CLIENT (couple) INFORMATION* as of ___ /___ / _____

[Strictly Confidential]

*Please complete all items as best you can. If any item does not apply to your situation, simply mark "N/A" in that space or leave it blank. * If you need more room to answer one or more questions, you can use the space provided after questions #19, #20, #21, and # 22, below.

Spouse/Partner #1 Full Legal Name:_____ Date of Birth ___/____/____

Other Names used by Spouse/Partner #1 :_____

Home Address: _____

Telephone: (home)_____ (work)_____ (cell)_____

Email address _____ alt email address_____

CA Driver's license # _____ Exp date: _____ Soc Sec #:_____-____-_____

US citizen? ☐ Yes ☐ No. If no, insert nationality: _____

Employment/Business(es) owned: _____

Spouse/partner #2 Full Legal Name: _____ Date of Birth ___/___/____

Other Names used by Spouse/Partner #2 _____

CA Driver's license # _____ Exp date: _____ Soc Sec #:_____-_____-_____

Telephone: (work) _____ (cell) _____

Email address _____ alt email address _____

Employment / Business(es) owned: _____

US citizen? ☐ Yes ☐ No. If no, what nationality:_____

Prior Marriages?

- Spouse/Partner #1: ☐ Yes ☐ No. If yes, name of prior spouse: _____

  How Terminated? ☐ Death ☐ Divorce Date:_____

- Spouse/Partner #2: ☐ Yes ☐ No. If yes, name of prior spouse:_____

  How Terminated? ☐ Death ☐ Divorce Date: _____

CHILDREN OF THIS MARRIAGE: ☐ None **AGE or DOB**

_____ _____
_____ _____
_____ _____
_____ _____

Number of grandchildren: _____ Range of Ages: _____

CHILDREN FROM PRIOR MARRIAGE: ☐ [Indicate whose child] **AGE**

_____ ☐ ☐ ____
_____ ☐ ☐ ____
_____ ☐ ☐ ____

	YES	NO
1. Treat all children as if they were the children of this marriage?	☐	☐
2. Any deceased children? …… ……..	☐	☐
If yes, name: _____		
If yes, survived by issue (heirs)? …… ……	☐	☐
3. Any adopted children? …… …...	☐	☐
If yes, name: _____		
4. Do any of your beneficiaries have a learning disability, special educational, medical or physical needs?.....	☐	☐
5. Do you have any relatives (other than children) who depend on you for all or part of their support? ……..	☐	☐
6. Do you think any of your beneficiaries have special problems with spouses, drugs, alcohol or handling money? ……	☐	☐
7. Do you wish to disinherit any of your children, grandchildren, or any other close relative? ……..……	☐	☐
8.Do you have an existing Marital Property Agreement? ….……..	☐	☐
9. Do you have existing wills? ……..……	☐	☐
10. Do you have any existing trusts? ……	☐	☐

	YES	NO
11. Should the surviving Spouse/Partner have the power to control the distribution of the entire estate after the first death? ……	☐	☐
12. Do you want any assets to pass to your children before the second spouse's death?.....	☐	☐
13. If a beneficiary dies prior to the second Spouse's/Partner's death, do you want the assets to go to that beneficiary's issue (heirs)? …	☐	☐
14. Do you want assets passing to your beneficiaries to be held in trust until a specific age or ages? ……..…..	☐	☐

If "Yes", briefly describe the age at which you would like specific portions of your estate to be distributed: (Example: pay trust income starting at age 21, principal to be distributed 1/3 at age 25; 1/3 at age 30; and remaining principal at age 35)

_____

_____

AGENTS / OTHER FIDUCIARIES WHO WILL ACT ON YOUR BEHALF IF NEEDED

These parties are known as Trustee(s), Executor(s), Agent(s) to hold Power of Attorney, Guardian(s) for minor beneficiaries, Agent for Healthcare and End-of-Life decisions **NOTE**: Please indicate instances where selections ***differ*** as between spouses.

15. **Trustee & Executor**: The name(s) of the person(s), other than the surviving Spouse/Partner, you want to be the decision-maker(s) to manage and control of your will and trust, if any.

	for Spouse/Partner #1	for Spouse/Partner #2 (if not same as Spouse/Partner #1)
1st successor: name, contact information, relationship to you		
2nd successor: name, contact information, relationship to you		
3rd successor: name, contact information, relationship to you		

16. **Durable Power of Attorney: Financial** The name(s) of the person(s), other than the surviving spouse, who you want to be the decision maker, if you are incapacitated, concerning the management and control of assets ***not*** in the name of your trust e.g. IRAs, 401k (s). **NOTE**: These are usually the same person(s) as for Trustee & Executor.)

	for Spouse/Partner #1	for Spouse/Partner #2 (if not same as Spouse/Partner #1)
1st successor: successor: name, contact information, relationship to you		
2nd successor: name, contact information, relationship to you		
3rd successor: name, contact information, relationship to you		

17. **Agent(s) for Healthcare and End-of-Life decisions** The name(s) of the person(s) other than the surviving Spouse/Partner who you want to make any major medical or end-of-life (EOL) decisions on your behalf:

	for Spouse/Partner #1	for Spouse/Partner #2 (if not same as Spouse #1)
1st successor: successor: name, contact information, relationship to you		
2nd successor: name, contact information, relationship to you		
3rd successor: name, contact information, relationship to you		

18. **Guardians**: The name(s) of the person(s) that you want to raise a child under the age of 18, or disabled or incapacitated person(s), or otherwise unable to be responsible for their own affairs if both Spouses/Partners are unable to do so:

	for Spouse/Partner #1	for Spouse/Partner #2 (if not same as Spouse #1)
1st successor: name, contact information, relationship to you		
2nd successor: name, contact information, relationship to you		
3rd successor: name, contact information, relationship to you		

19. In general, state how you want your estate distributed among your beneficiaries after the death of both of you? (For example, do you wish to make specific distributions to family members or other persons or charities not indicated elsewhere in this data sheet?)

_____

_____

20. State any specific concerns (not already mentioned) that you have regarding the distribution of your estate:

_____

_____

21. Do either of you anticipate a significant inheritance? If so, do you wish to make special provisions for those funds, e.g., keeping those funds titled as separate property?

- Please comment : _____

_____

22. Other Comments or Notes:

_____

_____

INSTRUCTIONS FOR MEDICAL, HEALTH CARE,

and END-OF-LIFE DECISIONS

Initial the statement(s) which best state your desires:

SPOUSE/Partner #1:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

_____

(b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

_____

YES	NO	
___	___	Should your health care agent have the authority to make a disposition of a part or parts of your body (i.e., make any anatomical gifts)?
___	___	Should your agent have the authority to authorize an autopsy even if an autopsy is not required by law?
____	___	Do you wish to designate a primary physician?

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____ (Add additional sheets if needed)

OTHER WISHES:

YES	NO	["YES" means I agree with the statement and :NO" means I do NOT agree.
___	___	If I ever fall into a persistently vegetative state, I wish my misery to be reduced as painlessly as possible.
___	___	If I become senile, I wish to die naturally and without any extraordinary medical treatment.
___	___	If I am in an irreversible coma or persistent vegetative state, I do not want any form of cardiopulmonary resuscitation (CPR.
___	___	If I am already in an irreversible coma, or persistent vegetative state and I develop some other illness or condition for which an additional course of treatment would be considered, I do not want any additional treatment to be initiated. For example, if I am in an irreversible coma and it is subsequently discovered that I have cancer, I do not want surgery, chemotherapy and or radiation. . (Add additional sheets if needed)

SPOUSE/Partner #2:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

_____

(b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

_____

YES	NO	
___	___	Should your health care agent have the authority to make a disposition of a part or parts of your body (i.e., make any anatomical gifts)?
___	___	Should your agent have the authority to authorize an autopsy even if an autopsy is not required by law?
___	___	Do you wish to designate a primary physician?

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____ (Add additional sheets if needed)

OTHER WISHES:

YES	NO	
___	___	If I ever fall into a persistently vegetative state, I wish my misery to be reduced as painlessly as possible.
___	___	If I become senile, I wish to die naturally and without any extraordinary medical treatment.
___	___	If I am in an irreversible coma or persistent vegetative state, I do not want any form of cardiopulmonary resuscitation (CPR.
___	___	If I am already in an irreversible coma, or persistent vegetative state and I develop some other illness or condition for which an additional course of treatment would be considered, I do not want any additional treatment to be initiated. For example, if I am in an irreversible coma and it is subsequently discovered that I have cancer, I do not want surgery, chemotherapy and or radiation. . (Add additional sheets if needed)

FINAL DISPOSITION / BURIAL WISHES

SPOUSE/Partner #1:

At my death, I wish to be: ☐ cremated ☐ buried.

- If cremation, I would like my ashes disposed as follows:

_____

_____

_____

- If buried, I would like my remains interred as follows:

_____

_____

_____

- I have already made arrangements at:

_____

_____

SPOUSE/Partner #2:

At my death, I wish to be: ☐ cremated ☐ buried.

- If cremation, I would like my ashes disposed as follows:

_____

_____

_____

- If buried, I would like my remains interred as follows:

_____

_____

_____

- I have already made arrangements at:

_____

_____

ESTATE ASSETS* (Use photocopies of these pages, if necessary)

*** Abbreviations for types of ownership / titling: CP = Community Property; CPWROS = Community Property with Rights of Survivorship; J/T = Joint Tenancy with Rights of Survivorship; S = Separate Property; TIC = Tenants in Common**

Real Estate [attach copy of deed(s) if available]

Property name / Description	Titling	APN / Parcel #	Notes

Vehicles, boats, etc. [does it have a title? If yes, indicate ownership.]

Make/ Model/ Description	Titling	Notes/Comments

Bank Accounts

Bank / Credit Union / Other	Titling	Notes/Comments

Other Personal Property: Collectibles, Notes Receivable, Royalties, other Intangible Assets, etc.

Description	Titling	Notes/Comments

ESTATE ASSETS (cont'd)

Investment / Brokerage accounts

Brokerage firm / Mutual Fund Other	**Titling**	**Account #**	**Beneficiary named?** (Y or N)

Retirement Accounts

Where held / Description	**Owner**	**Account #**	**Beneficiary named?** (Y or N)

Life Insurance

Company	**Insured**	**Policy #**	**Beneficiary named?** (Y or N)

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_____ _____ ___/____/_____
Name printed: Signature Date

_____ _____ ___/____/_____
Name printed: Signature Date