

Confidential Worksheet: Family Protection Planning



Date: _____

Instructions: Please complete and return before your consultation. Call **616-777-5293** if you have any questions.

Mail: 3083 Washington Avenue SW, Suite E, Grandville, MI 49418

Fax: 800-609-5298

Email: info@EyestoneLawOffices.com

Section 1: Personal Information

Client	<i>Name as you sign it:</i>	
	<i>What you prefer to be called (if different):</i>	
	<i>Date of Birth:</i>	<i>SS Number:</i>
	<i>Employer:</i>	<i>Job Title:</i>
	<i>Phone:</i>	<i>Email:</i>
	<i>Citizenship:</i>	<i>Ex / Dec'd Spouse(s):</i>

Marriage	<i>Date of Marriage:</i>
	<i>Place of Marriage:</i>

If you are married and all information on this worksheet is identical for you and your spouse, complete only one worksheet. If information for each spouse differs, make a copy of this worksheet so each spouse has a separate one.

Spouse	<i>Name as you sign it:</i>	
	<i>What you prefer to be called (if different):</i>	
	<i>Date of Birth:</i>	<i>SS Number:</i>
	<i>Employer:</i>	<i>Job Title:</i>
	<i>Phone:</i>	<i>Email:</i>
	<i>Citizenship:</i>	<i>Ex / Dec'd Spouse(s):</i>

Address	<i>Street:</i>	
	<i>City:</i>	<i>County:</i>
	<i>State:</i>	<i>Zip:</i>

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Section 2: Professional Advisors

Please include the names of the advisors you would like involved with your estate planning during your life or your trust / estate administration following death or incapacity.

Financial Advisor	<i>Name:</i>	<i>Email:</i>
	<i>Company:</i>	<i>Phone:</i>

Accountant	<i>Name:</i>	<i>Email:</i>
	<i>Company:</i>	<i>Phone:</i>

Insurance Agent	<i>Name:</i>	<i>Email:</i>
	<i>Company:</i>	<i>Phone:</i>

Religious Advisor	<i>Name:</i>	<i>Email:</i>
	<i>Company:</i>	<i>Phone:</i>

Other Advisor	<i>Name:</i>	<i>Email:</i>
	<i>Company:</i>	<i>Phone:</i>

Other Advisor	<i>Name:</i>	<i>Email:</i>
	<i>Company:</i>	<i>Phone:</i>

* If you have additional advisors, please make a copy of this worksheet for each one.

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Section 3: Your Reasons for Planning

Please identify the reasons you are considering estate planning or questions you have (check all applicable).

Protect Your Children or Other Beneficiaries:

- From predators who can access inheritance amounts and target young or vulnerable beneficiaries
- From claims of divorced spouses to have half of your child or beneficiary's inheritance
- From malpractice claims, for beneficiaries in their professions
- From other creditor claims (such as car accident plaintiffs)
- From the stress and delays of the average 16-month process of probate
- From financial immaturity resulting in a quick loss of the entire inheritance
- From sharing assets with heirs you would rather disinherit
- From lawsuits by disinherited heirs
- For parents only:* From relatives who would be poor, abusive or even dangerous guardians
- For parents only:* From acquaintances and relatives who should not be allowed to be alone with your children
- For parents only:* From a court proceeding that costs precious time in the event you are unable to authorize needed medical care for your child
- For special needs beneficiaries only:* From neglect in the government care system

Maximize Assets:

- By minimizing taxes during your life (income taxes, capital gains taxes, estate taxes on inheritances you expect to receive)
- By minimizing or eliminating estate taxes upon your death (up to 45% of your assets and life insurance benefits)
- By reducing estate administration costs through probate avoidance
- Avoid or limit Medicaid claims on your assets should you require long-term care
- Ensure that a special needs beneficiary has assets that are protected from government seizure while retaining eligibility for needed services
- Ensure that your family has enough life insurance to provide a reasonable lifestyle no matter what

Protect Yourself and Your Spouse:

- From malpractice or creditor claims
- From conservatorship proceedings (aka "living probate") if you or your spouse become incapacitated
- From probate delays and stress upon your death or the death of your spouse
- From hospital policies requiring life-sustaining procedures when you would rather not endure them
- From healthcare decisions made by people other than those you trust most

Ensure Quality of Life:

- Give to a charitable organization or activity
- Support a common family goal through coordinated planning
- Provide that your death will not be unnecessarily prolonged by artificial means
- For parents only:* Provide guidelines for how your children should be supported while their assets are in trust
- For special needs beneficiaries only:* Provide instructions, people, and assets to support your special needs beneficiary above a poverty lifestyle
- For business owners only:* Provide for the orderly continuation and transfer of family business interests rather than a distress sale

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Section 4: Timeline / Urgency

How soon would you like to complete planning? (Is there a specific deadline, such as an upcoming trip, surgery, etc.?) _____

Section 5: Current Planning

	<u>Client</u>	<u>Spouse</u>
Do you presently have a will?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you presently have a trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your planning options limited by previous marriages (divorce decree, prenuptial agreement, irrevocable trust, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of your children not from your current marriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or any of your children or other beneficiaries have disabilities, serious health problems or other special needs? If yes, please describe briefly: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you own a business or a farm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you own a long-term care (nursing home) insurance policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you lived in Michigan?	_____	_____
Have you ever lived in a community property state (e.g., Wisconsin, Oregon, Idaho, California, Nevada, Arizona, New Mexico, Texas, Louisiana)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you hold everything jointly with your spouse, or is some property separate?	<input type="checkbox"/> All Joint (Except IRA's, pensions, etc.)	<input type="checkbox"/> Some Separate

Section 6: Children / Beneficiaries

Name	Address	Phone	DOB	Relationship

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Section 7: Asset Information

Please list the information in the appropriate category below. (Attach additional pages if necessary.)

Type of Asset	Title in which Held (Client, Spouse, Joint w/ Spouse, Joint w/ Others, Tenants in Common, Community Property)	Current Value
Personal Residence		
Other Real Estate		
Cash, Checking, Savings, Money Market		
Stocks and Bonds and CDs		
Unlisted Securities (Not Publicly Traded)		
Business <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation		
IRA's		
Pension/Profit Sharing/401(k)		
Term Life Insurance		
Whole Life Insurance		
Other Assets		
Anticipated Inheritance, Gift, or Lawsuit Proceeds		
Automobiles		
Other Personal Property (e.g., Gold Coins, Jewelry, Valuable Collections)		
Total Asset Value:		

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Section 8: Liability Information

Type of Debt	Name Loan Taken in (Client, Spouse, Joint, Other)	Amount Owed
Mortgage		
Credit Cards and Student Loans		
Other (Attach Additional Pages)		
Total Liabilities:		

Section 9: Income Information

	<u>Client</u>	<u>Community/ Joint</u>	<u>Spouse</u>
Earned Monthly Income from Labor:	_____	_____	_____
Monthly Social Security Income:	_____	_____	_____
Monthly Pension Income:	_____	_____	_____
Other Monthly Income:	_____	_____	_____

Section 10: Fiduciary Information

Please indicate who you would trust to make decisions about your minor children, finances, and healthcare if you are unable.

Name	Address / Phone	Types	Relationship
		<input type="checkbox"/> Children <input type="checkbox"/> Healthcare <input type="checkbox"/> Financial	
		<input type="checkbox"/> Children <input type="checkbox"/> Healthcare <input type="checkbox"/> Financial	
		<input type="checkbox"/> Children <input type="checkbox"/> Healthcare <input type="checkbox"/> Financial	
		<input type="checkbox"/> Children <input type="checkbox"/> Healthcare <input type="checkbox"/> Financial	
		<input type="checkbox"/> Children <input type="checkbox"/> Healthcare <input type="checkbox"/> Financial	

Section 11: Notes and Your Questions
