

PLEASE FILL OUT ALL INFORMATION COMPLETELY, INCLUDING FULL NAMES AND FULL ADDRESSES

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PLEASE FILL OUT ALL INFORMATION COMPLETELY, INCLUDING FULL NAMES AND FULL ADDRESSES

Name _____

Date _____ File Number _____

Home Phone No. _____ Business Phone No. _____

E-mail address _____ Fax No. _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

A. PERSONAL DATA

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Borough Township or City (PLEASE CIRCLE ONE) COUNTY _____

Birth Date _____

U.S. Citizen? Yes No

Do you have a prenuptial agreement? _____ If so, please provide a copy.

Annual Income _____

B. REFERRAL

By whom were you referred to this office?

Name _____

Street Address _____

City _____ State _____ Zip _____

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Have you visited our Website? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

C. CHILDREN (if applicable)

Child's Name	Address (including zip code)	Home Phone Number	Work Phone Number	Date of Birth

Does the Client have any children by a previous marriage? If yes, please
Provide a copy of any judgment and/or settlement agreements. ___ Yes ___ No

Are all of your children in good health? ___ Yes ___ No

Are any of your children blind? ___ Yes ___ No

Are any of your children disabled? ___ Yes ___ No

Have all of your children completed their education? ___ Yes ___ No

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Are any of your children receiving SSI or other form of government entitlement?
i.e., disability awards or VA benefits? Yes No

Do any of your family members have any problems with:

- Aids? Yes No
- Drug Addiction? Yes No
- Alcoholism? Yes No
- Spendthrift? Yes No
- Do you have any pets? Yes No

D. GRANDCHILDREN

Grandchild's Name	Address (including zip code)	Date of Birth

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E. DISPOSITIVE INTENTIONS

1. CHILDREN

Do you wish to provide primarily for your children? Yes No

Do you wish to treat all of your children equally? Yes No

If not, why not? _____

At what age do you want distribution to your children? _____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

2. GRANDCHILDREN

Do you want to leave a specific amount of money or a percentage of your estate to your grandchildren? Yes No

Do you wish to treat all of your grandchildren equally? Yes No

If not, why not? _____

How much do you want to leave your grandchildren? _____

At what age do you want distribution to your grandchildren? _____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

3. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? Yes No

If yes, please list:

Name of Charity	Address of Charity	Dollar Amount

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4. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren or a charity?
__ Yes__ No

If so, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

F. EXECUTOR

Whom do you want to serve as your Executor?

First Choice: _____

Second Choice _____

(Name and Full Address)

Third Choice _____

(Name and Full Address)

G. TRUSTEE

Whom do you want to serve as your Trustee?

First Choice _____

(Name and Full Address)

Second Choice _____

(Name and Full Address)

H. GUARDIAN

If you have **minor** or **disabled** child/children, whom do you want to act as Guardian?

First Choice _____

(Name and Full Address)

Second Choice _____

(Name and Full Address)

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I. LIVING WILL

Do you want your Living Will to provide for withdrawal of extraordinary and heroic efforts to maintain you and to withdraw artificial food and fluid if you have no chance of recovery? Yes No

Do you want to donate your eyes or organs? Yes No

Do you want your Health Care Agent to consult with any other person prior to acting?
 Yes No

If yes, with whom? _____

Do you have any specific burial instructions? _____

Name of Proposed Health Care Agent _____
Street Address _____
City _____ State _____ Zip _____

Name of Proposed Alternate Health Care Agent _____
Street Address _____
City _____ State _____ Zip _____

What are the name and address of each of your primary care physician?

Full Name of Physician _____
Street Address _____
City _____ State _____ Zip _____

J. POWER OF ATTORNEY

Name of Proposed Financial Agent _____
Street Address _____
City _____ State _____ Zip _____
Effective Only on Disability Yes _____ No _____

Name of Proposed Alternate Financial Agent _____
Street Address _____
City _____ State _____ Zip _____

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K. MISCELLANEOUS

Do you have any other legal issues which I 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? Name of Bank _____

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

Do you expect any inheritances?

Yes No

L. Real Property.

Personal Residence:

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1) City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

(2) City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

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M. FINANCIAL SUMMARY

ASSETS

Bank Accounts	\$ _____
Real Estate (residence)	\$ _____
Real Estate (other)	\$ _____
Savings Certificates (CDS)	\$ _____
Stocks - Non Mutual Funds	\$ _____
Stocks - Non Mutual Funds	\$ _____
Bonds - Non Mutual Funds	\$ _____
Bonds - Non Mutual Funds	\$ _____
Mutual Funds	\$ _____
Note and Mortgages Receivables	\$ _____
Business Interests	\$ _____
Inheritance, etc.	\$ _____
Automobiles	\$ _____
Jewelry & Collections	\$ _____
Non-IRA Tax Qualified Retirement Plans	\$ _____
IRAs	\$ _____
Life Insurance	\$ _____
Annuities	\$ _____
Other Assets	\$ _____
TOTALS	\$ _____

N. LIFE INSURANCE

COMPANY	OWNER	INSURED	PRIMARY BENEFICIARY	CONTINGENT BENEFICIARY	AMOUNT
					\$
					\$
					\$
					\$
					\$
					\$

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Trusts _____

Business Interests _____

Mortgages and other loans and amounts _____

Insurance _____

O. Additional Information you may think we should know _____

P. CERTIFICATION

The undersigned hereby represents to DAVISON, EASTMAN, MUÑOZ LEDERMAN & PAONE, P.A and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client:
