

# Estate Planning Questionnaire



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**Please bring this form with you to your initial meeting. All information provided herein is considered CONFIDENTIAL INFORMATION by VIRGINIA LEGAL ASSOCIATES, PLLC and will not be shared with anyone outside of our office without your permission. Please call us if you have any questions.**

**Date Completed:** \_\_\_\_\_

**Please Print**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Name Used to Sign Legal Documents (please print) \_\_\_\_\_

Nickname \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State/ZIP \_\_\_\_\_

County/City of Residence \_\_\_\_\_ U.S. Citizen:  Yes  No

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Marital Status:  Single  Married, Date: \_\_\_\_\_  Divorced, Date: \_\_\_\_\_

Widowed, Date: \_\_\_\_\_ Deceased Spouse's Name: \_\_\_\_\_

Spouse Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Name Used to Sign Legal Documents (please print) \_\_\_\_\_

Nickname \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_

Cell phone \_\_\_\_\_ U.S. Citizen:  Yes  No

Employer \_\_\_\_\_ Position \_\_\_\_\_

Military Service

Husband: Branch \_\_\_\_\_ Length of Service \_\_\_\_\_

Wife: Branch \_\_\_\_\_ Length of Service \_\_\_\_\_

**Referred By:** \_\_\_\_\_ **Located in:** \_\_\_\_\_

# CHILDREN'S INFORMATION

**Child # 1** Age \_\_\_\_\_ Child of:  Client Only  Client & Spouse  Spouse Only

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Nickname \_\_\_\_\_

Home address \_\_\_\_\_

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

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Special Needs:  Medical  Financial  Educational

Marital Status of the Child:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

**Does this child have children?**

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Child # 2** Age \_\_\_\_\_ Child of:  Client Only  Client & Spouse  Spouse Only

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Nickname \_\_\_\_\_

Home address \_\_\_\_\_

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

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Special Needs:  Medical  Financial  Educational

Marital Status of the Child:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

**Does this child have children?**

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Child # 3** Age \_\_\_\_\_ Child of:  Client Only  Client & Spouse  Spouse Only

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Nickname \_\_\_\_\_

Home address \_\_\_\_\_

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

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Special Needs:  Medical  Financial  Educational

Marital Status of the Child:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

**Does this child have children?**

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Child # 4** Age \_\_\_\_\_ Child of:  Client Only  Client & Spouse  Spouse Only

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Nickname \_\_\_\_\_

Home address \_\_\_\_\_

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

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Special Needs:  Medical  Financial  Educational

Marital Status of the Child:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

**Does this child have children?**

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Child # 5** Age \_\_\_\_\_ Child of:  Client Only  Client & Spouse  Spouse Only

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Nickname \_\_\_\_\_

Home address \_\_\_\_\_

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

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Special Needs:  Medical  Financial  Educational

Marital Status of the Child:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

**Does this child have children?**

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Child # 6** Age \_\_\_\_\_ Child of:  Client Only  Client & Spouse  Spouse Only

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Male  Female Nickname \_\_\_\_\_

Home address \_\_\_\_\_

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

Home telephone \_\_\_\_\_ Cell phone \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Special Needs:  Medical  Financial  Educational

Marital Status of the Child:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

**Does this child have children?**

Children's Names	Ages	Birth-Child	Step-Child	Adopted	Special Needs
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# OTHER DEPENDENTS

Are there any persons that are dependent upon you for their support?

## Dependent # 1

Dependent's Full Legal Name \_\_\_\_\_

Relationship: \_\_\_\_\_

Birth date \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Special Needs?  Medical  Educational  Financial

Marital Status of this person:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

## Dependent # 2

Dependent's Full Legal Name \_\_\_\_\_

Relationship: \_\_\_\_\_

Birth date \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Special Needs?  Medical  Educational  Financial

Marital Status of this person:  Married  Divorced  Widowed  Single

If Married, Spouse's Name: \_\_\_\_\_

# PEOPLE WHO ADVISE YOU

Name & Company

Telephone

Insurance Agent \_\_\_\_\_

Tax Advisor \_\_\_\_\_

Family Attorney \_\_\_\_\_

Business Attorney \_\_\_\_\_

Financial Advisor \_\_\_\_\_

Stock Broker \_\_\_\_\_

Banker \_\_\_\_\_

Other Advisor \_\_\_\_\_

# ADDITIONAL PERSONAL INFORMATION

## Seasonal Address

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

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

When are you usually there (what months)? \_\_\_\_\_

## Other

- Are any of your parents living?  Yes  No

If yes,  
Father of: \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Mother of: \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Father of: \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Mother of: \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

- Please indicate any charitable, church, and/or community organizations in which you have strong personal involvement:

Name \_\_\_\_\_ Location \_\_\_\_\_

Name \_\_\_\_\_ Location \_\_\_\_\_

Name \_\_\_\_\_ Location \_\_\_\_\_

- Family Pets?

Name \_\_\_\_\_  Dog  Cat  Other: \_\_\_\_\_

Name \_\_\_\_\_  Dog  Cat  Other: \_\_\_\_\_

Name \_\_\_\_\_  Dog  Cat  Other: \_\_\_\_\_

# NOMINATIONS FOR ESTATE PLAN

If you were incapacitated for any period of time during life, who would you choose to handle your **financial** affairs? This is your financial power of attorney.

Financial Agents		You	Your Spouse
	Initial Choice		
	Back Up # 1		
	Back Up #2		

If you were incapacitated for any period of time during life, who would you choose to make **health care** decisions for you? This is your healthcare power of attorney.

Health Care Agents*		You*	Your Spouse*
	Initial Choice		
	Back Up # 1		
	Back Up # 2		

\*Ultimately, we will need the addresses and telephone numbers of the persons identified above. Please consider providing this information on a separate sheet as you complete this form.

Who would you want to assume the legal responsibility of **managing your Estate/Trust** when you are no longer living?

Disability Trustee/ Successor Trustee		You & Your Spouse	
	Initial Choice		
	Back Up # 1		
	Back Up # 2		

Who would you want to assume the legal responsibility of **taking your Last Will & Testament** to the Court when you are no longer living?

Personal Representative		You	Your Spouse
	Initial Choice		
	Back Up # 1		
	Back Up # 2		

Who would you like to nominate to serve as **guardian** for your minor children (if any)?

Guardians		You & Your Spouse	
	Initial Choice		
	Back Up # 1		
	Back Up #2		

HIPAA (Health Insurance Portability and Accountability Act) is the medical privacy act that was passed to protect your healthcare information. Our HIPAA Authorization allows you to choose who you want to receive information regarding your health and medical status. Please try to keep this list to only 5 names.

You: \_\_\_\_\_

Spouse: \_\_\_\_\_



# ESTIMATED VALUE OF MY ESTATE

Please use estimated figures, round where necessary.  
Indicate whether individual or joint, Indicate owner(s).

	<u>Value</u>	<u>Company</u>
Primary Home	\$ _____	_____
Other Real Estate (value & type of property)	\$ _____	_____
Business Interests (value and entity type)	\$ _____	_____
Checking/ Money Market	\$ _____	_____
Savings Accounts	\$ _____	_____
Certificates of Deposit	\$ _____	_____
Stocks/Bonds /Mutual Funds (non IRA)	\$ _____	_____
Annuities (non-IRA)	\$ _____	_____
Retirement: IRA/Pension/TSA /401k	\$ _____	_____
Life Insurance (Death Benefit & Cash Value) <small>Circle one: Term Whole Life</small>	\$ _____	_____
Autos, Boats, RV's, etc.	\$ _____	_____
Personal Property (antiques, valuables)	\$ _____	_____
Collectible Loans or money due to you	\$ _____	_____
Expected Inheritance	\$ _____	_____
<b>Total Assets:</b> (add everything up)	\$ _____	_____
How much do you owe right now? (Total mortgages, loans, etc.)	\$ _____	_____
<b>Approximate Net Worth:</b> (Total assets minus debt)	\$ _____	_____

PLEASE USE THIS SPACE FOR ANY ADDITIONAL FAMILY  
INFORMATION OR FOR ANY QUESTIONS YOU MAY HAVE: