GENEVIEVE CHESNUT, INC.
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ESTATE PLANNING QUESTIONNAIRE

Date: _____

Home address: _____

Person 1 information:

- Name: _____
- Cell: _____
- Email: _____
- DOB: _____
- SSN: _____
- U.S. citizen? YES / NO If no, permanent resident? YES / NO
- Driver's license # and expiration date: _____
- Business occupation / title: _____
- Previously married with child/spousal obligations? YES / NO

Person 2 information:

- Name: _____
- Cell: _____
- Email: _____
- DOB: _____
- SSN: _____
- U.S. citizen? YES / NO If no, permanent resident? YES / NO
- Driver's license # and expiration date: _____
- Business occupation / title: _____
- Previously married with child/spousal obligations? YES / NO

If married, date of marriage: _____ Property Agreement? YES / NO

Each child's name, DOB, & any stepchild relationships or name of other parent:

1. _____
2. _____
3. _____
4. _____
5. _____

Explain a child's special needs: _____

_____

_____

_____

FIDUCIARIES

(person or entity to manage your finances / health care if you are incapacitated / die)

Person 1: Is Person 2 your primary fiduciary? YES / NO / N/A

Financial fiduciary name and contact information:

1. _____
2. _____

Health care fiduciary and contact information:

1. _____
2. _____

Person 2: Is Person 1 your primary fiduciary? YES / NO

Are your fiduciaries the same as for Person 1? YES / NO

Financial fiduciary name and contact information:

1. _____
2. _____

Health care fiduciary name and contact information:

1. _____
2. _____

Guardians for minor children (if you name a couple, indicate PRIMARY person)

1. _____
2. _____

DISTRIBUTION UPON DEATH

Person 1 estate distribution: All to Person 2 if alive? YES / NO / N/A

If no (or if Person 2 is deceased) explain how you want your estate distributed (provide full names of person and/or charities and contact information):

_____

_____

_____

_____

_____

Person 2 estate distribution: All to Person 1 if alive? YES / NO

If no (or if Person 1 is deceased) explain how you want your estate distributed (provide full names of person and/or charities and contact information):

_____

_____

_____

_____

_____

HEALTH CARE POWERS

Mark out any powers you do NOT want your health care agent to have: (1) to authorize your autopsy; (2) to dispose of your body parts or organs needed for any transplant, therapeutic, educational, or research purposes; and (3) if you previously have not done so, to direct the disposition of your remains and to make any advance arrangements for your funeral, burial or cremation, including the purchase of a burial plot and marker.

Your health care power will state that you desire that all life sustaining treatment be withheld or withdrawn if the burdens of proposed or continuing treatment to keep you alive outweigh the expected benefits unless you tell me otherwise.

ASSET INFORMATION

Do you own subchapter s corporation stock? YES / NO

Do you have a buy-sell agreement? YES / NO

If married, are all of your assets community property? YES / NO

List your assets and liabilities with current values or provide a current financial statement. If married and you have separate property, indicate character of assets:

List your professional advisors and contact information:

List any other information or questions you want to discuss: