WILL INFORMATION SHEET

Name: _____ DOB:
Street Address: _____City:
State: ___ Zip: _____ Home #:
E-mail: _____ Cell #:
Last 3 # of SSN: _____ Last 3 # of DL:

Spouse's Name: _____ DOB:
Street Address: _____ City:
State: ___ Zip: _____ Home #:
E-mail: _____ Cell #:
Last 3 # of SSN: _____ Last 3 # of DL:

CHILDREN'S INFORMATION:

Name	Age	DOB

YOUR DISPOSITIVE PLAN

Do you wish to leave everything to your spouse, then children, in equal shares? Yes No

If not, describe in general terms how you wish to distribute your property under your will:

Do you wish to include a no-contest clause? (Any beneficiary who contests the will would forfeit their inheritance.) Yes No

Do you have any special requests regarding funeral arrangements?

If your children are beneficiaries of your property, do you want the property to be distributed to your children outright or in trust until a certain date?

Outright _____ In Trust until reach age _____, then outright

EXECUTOR (i.e., the person who will be responsible for probating your will, filing the estate tax return, if necessary, and distributing assets to the beneficiaries)

Name of Executor: _____ Relation:
1st Alternate Executor: _____ Relation:

TRUSTEE (i.e., the person who will be responsible for the long-term management of property for the surviving spouse, children or other beneficiaries)

Name of Trustee: _____ Relation:
1st Alternate Trustee: _____ Relation:

GUARDIAN OF MINOR CHILDREN (i.e. the person who will take physical care of your minor children should both parents die)

Name of Guardian: _____ Relation:
1st Alternate Guardian: _____ Relation:

POWER OF ATTORNEY (i.e., the person who will be responsible for handling your financial affairs in the event you become incapacitated)

Name of Power of Attorney: _____ Relation:
Address:
Home Phone No.: _____ Cell Phone No.:

Alternate Power of Attorney: _____ Relation:
Address:
Home Phone No.: _____ Cell Phone No.:

MEDICAL POWER OF ATTORNEY (i.e. the person designated to make health care decisions on your behalf)

Name of Medical Power of Attorney: _____ Relation:
Address:
Home Phone No.: _____ Cell Phone No.:

Alternate Medical Power of Attorney: _____ Relation:
Address:
Home Phone No.: _____ Cell Phone No.:

DIRECTIVE TO PHYSICIAN (Allows you to instruct your physician to withhold artificial life-sustaining procedures or treatment after your physician determines that you are terminally ill.)

Yes _____ No