

# Benenati Law Firm

A Professional Corporation

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## Estate Planning Questionnaire (Single, No Children)

This questionnaire consists of questions that are related to your estate planning. It is designed to streamline the estate planning process by supplying information that is generally required to commence your estate plan. Please provide names as you want them to appear in your estate planning documents.

1. Name: \_\_\_\_\_

Preferred Name for Legal Documents: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Citizenship:** \_\_\_\_\_

Business/Employer: \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

FAX: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

3. Please complete the following statement of assets and liabilities generally reflecting the fair market value of your assets.

<u>ASSETS</u>		<u>LIABILITIES</u>	
Cash:	\$ _____	Mortgage:	\$ _____
Investments: (Other than Retirement)	\$ _____	Secured Debt:	\$ _____
Closely-owned Businesses:	\$ _____	Other Debt:	\$ _____
Residence:	\$ _____		
Other Residence:	\$ _____		
Cars:	\$ _____		
Personal Effects:	\$ _____		
IRA's & Retirement:	\$ _____		
Face Value of Life Insurance:	\$ _____		
Other:	\$ _____		
<b>TOTAL</b>	<b>\$ _____</b>		<b>\$ _____</b>

4. Please list life insurance policies that you own and indicate whose life it insures.

<u>Company</u>	<u>Insured</u>	<u>Face Amount</u>	<u>Cash Value</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Do you expect to inherit a substantial amount of property? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the nature and extent of this property and the state in which it is located:

\_\_\_\_\_

If you own real estate in another state, please indicate which state \_\_\_\_\_

6. If you are a beneficiary under a trust established by someone other than yourself, please indicate below:

\_\_\_\_\_

If you are a beneficiary under a trust, please indicate whether you have been given a power of appointment and whether you want to exercise this power:

\_\_\_\_\_

7. Choosing your **EXECUTOR**: The Executor is the person you appoint to settle the affairs of your estate. Adult children, a bank, another relative, or a very reliable and long time friend may be named as Executor. Whom do you want to appoint as Executor of your estate? Please indicate successors if the person initially named is unable to serve.

Executor: \_\_\_\_\_

Successor(s): \_\_\_\_\_

\_\_\_\_\_

8. Naming a **TRUSTEE**: There are tax reasons that a trust may be appropriate for your benefit. You may want to name a trustee to manage your property if you are not able. You may name an individual alone or as a co-trustee with a group of individuals.

If a trust is appropriate, whom do you want to appoint as trustee or co-trustees? Please indicate successors if the person initially named is unable to serve.

Trustee: \_\_\_\_\_

Successor(s): \_\_\_\_\_

\_\_\_\_\_

9. Do you authorize Trustee to require, at the Trustee's discretion, beneficiary(ies) to submit to a drug test prior to receiving distribution? Yes \_\_\_\_\_ No \_\_\_\_\_

10. To whom do you want to leave your property?

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11. Other documents that complement your Wills include a Directive to Physicians, a financial Power of Attorney, a Health Care Power of Attorney, and a Declaration of Guardianship.

a. The **DIRECTIVE TO PHYSICIANS** directs that in the event artificial procedures are used to sustain your life, such life sustaining procedures are to be removed. Also, if you are mentally incapacitated and terminally ill, which is defined as not more than six (6) months to live, you ask that all further treatment and procedures be terminated and you be made comfortable

Do you desire a DIRECTIVE TO PHYSICIANS? Yes \_\_\_\_\_ No \_\_\_\_\_

b. The purpose of the financial **POWER OF ATTORNEY** is to name an agent to handle your financial affairs. This is designed to avoid a costly guardianship proceeding. Whom do you want to serve as your agent? Please indicate a successor if your designated agent is unable to serve.

**Agent:** \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**1<sup>st</sup> Successor  
Agent:**

\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**2<sup>nd</sup> Successor  
Agent:**

\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

- c. A **HEALTH CARE POWER OF ATTORNEY** designates an agent who may make health care decisions for you in the event of your incapacity. Whom do you want to serve as your designated agent? Please indicate a successor if your designated agent is unable to serve.

PLEASE PROVIDE THE ADDRESSES AND TELEPHONE NUMBERS OF DESIGNATED AGENTS AND SUCCESSORS.

**Agent:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

**1<sup>st</sup> Successor**

**Agent:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

**2<sup>nd</sup> Successor**

**Agent:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

- d. A **DECLARATION OF GUARDIANSHIP** gives you the ability to designate those persons who you specifically want to serve as your guardian should you need one. You may also designate specific persons who you do not want to serve as your guardian. Although the financial Power of Attorney, as well as the Health Care Power of Attorney, are both designed to prevent guardianships, a guardianship may still be necessary. Whom do you want **not** to serve?

Not to serve as a guardian: \_\_\_\_\_

Not to serve as a guardian: \_\_\_\_\_

12. The Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”) **AUTHORIZATION** gives you the ability to designate those persons to whom a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information regarding your health. **If you would like to have this authorization form prepared, please provide the addresses and telephone numbers of those designated to receive protected health information regarding your health.**

**Husband**

**Wife**

**Name :** \_\_\_\_\_

**Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**Name :** \_\_\_\_\_

**Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please note:** if you choose to complete the HIPAA Authorization, all persons named have equal access to your health information.

13. **SAFEKEEPING:** These are important documents. I encourage you to place the originals of these documents in a safety deposit box or other secure and fire proof place. My office will maintain signed copies for emergency reference.

14. **MISCELLANEOUS ESTATE PLANNING INFORMATION:**

If you desire to set out specific property, please list the information requested.

Personal Property Description

Person to Receive Property

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