

**ESTATE PLANNING QUESTIONNAIRE  
(Single)**

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File # \_\_\_\_\_ Date \_\_\_\_\_

**This form is extremely important. Your accuracy and completeness in responding will help us best represent you.**

**A. PERSONAL DATA**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

May we correspond with you by e-mail? \_\_\_ Yes \_\_\_ No. If so, state e-mail address: \_\_\_\_\_

Age & Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

U.S. Citizen? Yes  No

**Existing Planning Documents:**

Will? Yes  No

Living trust? Yes  No

Durable Power of Attorney? Yes  No

Health Care Power of Attorney  
and Living Will? Yes  No

**PLEASE BRING COPIES OF YOUR EXISTING PLANNING DOCUMENTS TO OUR FIRST MEETING.**

**B. BASIC PLANNING CHOICES:**

Do you wish to set up Wills or do you prefer Revocable Living Trust? Will  Trust  Not Sure

1. **Proposed Personal Representatives:** Who do you choose to be your Personal Representatives (Executors) in your Will? Identify a Primary and one or more Alternate Personal Representatives.

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

2. **Trusts and Trustees:** Who do you choose as your Trustees?

(1) [  ] **Myself**, as initial Trustee, **AND/OR:** [  ] \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

**3. Proposed Agents for Financial Power of Attorney:**

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_

**4. Proposed Agents for Health Care Power of Attorney (Health Care Agents):**

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_

**C. ASSETS/LIABILITIES:** Please insert the approximate **value** of each asset/liability in the appropriate space. Use additional sheets, if necessary. If assets are jointly held with another (child, etc., indicate below).

ASSETS (explanation if necessary)	Owned by You		JOINTLY OWNED	
	Value		Value	(Who is joint owner?)
RESIDENCE				
CHECKING & SAVINGS ACCOUNTS				
CERTIFICATES OF DEPOSIT				
BROKERAGE ACCOUNTS				
IRAs				
ANNUITIES				
OTHER REAL ESTATE				
LIFE INSURANCE				
OTHER				
TOTALS				

(Attach additional information if necessary)

**D. CHILDREN:**

Please list your children.

1. \_\_\_\_\_ Telephone: \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Names & Ages: \_\_\_\_\_
  
2. \_\_\_\_\_ Telephone: \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Names & Ages: \_\_\_\_\_
  
3. \_\_\_\_\_ Telephone: \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Names & Ages: \_\_\_\_\_
  
4. \_\_\_\_\_ Telephone: \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Names & Ages: \_\_\_\_\_

**(Add additional pages if necessary)**

Are all of your children in good health? Yes  No

Are any of your children or grandchildren blind or disabled? Yes  No

If yes, Name(s): \_\_\_\_\_

Are any of your children receiving SS Disability or other form of government entitlement? (if yes, enter name(s) above) Yes  No

Have all of your children completed their education? Yes  No

Do any of your family members have significant problems with:

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| AIDS?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Drug Addiction? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Alcoholism?     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Spendthrift?    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Do any of your children or other relatives live with you in your home? Yes  No

If yes, name of child or other relative \_\_\_\_\_

Please describe any yes answers that may affect your disposition of property under your will or trusts.

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

**E. DISPOSITIVE INTENTIONS:**

**NOTE: PLEASE LIST ON A SEPARATE PAGE ANY SPECIFIC ITEMS YOU WISH TO LEAVE, BOTH PERSONAL ITEMS AND SPECIFIC FINANCIAL BEQUESTS AND DEVICES**

**WHO DO YOU WANT TO LEAVE YOUR ESTATE TO, WHETHER BY WILL OR IN TRUST? PLEASE INDICATE THE PERSON(S) AND ANY PERCENTAGES OR AMOUNTS.**

**AT OUR MEETING, WE WILL DISCUSS THESE QUESTIONS FURTHER.**

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

\_\_\_\_\_

(Add additional sheets for specific bequests, etc., if necessary)

If any of your beneficiaries die before you do, do you want their shares to go to their children instead? To others? Please specify:

\_\_\_\_\_

If the children/grandchildren are under the age at which they can safely receive their inheritance outright, you may want to consider their share(s) going into a trust. If so, at what age to you want the trust to be distributed to your younger beneficiaries? \_\_\_\_\_

(e.g., a typical plan might provide for 1/3 at age 25, 1/3 at age 30, and 1/3 at age 35)

**F. GUARDIAN:**

If you have **minor** children, whom do you want to act as Guardian?

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

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

**G. PRIOR GIFTS:**

Have you ever made gifts to any one person in excess of \$10,000 in any one calendar year? Yes  No

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

If so, please explain briefly. \_\_\_\_\_  
\_\_\_\_\_

**H. MISCELLANEOUS:**

Do you have any other legal issues that we 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: \_\_\_\_\_  
\_\_\_\_\_

**I. REFERRAL:**

By whom were you referred to this office? May we contact them to thank them? Yes  No

Name \_\_\_\_\_

Street Address \_\_\_\_\_

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

**J. CERTIFICATION:**

Signature of Client:

\_\_\_\_\_