

ESTATE PLANNING QUESTIONNAIRE

Date	File	Number
Home Phone No		#:
		Fax No
This form is extremely important. you. Please bring this information		ess in responding will help me best represent
A. PERSONAL DATA		
Full Name		<u></u>
(print nam	e 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 Unite	ed States? Yes No	
Annual Income <u>\$</u>		
B. REFERRAL		
By whom were you referred to	o this office?	
Name		
Street Address		
City	State	Zip







500 Fifth Avenue South Suite 526 Naples, Florida 34102







ESTATE PLANNING QUESTIONNAIRE

. CHILDREN (if applicable)
ame 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
ame 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
ame 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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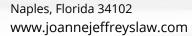
ESTATE PLANNING QUESTIONNAIRE

Name of Child:	
☐ MARRIED ☐ SINGLE	
Date of Birth:	
Address:	
Cell Phone.:	
Cen r none	
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 toreceive 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 Grandhild:	
Date of Birth:	
Address:	
Cell Phone.:	









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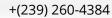




ESTATE PLANNING QUESTIONNAIRE

Name of Grandhild:	
Date of Birth: _	
Name of Grandhild:	
Cell Phone.: _	
Name of Grandhild:	
Date of Birth:	
Address:	
Cell Phone.:	
Name of Grandhild:	
Date of Birth:	
Address:	
Cell Phone.:	









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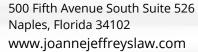
ESTATE PLANNING QUESTIONNAIRE

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 yo 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:









ESTATE PLANNING QUESTIONNAIRE

Name of Charity	Address (include zipcode)	Dollar Amount

4. OTHER BENEFICIARIES

Do yo	ou 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
FOO Fifth Avenue Couth Cuite FOC







info@joannejeffreyslaw.com



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ESTATE PLANNING QUESTIONNAIRE

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If you have minor or disabled c	hild/childr	en, whom do	o you want to act as Guardian?		
First Choice:					
Address				_	
Second Choice					
Address				_	
I. LIVING WILL					
Do you want your Living Will t	o provide f	or withdraw	al of artificial food and fluid?		
Do you want to donate your ey	es or organ	s? Yes _		_ Yes	_ No
Do you want your Health Care	Agent to co	onsult with a	ny 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
CityStateZip
Name of Proposed Alternate Financial Agent
Street Address
CityStateZip
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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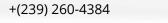




ESTATE PLANNING QUESTIONNAIRE

DESCRIPTION	<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	\$	\$
TOTALS:	\$	\$









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Personal Residence	e:					
Tax Block #	, Lot #	(Can be obtained	Can be obtained from Tax Bill)			
Addresses of real pr	operty other than j	personal residence:				
(I)Street		City	State	Zip		
Tax Block #	, Lot #	(Can be obtained f	n be obtained from Tax Bill)			
(I)Street		City	State	Zip		
Tax Block #	ax Block #, Lot # (Can be obtained from Tax Bill)					
M. CERTIFICATIO	N					
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):						







