Trailhead Estate Planning
P.O. Box 242
Signal Mountain, TN 37377
(423) 228-7029
trailheadep.com

Estate Planning Questionnaire

These questions pertain to the persons named below for whom we are planning. I ask a lot of questions on this form because we need a lot of information about you for our planning for you.

If a question is inapplicable to you, note "N/A", and skip to the next applicable question.

If you are unsure how to answer a question, have concerns, or need assistance, please contact me.

Note: The initial consultation to discuss your estate planning needs is NOT a free consultation. However, completion of at least the first 6 pages (as applicable) and submission of this form at least 1 calendar week prior to your initial appointment will entitle you to a discount of up to one hour of the consultation time.

Date _____ How did you hear about me? _____

1. Personal Information

	Spouse 1 (i.e., you/one of you)	Spouse 2 (i.e., your spouse/fiancée)
Title		
Legal Name		
Preferred Name		
Address		
County		
D/O/B	Age	Age
Phone		
SSN		
*NOTE: Never email your SSN unless secured and encrypted.		
Email		
U.S. Citizen?	☐ No | ☐ Yes	☐ No | ☐ Yes
Veteran?	☐ No | ☐ Yes	☐ No | ☐ Yes

Marriage Information

Date and place of marriage _____

2. Children (Attach additional sheets if necessary.)

Full Name: _____ Child of: _____ D/O/B _____ Age _____ Predeceased? _____ D/O/D _____ Address Email _____ Telephone _____ Spouse _____ Children (and ages) Financial Trouble? ☐ No | ☐ Yes Marital Trouble? ☐ No | ☐ Yes Medical Trouble? ☐ No | ☐ Yes Disabled? ☐ No | ☐ Yes Benefits received? SSI / SSDI / Medicaid Other _____	Full Name: _____ Child of: _____ D/O/B _____ Age _____ Predeceased? _____ D/O/D _____ Address Email _____ Telephone _____ Spouse _____ Children (and ages) Financial Trouble? ☐ No | ☐ Yes Marital Trouble? ☐ No | ☐ Yes Medical Trouble? ☐ No | ☐ Yes Disabled? ☐ No | ☐ Yes Benefits received? SSI / SSDI / Medicaid Other _____
Full Name: _____ Child of: _____ D/O/B _____ Age _____ Predeceased? _____ D/O/D _____ Address Email _____ Telephone _____ Spouse _____ Children (and ages) Financial Trouble? ☐ No | ☐ Yes Marital Trouble? ☐ No | ☐ Yes Medical Trouble? ☐ No | ☐ Yes Disabled? ☐ No | ☐ Yes Benefits received? SSI / SSDI / Medicaid Other _____	Full Name: _____ Child of: _____ D/O/B _____ Age _____ Predeceased? _____ D/O/D _____ Address Email _____ Telephone _____ Spouse _____ Children (and ages) Financial Trouble? ☐ No | ☐ Yes Marital Trouble? ☐ No | ☐ Yes Medical Trouble? ☐ No | ☐ Yes Disabled? ☐ No | ☐ Yes Benefits received? SSI / SSDI / Medicaid Other _____

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)? ☐ No | ☐ Yes. Who? _____

3. Advisors

Do you have the following advisors? (Attach additional pages if necessary.)

Accountant? ☐ No | ☐ Yes. Who? _____
Company _____ Phone/email _____
When was the last time you reviewed your books/tax situation? _____
When was the last time you and your accountant talked? _____

Relationship Banker? ☐ No | ☐ Yes. Who? _____
Company _____ Phone/email _____
When was the last time you and your relationship banker reviewed your accounts and what the bank can do for you? _____
When was the last time you and your relationship banker talked? _____

Financial Advisor/Planner? ☐ No | ☐ Yes. Who? _____
Company _____ Phone/email _____
When was the last time you and your financial advisor/planner reviewed your investments, portfolio, risk tolerance, and goals? _____
When was the last time you and your financial advisor/planner talked? _____

Insurance Agent? ☐ No | ☐ Yes. Who? _____
Company _____ Phone/email _____
When was the last time you reviewed your insurance portfolio, policy performance, risk analysis, and goals? _____
When was the last time you and your insurance agent talked? _____

Do your advisors know about what your other advisors are doing for you? _____

4. Resources

A. Monthly Income

Type	Spouse 1	Source/Notes	Spouse 2	Source/Notes
Wages				
Rental				
Social Security				
Pension				
Other				
Total				

B. Real Property (Attach additional sheets as necessary.)

Primary Residence		**Other Real Property**	
Property Address		Property Address	
Names as on Deed		Names as on Deed	
Date Acquired		Date Acquired	
Purchase Price		Purchase Price	
Current Value		Current Value	
Tax-Appraised Value		Tax-Appraised Value	
Mortgage Company		Mortgage Company	
Mortgage Balance		Mortgage Balance	
Other Real Property		**Other Real Property**	
Property Address		Property Address	
Names as on Deed		Names as on Deed	
Date Acquired		Date Acquired	
Purchase Price		Purchase Price	
Current Value		Current Value	
Tax-Appraised Value		Tax-Appraised Value	
Mortgage Company		Mortgage Company	
Mortgage Balance		Mortgage Balance	

C. Business Interests (Attach additional pages if necessary.)

These are your **interests in businesses you own**. This is for businesses you are involved in beyond mere ownership of stock in a publicly traded company.

Business Name		Business Name	
Type (e.g., LLC)		Type (e.g., LLC)	
Share owned		Share owned	
Value of shares		Value of shares	
Other owners		Other owners	
Business Name		Business Name	
Type (e.g., LLC)		Type (e.g., LLC)	
Share owned		Share owned	
Value of shares		Value of shares	
Other owners		Other owners	

NOTE: Please attach a copy of the articles of incorporation, operating agreement/bylaws, and other business formation documents for further discussion.

D. Non-Qualified Investments and Accounts (Attach additional pages if necessary.)

These are your **bank accounts, CD's, annuities, stocks, bonds, mutual funds, money market accounts**, and the like. TOD/POD means "Transfer on Death" or "Payable on Death."

Asset (e.g., checking)		Asset (e.g., checking)	
Company		Company	
Value (to hundreds)		Value (to hundreds)	
How is it titled?		How is it titled?	
TOD/POD?		TOD/POD?	
Asset (e.g., checking)		Asset (e.g., checking)	
Company		Company	
Value (to hundreds)		Value (to hundreds)	
How is it titled?		How is it titled?	
TOD/POD?		TOD/POD?	
Asset (e.g., checking)		Asset (e.g., checking)	
Company		Company	
Value (to hundreds)		Value (to hundreds)	
How is it titled?		How is it titled?	
TOD/POD?		TOD/POD?	

E. Qualified Accounts (Attach additional pages if necessary.)

These are your retirement plans, such as **IRAs, 401(k)s, 403(b)s**, and the like.

Type (e.g., IRA)?		Type (e.g., IRA)?	
Thru whom?		Thru whom?	
Value?		Value?	
Owner (e.g., you)?		Owner (e.g., you)?	
Primary beneficiary?		Primary beneficiary?	
Contingent beneficiar(ies)?		Contingent beneficiar(ies)?	
Type (e.g., IRA)?		Type (e.g., IRA)?	
Thru whom?		Thru whom?	
Value?		Value?	
Owner (e.g., you)?		Owner (e.g., you)?	
Primary beneficiary?		Primary beneficiary?	
Contingent beneficiar(ies)?		Contingent beneficiar(ies)?	

F. Life Insurance. (Attach additional pages if necessary.)

Issuer		Issuer	
Type (e.g., term)		Type (e.g., term)	
Owner (e.g., you)		Owner (e.g., you)	
Insured		Insured	
Death Benefit (face value)		Death Benefit (face value)	
Cash surrender value		Cash surrender value	
Loans against (if any)		Loans against (if any)	
Primary Beneficiary		Primary Beneficiary	
Contingent beneficiar(ies)		Contingent beneficiar(ies)	
Issuer		Issuer	
Type (e.g., term)		Type (e.g., term)	
Owner (e.g., you)		Owner (e.g., you)	
Insured		Insured	
Death Benefit (face value)		Death Benefit (face value)	
Cash surrender value		Cash surrender value	
Loan policy (if any)		Loan policy (if any)	
Primary Beneficiary		Primary Beneficiary	
Contingent beneficiar(ies)		Contingent beneficiar(ies)	

G. Personal Property. (Attach additional pages if necessary.)

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins and stamps, guns, etc.)

Personal Property (Item)	Value	Current Owner

H. Money You Owe (non-mortgage debt) (Attach additional pages if necessary.)

Debt Type	Who owes the debt?	Creditor's Name	Amount Owed
		Total	

5. Gifts and Transfers

Have you made any sizable gifts or transfers, greater than $1,000.00? ☐ No | ☐ Yes

If yes, please provide details for each gift or transfer here or on a separate page.

6. Information About Your Health

Spouse 1 (i.e., you/one of you)	Spouse 2
1. If any, what medical or health problems do you currently have?	1. If any, what medical or health problems do you currently have?
2. If any, what medical problems have you had in the past?	2. If any, what medical problems have you had in the past?

7. Other "big-picture" concerns.

Are either of you in a high risk (liability) profession? ☐ No | ☐ Yes
Are either of you worried about other potential creditors? ☐ No | ☐ Yes
Are either of you worried about the costs of long-term care? ☐ No | ☐ Yes
Are you worried about gift and estate taxes? ☐ No | ☐ Yes
Are you worried about capital gains taxes? ☐ No | ☐ Yes
Do you want to keep your estate plan out of the public record at your death? ☐ No | ☐ Yes
Do you want someone to manage your assets for you prior to death? ☐ No | ☐ Yes
Are you worried about shielding a child's inheritance until he/she can handle it? ☐ No | ☐ Yes

8. Estate Planning

Mark in the box that applies. Please bring the existing documents with you to our meeting.

Do you have any of the following documents?	Spouse 1 (i.e., you / one of you)	If so, what year did you make it?	Spouse 2	If so, what year did you make it?
Durable Power of Attorney	☐ No | ☐ Yes		☐ No | ☐ Yes	
Health Care Power of Attorney	☐ No | ☐ Yes		☐ No | ☐ Yes	
Living Will	☐ No | ☐ Yes		☐ No | ☐ Yes	
Will	☐ No | ☐ Yes		☐ No | ☐ Yes	
Revocable Living Trust	☐ No | ☐ Yes		☐ No | ☐ Yes	

Note The following sections are to be completed for each of you. Please read all the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.) **We will discuss what tools match your "big-picture" goals** with your choices listed below.
Attorney Notes: Descendant POAppt? ☐ GPOA | ☐ LPOA | ☐ None Adopted? ☐ Any | ☐ Minors Revoke prior DGPOA? ☐ No | ☐ Yes TProt? ☐ No | ☐ Yes Tax summary? ☐ No | ☐ Yes Keep? ☐ TEP | ☐ Client

A. Spouse 1:

i. Specific Bequests.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

ii. Division of Estate

Rank how you want the balance of your property to be divided on your death and in what percentage. Leave a line blank if you do not want that distribution. If you give two groups the same rank, that indicates you wish to split the property between the groups at that rank level (e.g. two groups ranked #2 with 50% each will split all your property if the #1 ranked beneficiary predeceased).

We'll talk about **how** your beneficiaries receive this property at our meeting.

#____ ____% to my spouse.
#____ ____% to my children, divided equally.
#____ ____% to my spouse's children, divided equally.
#____ ____% to my grandchildren, divided as if inherited from their parents.
#____ ____% to my grandchildren, divided equally, regardless of family size.
#____ ____% to friends and family named below.
#____ ____% to charities/causes named below.
#____ ____% in a different manner than the above options.
Names/Notes for above _____
_____

iii. Fiduciaries to carry out estate plan (Attach additional sheets if necessary.)

Rank whom you want to serve as your executor. If you want two people to serve at the same time, rank them at the same level. Co-executors' decisions will be joint, and therefore it is not recommended to have more than two serving at a time. If you want someone to always serve with a co-executor, check the "not solo" box next to that person's name.

#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____

Rank whom you want to serve as guardian of minor children, if needed. If you want two or more people to serve at the same time, rank them at the same level. Co-guardians' decisions will be by majority, so more than two may serve at a time, but too many guardians will make administration difficult. If you want someone to always serve with a co-guardian, check the "not solo" box next to that person's name.

#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____

Rank whom you want to serve as trustee, if needed. If you want two or more people to serve at the same time, rank them at the same level. Co-trustees' decisions will be by majority, so more than two may serve at a time, but too many trustees will make administration difficult. If you want someone to always serve with a co-trustee, check the "not solo" box next to that person's name.

#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
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#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____

iv. Decision Making

Legal and Financial.

Decision makers. If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? **Please list and rank the individuals you trust to take care of your legal, business, personal, and financial affairs**. If you want more than one agent ("attorney-in-fact"), please indicate whether this person can act independently or if the decision must be made by majority. Again, too many individuals named at the same time can make administration difficult. If you want someone to always serve with a co-agent, check the "not solo" box next to that person's name.

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#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?
☐ No | ☐ Yes | ☐ Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?
☐ No restrictions, I trust my attorney-in-fact to make the right decision.
☐ My restrictions are _____

Health Care.

Decision makers. If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? **Please list and rank the individuals you trust to be your health care advocate**. If you want more than one advocate, please indicate whether this person can act independently or if the decision must be made by majority. Again, too many individuals named at the same time can make administration difficult. If you want someone to always serve with a co-agent, check the "not solo" box next to that person's name.

#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____
#___ ☐ Not Solo	Name _____ Relationship _____	Address	Phone _____ Email _____

Quality of Life. Which of the following conditions would you be willing to live with if you had adequate comfort care and pain management?

☐ ☐ Acceptable | Unacceptable	**Permanent unconsciousness**. You are totally unaware of people or your surroundings and have little chance of ever waking.
☐ ☐ Acceptable | Unacceptable	**Permanent confusion**. You are unable to remember, understand, or make decisions, and you do not recognize loved ones or have a clear conversation with them.
☐ ☐ Acceptable | Unacceptable	**Dependent in all activities of daily living.** You are no longer able to communicate clearly or move and are completely dependent on others for feeding, bathing, dressing, and walking with no chance to recover through rehabilitation or other treatment.
☐ ☐ Acceptable | Unacceptable	**End-Stage Illness**. You have an illness that reached its final stages despite full treatment, and you are no longer able to communicate your wishes.

If your quality of life becomes unacceptable under one of the scenarios above, do you want any of the following treatments?

☐ ☐ May Use | Do Not Use	**CPR (Cardiopulmonary Resuscitation)**. Attempt to cause your heart to beat again and restore breathing when you have an unacceptable quality of life condition.
☐ ☐ May Use | Do Not Use	**Life Support**. Continuous use of equipment to help the lungs, heart, kidneys, or other organs continue to function when you have an unacceptable quality of life condition.
☐ ☐ May Use | Do Not Use	**Treatment of New Conditions.** Use of surgery, antibiotics or other treatments to address a new condition, but which will not help the main unacceptable quality of life condition.
☐ ☐ May Use | Do Not Use	**Tube Feeding/IV fluids**. Use of tubes to deliver food/nutrition and water to your stomach or a vein when you have an unacceptable quality of life condition.

Do you want to be an organ donor? ☐ No | ☐ Yes | ☐ Don't know

When health care decisions must be made on your behalf, do you have any religious beliefs that need to be taken into account? ☐ No | ☐ Yes. What preferences? _____

Funeral/Burial arrangements (attach additional sheets if necessary)

Do you wish ☐ Burial | ☐ Cremation| ☐ No preference | ☐ Other:
Do you have a prepaid funeral or burial? ☐ No | ☐ Yes
Have you discussed your final arrangements with any family, your religious/spiritual advisor or funeral director? ☐ No | ☐ Yes. Details:

Attorney Notes:
Descendant POAppt? ☐ GPOA | ☐ LPOA | ☐ None Adopted? ☐ Any | ☐ Minors Revoke prior DGPOA? ☐ No | ☐ Yes TProt? ☐ No | ☐ Yes Tax summary? ☐ No | ☐ Yes Keep? ☐ TEP | ☐ Client

B. Spouse 2:

i. Specific Bequests.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

ii. Division of Estate

Rank how you want the balance of your property to be divided on your death and in what percentage. Leave a line blank if you do not want that distribution. If you give two groups the same rank, that indicates you wish to split the property between the groups at that rank level (e.g. two groups ranked #2 with 50% each will split all your property if the #1 ranked beneficiary predeceased).

We'll talk about **how** your beneficiaries receive this property at our meeting.

#___ ____% to my spouse.
#___ ____% to my children, divided equally.
#___ ____% to my spouse's children, divided equally.
#___ ____% to my grandchildren, divided as if inherited from their parents.
#___ ____% to my grandchildren, divided equally, regardless of family size.
#___ ____% to friends and family named below.
#___ ____% to charities/causes named below.
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Names/Notes for above _____
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iii. Fiduciaries to carry out estate plan (Attach additional sheets if necessary.)

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Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?
☐ No | ☐ Yes | ☐ Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?
☐ No restrictions, I trust my attorney-in-fact to make the right decision.
☐ My restrictions are _____

Health Care.

Decision makers. If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? **Please list and rank the individuals you trust to be your health care advocate**. If you want more than one advocate, please indicate whether this person can act independently or if the decision must be made by majority. Again, too many individuals named at the same time can make administration difficult. If you want someone to always serve with a co-agent, check the "not solo" box next to that person's name.

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☐ ☐ Acceptable | Unacceptable	**Dependent in all activities of daily living.** You are no longer able to communicate clearly or move and are completely dependent on others for feeding, bathing, dressing, and walking with no chance to recover through rehabilitation or other treatment.
☐ ☐ Acceptable | Unacceptable	**End-Stage Illness**. You have an illness that reached its final stages despite full treatment, and you are no longer able to communicate your wishes.

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☐ ☐ May Use | Do Not Use	**Life Support**. Continuous use of equipment to help the lungs, heart, kidneys, or other organs continue to function when you have an unacceptable quality of life condition.
☐ ☐ May Use | Do Not Use	**Treatment of New Conditions.** Use of surgery, antibiotics or other treatments to address a new condition, but which will not help the main unacceptable quality of life condition.
☐ ☐ May Use | Do Not Use	**Tube Feeding/IV fluids**. Use of tubes to deliver food/nutrition and water to your stomach or a vein when you have an unacceptable quality of life condition.

Do you want to be an organ donor? ☐ No | ☐ Yes | ☐ Don't know

When health care decisions must be made on your behalf, do you have any religious beliefs that need to be taken into account? ☐ No | ☐ Yes. What preferences? _____

Funeral/Burial arrangements (attach additional sheets if necessary)

Do you wish ☐ Burial | ☐ Cremation| ☐ No preference | ☐ Other:
Do you have a prepaid funeral or burial? ☐ No | ☐ Yes
Have you discussed your final arrangements with any family, your religious/spiritual advisor or funeral director? ☐ No | ☐ Yes. Details: