



Estate Planning Worksheet

Date:		Desired Completion Date (if any):										
Referred By:	<input type="checkbox"/> Individual:	<input type="checkbox"/> Association:	<input type="checkbox"/> Internet Search:									
Client #1 Name	First	Middle	Last									
Physical Address:												
Mailing Address:												
Home Phone:		Cell Phone:										
Email:												
Date of Birth:												
Occupation:												
U.S. Citizen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other									
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed									
List all current and previous marriages:	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Spouse Name</u></td> <td style="text-align: center;"><u>Marriage Date</u></td> <td style="text-align: center;"><u>End of Marriage Date</u></td> </tr> <tr> <td colspan="3">1. _____</td> </tr> <tr> <td colspan="3">2. _____</td> </tr> </table>			<u>Spouse Name</u>	<u>Marriage Date</u>	<u>End of Marriage Date</u>	1. _____			2. _____		
<u>Spouse Name</u>	<u>Marriage Date</u>	<u>End of Marriage Date</u>										
1. _____												
2. _____												
Client #2 Name	First	Middle	Last									
Home Phone:		Work Phone:										
Cell Phone:		Preferred Phone:										
Email:												
Date of Birth:												
Occupation:												
U.S. Citizen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other									
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed									
List all current and previous marriages:	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Spouse Name</u></td> <td style="text-align: center;"><u>Marriage Date</u></td> <td style="text-align: center;"><u>End of Marriage Date</u></td> </tr> <tr> <td colspan="3">1. _____</td> </tr> <tr> <td colspan="3">2. _____</td> </tr> </table>			<u>Spouse Name</u>	<u>Marriage Date</u>	<u>End of Marriage Date</u>	1. _____			2. _____		
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1. _____												
2. _____												

***Please review your answers for accuracy. We use the information on this worksheet to prepare your estate planning documents. ***

Section 1. Children

1) Do you have children, living or deceased? Please check one.

Yes (If yes, see below) No (if no, skip to section #2)

1) Name:	
Gender:	
Date of Birth:	
Address:	
Other Parent:	
<input type="checkbox"/> Living	If deceased , does the deceased child have any living children? Yes (list living children of deceased) <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Deceased	1. _____ 3. _____ 2. _____ 4. _____

2) Name:	
Gender:	
Date of Birth:	
Address:	
Other Parent:	
<input type="checkbox"/> Living	If deceased , does the deceased child have any living children? Yes (list living children) <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Deceased	1. _____ 3. _____ 2. _____ 4. _____

3) Name:	
Gender:	
Date of Birth:	
Address:	
Other Parent:	
<input type="checkbox"/> Living	If deceased , does the deceased child have any living children? Yes (list living children) <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Deceased	1. _____ 3. _____ 2. _____ 4. _____

4) Name:	
Gender:	
Date of Birth:	
Address:	
Other Parent:	
<input type="checkbox"/> Living	If deceased , does the deceased child have any living children? Yes (list living children) <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Deceased	1. _____ 3. _____ 2. _____ 4. _____

2) Do you have a child or children with special needs? Please check one.

Yes (if yes, please explain) No

Section 2. Plans

Please check one for each client.

1) Do you currently have a Will?	Client #1 Yes <input type="checkbox"/> No <input type="checkbox"/>	Client #2 Yes <input type="checkbox"/> No <input type="checkbox"/>
2) Do you currently have a Trust?	Client #1 Yes <input type="checkbox"/> No <input type="checkbox"/>	Client #2 Yes <input type="checkbox"/> No <input type="checkbox"/>
3) Do you have Long-Term Care (nursing home) Insurance policy?	Client #1 Yes <input type="checkbox"/> No <input type="checkbox"/>	Client #2 Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3. Health Care Decisions

Please check one for each client.

Client #1

1) Do you want to be an organ donor? Yes No

1) Do you want to designate what your organ donation will be used for?	Transplant	Exclusions:
	Education	
	All purposes	
2) Life Prolonging Treatment (Please choose one)	No medical treatment if principal is in an irreversible, persistent vegetative state, if terminally ill and life-sustaining procedures would only artificially delay death; or if burdens of treatment outweigh expected benefits	
	Medical treatment unless principal is in an irreversible coma	
	Preclude life-sustaining procedures if principal is in a terminal condition	
	Receive medical treatment that will allow the principal to live as long as possible	
	Other:	

Client #2

2) Do you want to be an organ donor? Yes No

1) Do you want to designate what your organ donation will be used for?	Transplant	Exclusions:
	Education	
	All purposes	
2) Life Prolonging Treatment (Please choose one)	No medical treatment if principal is in an irreversible, persistent vegetative state, if terminally ill and life-sustaining procedures would only artificially delay death; or if burdens of treatment outweigh expected benefits	
	Medical treatment unless principal is in an irreversible coma	
	Preclude life-sustaining procedures if principal is in a terminal condition	
	Receive medical treatment that will allow the principal to live as long as possible	
	Other:	

3) If something were to happen to you, who would you want making medical decisions for you? Note: If you are married, your spouse is typically the primary agent for these decisions.

Client #1

Primary Agent: Address: Phone Number: Relation to you:	
First Alternate Agent: Address: Phone Number: Relation to you:	
Second Alternate Agent: Address: Phone Number: Relation to you:	

Client #2

Primary Agent: Address: Phone Number: Relation to you:	
First Alternate Agent: Address: Phone Number: Relation to you:	
Second Alternate Agent: Address: Phone Number: Relation to you:	

4) Burial and Funeral Instructions (if any):

Section 4. Financial Decisions (Power of Attorney Agents, Executor, and Trustee)

Primary Agent: Address: Phone Number: Relation to you: U.S Citizen:	
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First Alternate Agent: Address: Phone Number: Relation to you: U.S. Citizen	
Second Alternate Agent: Address: Phone Number: Relation to you: U.S. Citizen:	

Section 5: Guardian of Minor Children

1) If any of your children are 17 years old or younger and/or have special needs, in case of death or incapacity (of you and their other parent) who do want to care for them? This person has physical custody of your child(ren) & manages their financial assets.

Primary: Address: Phone Number: Relation to you:	
First Alternate: Address: Phone Number: Relation to you:	
Second Alternate: Address: Phone Number: Relation to you:	

Section 6. Distributions

1) Specific Gifts. Do you want to make any specific gifts or personal property? Please check one.

Yes (if yes, please list) No

2) Charitable Gifts. Do you want to make any charitable gifts? Please check one.

Yes (if yes, please list) No

3) How do you want your assets distributed after your death? Please mark one.

<input type="checkbox"/>	Equally between children/beneficiaries
<input type="checkbox"/>	To Sole Beneficiary (Listed in Section 5)
<input type="checkbox"/>	Unequally Amongst Children/Beneficiaries
<input type="checkbox"/>	(Explain Below)
<input type="checkbox"/>	Other (Explain Below)
<input type="checkbox"/>	
<input type="checkbox"/>	

4) At what age do you want your children or beneficiaries to receive their share of your assets?
Please mark one.

<input type="checkbox"/>	Receive 1/3 at the age of 25, 1/2 at the age of 30, remainder at age 35
<input type="checkbox"/>	Receive 1/2 at the age of 25, 1/2 at the age of 30
<input type="checkbox"/>	Receive all assets at the age of 30
<input type="checkbox"/>	Receive all assets outright (no age restrictions)
<input type="checkbox"/>	Other (Explain Below)
<input type="checkbox"/>	
<input type="checkbox"/>	

5) If no children, or if your children predecease you, who would you want to receive your assets?

1) Name: Address: Phone Number: Relation to you:	
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2) Name: Address: Phone Number: Relation to you:	
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3) Name: Address: Phone Number: Relation to you:	
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Section 7. Assets

Please answer the following to the best of your ability. If do not have the listed asset, please skip that question. Please note if you own any of the following with a third party.

1) Client #1

Monthly Income: _____

Other Income: _____

2) Client #2

Monthly Income: _____

Other Income: _____

3) Do you own any real property?

1) Address: Current Value:	
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2) Address:	
Current Value:	
3) Address:	
Current Value:	

4) If you have any of the following assets, please provide the approximate value of the asset(s).

Checking Account (Bank name.):	
Savings Account (Bank name):	
IRA/401(k):	
Stocks, Bonds, Mutual Funds, Other Investments:	
Business Interests (Type of Business – LLC, Corporation, Other):	
Automobiles (Year, Make and Model):	
Digital assets:	
<input type="checkbox"/> Paypal	\$ _____
<input type="checkbox"/> E-Trade	\$ _____
<input type="checkbox"/> Cryptocurrency approx. value	\$ _____
<input type="checkbox"/> Other assets	\$ _____

5) Do you have life insurance policies?

Client #1	<input type="checkbox"/> Term <input type="checkbox"/> Universal Form <input type="checkbox"/> Whole
Type (Check One):	
Cash Value:	
Death Benefit:	Primary Beneficiary: _____
Who are the Beneficiaries?	Secondary Beneficiary: _____

Client #2	<input type="checkbox"/> Term
Type(Check One):	<input type="checkbox"/> Universal Form
Cash Value:	<input type="checkbox"/> Whole
Death Benefit:	Primary Beneficiary: _____
Who are the Beneficiaries?	Secondary Beneficiary: _____

6) If married, are any of the assets listed above separately held (i.e., not community property)? Please check one:

Client #1: Yes No Client #2: Yes No

If yes, please explain:

7) Do you expect any inheritances? If yes, please describe generally.

Section 8. Liabilities

Do you owe any money? If so, how much? [Ex: Loan for automobile or home]

Loan Type	Amount Owed
1.	
2.	
3.	

Section 10. Notes - Questions

Questions, Notes, or Clarifications:

To Return the Completed Worksheet:

BY EMAIL: Attach to an email and send to amandaburel@grtlaw.com

BY FAX: Send to (916) 851-1995

BY MAIL: Mail to 2366 Gold Meadow Way, Suite 200, Gold River, CA 95670

If you have any questions or concerns please contact our office at (916) 851-1900, or email amandaburel@grtlaw.com, or Shea@grtlaw.com.

Please make sure to double check your answers for accuracy

ADDITIONAL INFORMATION