone Number _____
Date of Birth _____
E-mail Address _____

2. OTHER BENEFICIARIES

Do you want your Will or Trust to benefit anyone other than your a spouse, children, grandchildren or a charity? _____ Yes _____ No

If so, please list their name, address and relationship to you:

C. EXECUTOR

Whom do you want to serve as your Executor?

First Choice: _____

Second Choice _____

D. TRUSTEE

Whom do you want to serve as your Trustee?

First Choice _____

Second Choice _____

E. GUARDIAN

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

First Choice _____

Second Choice _____

F. LIVING WILL

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

Do you want your Living Will to provide for withdrawal of mechanical respiration or other heroic efforts, if you are in a persistent vegetative state?

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 Proxy _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed Alternate Health Care Proxy _____

Street Address _____

City _____ State _____ Zip _____

G. POWER OF ATTORNEY

Name of Proposed Financial Agent _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed Alternate Financial Agent _____

Street Address _____

City _____ State _____ Zip _____

H. 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

Does any child or possible beneficiary have special needs or receive governmental benefits ___ Yes ___ No

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			

J. 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:
