

The Law Office of  
Jo-Anne Herina Jeffreys, Esq.  
ESTATE PLANNING QUESTIONNAIRE



Date \_\_\_\_\_ File Number \_\_\_\_\_  
Home Phone No. \_\_\_\_\_ Cell #: \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

*This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.*

**A. PERSONAL DATA**

Full Name \_\_\_\_\_  
(print name as shown on your checks)

Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_

Social Security No. \_\_\_\_\_

U.S. Citizen? \_\_\_ Yes \_\_\_ No


Are you a Veteran of the United States? \_\_\_ Yes \_\_\_ No


Annual Income \$ \_\_\_\_\_


**B. REFERRAL**


By whom were you referred to this office?

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

 + (239) 260-4384

 info@joannejeffreyslaw.com

 500 Fifth Avenue South Suite 526  
Naples, Florida 34102

 www.joannejeffreyslaw.com

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**C. CHILDREN (if applicable)**

Name of Child: \_\_\_\_\_

MARRIED     SINGLE

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

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

Cell Phone.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Does he or she have any children?     YES     NO

If so, please list in **Section D. Grandchildren**

Name of Child: \_\_\_\_\_

MARRIED     SINGLE

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

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

Cell Phone.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Does he or she have any children?     YES     NO

If so, please list in **Section D. Grandchildren**

Name of Child: \_\_\_\_\_

MARRIED     SINGLE

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

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

Cell Phone.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Does he or she have any children?     YES     NO

If so, please list in **Section D. Grandchildren**

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Name of Child: \_\_\_\_\_

MARRIED     SINGLE

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

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

Cell Phone.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Does he or she have any children?     YES     NO

If so, please list in **Section D. Grandchildren**

Are all of your children in good health?     YES     NO

Are any of your children blind?     YES     NO

Are any of your children disabled?     YES     NO

Are any of your children receiving or expect to receive SSI  
or other form of government entitlement?     YES     NO

Do any of your family members have any problems with:  
Aids?     YES     NO

Drug Addiction?     YES     NO

Alcoholism?     YES     NO

Spendthrift?     YES     NO


**D. GRANDCHILDREN (if applicable)**

Name of Grandchild: \_\_\_\_\_


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


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

Cell Phone.: \_\_\_\_\_

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Name of Grandchild: \_\_\_\_\_

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

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

\_\_\_\_\_

Cell Phone.: \_\_\_\_\_

Name of Grandchild: \_\_\_\_\_

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

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

\_\_\_\_\_

Cell Phone.: \_\_\_\_\_

Name of Grandchild: \_\_\_\_\_

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

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

\_\_\_\_\_

Cell Phone.: \_\_\_\_\_

Name of Grandchild: \_\_\_\_\_

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

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

\_\_\_\_\_

Cell Phone.: \_\_\_\_\_

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**E. DISPOSITIVE INTENTIONS**

**I. CHILDREN**

If you have children, do you wish to treat all of your children equally? \_\_\_ Yes \_\_\_ No

If not, why not? \_\_\_\_\_

After your death, at what age do you want distribution to your children?

\_\_\_\_\_  
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

**2. GRANDCHILDREN**

If you have grandchildren, do you want to leave a specific amount of money or a percentage of your estate to your grandchildren? \_\_\_ Yes \_\_\_ No

Do you wish to treat all of your grandchildren equally? \_\_\_ Yes \_\_\_ No

If not, why not? \_\_\_\_\_

How much do you want to leave your grandchildren? \_\_\_\_\_


After your death, at what age do you want distribution to your grandchildren?

\_\_\_\_\_  
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)


**3. CHARITIES**


Do you want to leave a specific amount of money or other assets to any charity? \_\_\_ Yes \_\_\_ No

If yes, please list:

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Name of Charity	Address (include zipcode)	Dollar Amount

**4. OTHER BENEFICIARIES**

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

\_\_\_ Yes \_\_\_ No

If so, please list:

Name of Beneficiary	Address (include zipcode)	Relationship	Dollar Amount

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**F. PERSONAL REPRESENTATIVE**

Whom do you want to serve as your PERSONAL REPRESENTATIVE?

First Choice: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Second Choice \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Third Choice \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

**G. TRUSTEE**

Whom do you want to serve as your Trustee?

First Choice: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Second Choice \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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**H. GUARDIAN**

If you have minor or disabled child/children, whom do you want to act as Guardian?

First Choice: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Second Choice \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

**I. LIVING WILL**

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 \_\_\_\_\_ Tel. No. \_\_\_\_\_

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What is the name and address of your primary care physician?

Full Name of Physician: \_\_\_\_\_

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

\_\_\_\_\_

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

**J. POWER OF ATTORNEY**

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 \$15,000 in any one calendar year?

Yes \_\_\_ No \_\_\_

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

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<u>DESCRIPTION</u>	<u>ASSETS</u>	<u>LIABILITIES</u>
Bank Accounts [attach copies of statements]	\$	\$
Real Estate (residence)	\$	\$
Real Estate (other)	\$	\$
Certificates of Deposit (CDS)	\$	\$
Stocks – Non Mutual Funds (not held by Broker)	\$	\$
Stocks – Non Mutual Funds (held by Broker)	\$	\$
Mutual Funds	\$	\$
Note and Mortgage Receivables	\$	\$
Business Interests	\$	\$
Inheritance, etc.	\$	\$
Automobiles	\$	\$
Jewelry & Collections	\$	\$
Non-IRA Tax Qualified Retirement Plans	\$	\$
IRAs	\$	\$
Life Insurance	\$	\$
Annuities	\$	\$
Other Assets	\$	\$
<b>TOTALS :</b>	<b>\$</b>	<b>\$</b>

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**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)

(1) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tax Block # \_\_\_\_\_, Lot # \_\_\_\_\_ (Can be obtained from Tax Bill)

**M. CERTIFICATION**

The undersigned hereby represents to Jo-Anne Herina Jeffreys, Esq. P.A., 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(s) or Client Representative(s):

\_\_\_\_\_  
\_\_\_\_\_