ESTATE PLANNING CHECKLIST

SECTION 1 – FAMILY INFORMATION

A. Yourself. **Date:** _____

1. Your name: _____
2. Other names by which you are known (e.g., maiden name) _____
3. Your home address and phone/e-mail _____
   _____
   _____
4. Your county of residence: _____
5. Your social security #: _____
6. Your date of birth: _____
7. Your place of birth: _____
8. Your citizenship: _____
9. Your occupation: _____
10. Your business address, phone, fax and e-mail: _____
    _____
    _____
11. General state of health: _____
12. Date of marriage: _____
13. Any prior marriages – divorces, separations, annulments, etc.? _____
14. Do you have a premarital agreement (or similar agreement) between you and your spouse? (If yes, please attach a copy) _____

B. Spouse.

1. Spouse's name: _____
2. Other names by which spouse is known (e.g., maiden name) _____
3. Spouse's social security #: _____
4. Spouse's date of birth: _____
5. Spouse's place of birth: _____
6. Spouse's citizenship: _____
7. Spouse's occupation: _____
8. Spouse's business address, phone and fax: _____
   _____
   _____
   _____
9. General state of health: _____
10. Any prior marriages – divorces, separations, annulments, etc.? _____

C. <u>Children (including adopted children and stepchildren)</u>.

Do you anticipate any more children? _____

Are any children adopted or stepchildren? _____

_____

Are you or anyone in your family disabled? _____

Does anyone in your family receive government benefits? _____

If yes, when did these benefits start. _____

<u>Child 1</u>

1. Name: _____
2. Address and Phone Number: _____
   _____
   _____
3. Date of birth: _____
4. If deceased, date of death: _____
5. Place of birth: _____
6. If married, spouse's name: _____
7. Stability of marriage? _____
8. Any children born of the child's marriage? If yes, list names and birth dates. ____
   _____
   _____
   _____

<u>Child 2</u>

1. Name: _____
2. Address and Phone Number: _____
   _____
   _____
3. Date of birth: _____
4. If deceased, date of death: _____
5. Place of birth: _____
6. If married, spouse's name:_____
7. Stability of marriage? _____
8. Any children born of the child's marriage? If yes, list names and birth dates. ____
   _____
   _____
   _____

Child 3

1. Name: _____
2. Address and Phone Number: _____
   _____
   _____
3. Date of birth: _____
4. If deceased, date of death: _____
5. Place of birth: _____
6. If married, spouse's name: _____
7. Stability of marriage? _____
8. Any children born of the child's marriage? If yes, list names and birth dates. ____
   _____
   _____
   _____

Child 4

1. Name: _____
2. Address and Phone Number: _____
   _____
   _____
3. Date of birth: _____
4. If deceased, date of death: _____
5. Place of birth: _____
6. If married, spouse's name: _____
7. Stability of marriage? _____
8. Any children born of the child's marriage? If yes, list names and birth dates. ____
   _____
   _____
   _____

Child 5

1. Name: _____
2. Address and Phone Number: _____
   _____
   _____
3. Date of birth: _____
4. If deceased, date of death: _____
5. Place of birth: _____
6. If married, spouse's name: _____
7. Stability of marriage? _____
8. Any children born of the child's marriage? If yes, list names and birth dates. ____
   _____
   _____
   _____

D. <u>Your Closet Living Relatives</u>.

Father: _____ Age:__
Address: _____
_____
_____

Mother: _____ Age:__
Address: _____
_____
_____

Sibling: _____ Age:__
Address: _____
_____
_____

Sibling: _____ Age:__
Address: _____
_____
_____

Sibling: _____ Age:__
Address: _____
_____
_____

E. <u>Your Spouse's Closest Living Relatives</u>.

Father: _____ Age:__
Address: _____
_____
_____

Mother: _____ Age:__
Address: _____
_____
_____

Sibling: _____ Age:__
Address: _____
_____
_____

Sibling: _____ Age:__
Address: _____
_____
_____

Sibling: _____ Age: ___
Address: _____
_____
_____

SECTION 2 – MISCELLANEOUS

A. Do you or your spouse own any assets located outside the State of Michigan? (If yes, please describe the asset and its location.)

_____
_____
_____

B. Have you or your spouse ever lived in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, or Washington)?

_____

C. Do you have a safe deposit box? (If yes, please give the name of the bank and the number of the box.)

_____
_____
_____

D. **Excluded Heirs.**

Is there anyone who you or your spouse would wish to exclude from any portion of your estate? (If yes, please identify) _____
_____
_____
_____

E. Do any persons owe you money? If so, provide the name of the borrower and the amount outstanding.

_____
_____

Remarks

_____
_____
_____
_____
_____
_____
_____
_____
_____

SECTION 3 – ASSETS

D. Assets – Please Enter Approximate Dollar Amounts. Single individuals please use fist and third columns only.

	Husband	Wife	Joint
1. Real estate			
a. Home-present value			
b. (Less mortgage)			
Home equity	( )	( )	( )
c. Other real estate			
d. Other real estate			
2. Bank accounts and CDs			
a. Savings			
b. Checking			
c. Certificate of Deposit			
d. Money Market Accounts			
3. Marketable stocks			
a. You Hold Certificates			
b. Brokerage Account			
4. Bonds			
5. Mutual Funds			
6. Notes & Loan receivable			
7. Life Insurance			
8. Closely-held business			
9. Pension & retirement benefits			
10. Personal nonbusiness property			
11. Annuities			
12. Individual Retirement Accts			
13. Other Assets (describe)			
a.			
b.			
c.			
TOTAL ASSETS			

When was the last time your Homeowner's Insurance and Auto Insurance Policies were reviewed? _____

_____

Do you have long term care insurance? _____

Remarks

_____

_____

_____

_____

_____

_____

SECTION 4 – ESTATE PLANNING DOCUMENTS TO BE PREPARED

A. Trustee Matters

1) Trustee

Name: _____
Address and Phone Number: _____
_____
_____
Social Security Number: _____
Relationship: _____

2) Alternate Trustee

Name: _____
Address and Phone Number: _____
_____
_____
Social Security Number: _____
Relationship: _____

B. Durable Power of Attorney.

1) Person to have power of attorney:

Name: _____
Address and Phone Number: _____
_____
_____
Relationship: _____

2) Alternate person to have power of attorney:

Name: _____
Address and Phone Number: _____
_____
_____
Relationship: _____

C. Medical Directive (also known as "Living Will" and Medical Power of Attorney.

1) Person to make decision concerning your health care in the event you are unable to make your own decisions.

Name: _____
Address and Phone Number: _____
_____
_____
Relationship: _____

2) Alternate person to make decisions concerning your health care in the event you are unable to make your own decisions.

Name: _____
Address and Phone Number: _____
_____
_____
Relationship: _____

D. Guardian For Minor or Person With Disability.

1) Person(s) to have care and custody of your children in the event both of you are deceased or unable.

Name(s): _____

Address and Phone Number: _____
_____
_____

Relationship: _____

2) Alternate person(s): _____

Address and Phone Number: _____
_____
_____

Relationship: _____

PLEASE FILL OUT FOR ANY SIGNIFICANT FAMILY MEMBER IN YOUR ESTATE PLAN WITH A DISABILITY

INSTRUCTIONS

PURPOSE: TO PROVIDE CURRENT INFORMATION REGARDING THE HISTORY OF [INSERT DISABLED PERSON'S NAME] _____, THE DAILY AND WEEKLY ROUTINES, AND RELATIONSHIPS AND ACTIVITIES THAT CONTRIBUTE TO HIS/HER QUALITY OF LIFE.

COMPLETION AND REVIEW: TO BE COMPLETED BY _____ [PARENT(S)] AND REVISED AS NECESSARY.

ATTACH SUPPLEMENTAL NOTES AS NECESSARY

GENERAL INFORMATION

PLEASE INSERT DISABLED PERSON'S NAME BELOW.

_____

PREFERS TO BE CALLED: _____

SOCIAL SECURITY NUMBER: _____

HEIGHT, WEIGHT: _____

CLOTHING AND SHOE SIZES: _____

_____

DATE OF BIRTH: _____

CITY WHERE RAISED: _____

MEDICAL INFORMATION – HISTORY, CURRENT STATUS AND CARE REQUIREMENTS

Diagnosis – primary diagnoses of condition and physical limitations:

_____

_____

_____

MEDICAL COMPLICATIONS:

_____

_____

SEIZURES (HISTORY, CURRENT STATUS):

_____

_____

INTELLECTUAL FUNCTIONING:

_____

_____

_____

VISION – STATUS OF VISION, NEED FOR GLASSES, DATE OF LAST EYE EXAM:

HEARING – NORMAL, NEED HEARING AID, ETC.:

SPEECH/ COMMUNICATIONS – NORMAL, IMPAIRED, DIFFICULT TO UNDERSTAND:

MOBILITY – ASSISTANCE NEEDED, ASSISTIVE DEVICES USED:

HEATH INSURANCE COVERAGE (COMPANY AND POLICY NUMBERS):

CURRENT PHYSICIANS AND HEALTH PRACTITIONERS (NAME, LOCATION, AND SPECIALTY):

FORMER PHYSICIANS (NAME, LOCATION, AND SPECIALTY):

DOES DISABLED PERSON CURRENTLY NEED NURSING CARE? IF YES, DESCRIBE PLACE AND TYPE REQUIRED (CLINIC, HOME, ETC.)

MENTAL HEALTH PRACTITIONERS CURRENTLY TREATING DISABLED PERSON (NAME, LOCATION)

THERAPY – IS DISABLED PERSON CURRENTLY UNDERGOING ANY TYPE OF THERAPY (PHYSICAL, SPEECH, OR OCCUPATIONAL)? IF YES, LIST NAME(S) OF THERAPIST(S), SPECIALTY AND LOCATION:

DIAGNOSTIC TESTING – LIST ANY DIAGNOSTIC TESTS REGULARLY UNDERGONE BY DISABLED PERSON (PURP LOCATION, FREQUENCY):

IMMUNIZATIONS – TYPE AND DATES OF IMMUNIZATIONS DISABLED PERSON HAS RECEIVED:

DISEASES – CHILDHOOD AND ADULTHOOD, DATES AND TYPES

OPERATIONS OR OTHER HOSPITALIZATION (DATES, PURPOSE, LOCATION):

ALLERGIES AND CURRENT TREATMENT:

PARENTS' OF DISALED PERSON AND THEIR RESPECTIVE HEALTH HISTORIES, CURRENT CONDITION:

Remarks