

LAW OFFICE OF STEPHANIE L. SCHNEIDER, P.A.
PLANNING FOR VETERAN BENEFITS QUESTIONNAIRE-MARRIED

I. GENERAL INFORMATION

1. Were you referred to our office and if so, by whom? _____.
2. If not, what made you choose our office? _____.
3. Do you or your spouse have any other legal issues which our office should be aware of? ____. If yes, please explain: _____.

II. BACKGROUND INFORMATION

1. Husband's Name: _____
Husband's D.O.B.: _____ SS# _____
Phone Number(s):(H) _____ (O) _____; Email: _____
Current Address: _____

2. Wife's Name: _____
Wife's D.O.B.: _____ SS# _____
Phone Number(s): (H) _____ (O) _____; Email: _____
Current Address: _____

3. Date of Marriage: _____ Is this a 1st, 2nd, 3rd, or 4th Marriage: _____.

4. Children (please indicate whether any child is from a prior marriage). For minors, include their age:

Include Deceased Children

HUSBAND

WIFE

Name\Age _____
Relationship _____
Address _____
Phone # _____
Adopted/Half-blood _____

Name\Age _____
Relationship _____
Address _____
Phone # _____
Adopted/Half-blood _____

Name\Age _____
Relationship _____
Address _____
Phone # _____
Adopted/Half-blood _____

5. Grandchildren:

Name\Age _____
Relationship _____
Address _____
Phone # _____
Adopted/Half-blood _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

Name\Age _____
Relationship _____
Address _____
Phone # _____
Adopted/Half-blood _____

Name\Age _____
Relationship _____
Address _____
Phone # _____
Adopted/Half-blood _____

6. If no surviving children, list names of living siblings for each spouse.

HUSBAND

WIFE

Name\Age _____
Relationship _____
Address _____
Phone # _____

Name\Age _____
Relationship _____
Address _____
Phone # _____

Name\Age _____
Relationship _____
Address _____
Phone # _____

III. HEALTH INSURANCE: PLEASE PROVIDE THE NAME AND ADDRESS OF THE COMPANY FOR THE FOLLOWING:

HUSBAND

WIFE

Medicare/Private Insurance
Company: _____
Address: _____

Medicare Supplement
Company: _____
Address: _____

Long Term Care Insurance
Company: _____
Address: _____

Other, Cancer, Accidental
Company: _____
Address: _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

IV. PERSONAL INFORMATION

1. Have you and your spouse used your over-age 55 exemption from capital gains taxes on the sale of a residence? _____
2. Have arrangements been made for the disposition of your body at death? _____ Are they paid for? _____ Please describe the arrangements and who they are with: _____
3. Does anyone to whom you may be leaving part of your estate require help or protection in managing money or other property? ___ If yes, please explain. _____

V. MILITARY SERVICE: Indicate the time frame you served by 'yes' or 'no'.

	<u>HUSBAND</u>	<u>WIFE</u>
Mexican Border (5/9/16 - 4/5/17)	_____	_____
World War I (4/16/17 - 11/11/18)	_____	_____
WWI Russia (4/6/17-4/1/20 - 7/1/21)	_____	_____
World War II (12/7/41- 12/31/46)	_____	_____
Korean Conflict (6/27/50 - 1/31/55)	_____	_____
Vietnam Era (8/5/64- 5/7/75)	_____	_____
Vietnam (2/28/61 - 8/5/64)	_____	_____
Persian Gulf War (8/2/90 - ?)	_____	_____
1. Did you receive an Honorable Discharge?	Yes _____	No _____
2. Did you have 90+ days of active duty?	Yes _____	No _____
3. Was at least 1 day during wartime?	Yes _____	No _____
4. Do you require care or assistance on a regular basis to protect you from dangers in your daily environment?	Yes _____	No _____
5. Do you have a current medical condition that may have been caused by an event during your service?	Yes _____	No _____
6. Did you have a medical condition prior to entering the service that may have been aggravated since your service?	Yes _____	No _____
Do you now receive service connected compensation for this aggravated condition?	Yes _____ \$ _____	No _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

7. Were your service records documented with a medical condition or, symptom caused during your service?
Yes _____ No _____

VI. ASSETS

1. Your home located in Florida:

Address: _____

FMV: _____
(Indicate whether based on sale price, appraisal or tax bill)

Mortgage: _____
(Indicate name of mortgagee and balance of mortgage)

Title held by: _____
(Indicate persons and whether title is held as tenants in common, joint tenancy with rights of survivorship, tenancy by entirety)

Homestead Exemption Filed: _____

2. Other real estate (other than your home) located in or outside Florida:

Address: _____

FMV: _____
(Indicate whether based on sale price, appraisal or tax bill)

Mortgage: _____
(Indicate name of mortgagee and balance of mortgage)

Title held by: _____
(Indicate persons and whether title is held as tenants in common, joint tenancy with rights of survivorship, tenancy by entirety)

3. Automobiles, Mobile Homes, Recreational Vehicles, Boats:

Type	Year	FMV	Liens	Owner
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Stocks, securities, bonds, and investments:

Asset: _____

Name & Address of Co. _____

Value: _____ Account #: _____

How is it titled: _____

When does it come due and interest rate: _____

Asset: _____

Name & Address of Co. _____

Value: _____ Account #: _____

How is it titled: _____

When does it come due and interest rate: _____

Asset: _____

Name & Address of Co. _____

Value: _____ Account #: _____

How is it titled: _____

When does it come due and interest rate: _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

5. Retirement and pension plans (include IRAs and 401Ks):

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
Taking minimum distribution Y-N: _____ Amount \$ _____ Frequency _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
Taking minimum distribution Y-N _____ Amount \$ _____ Frequency _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
Taking minimum distribution Y-N _____ Amount\$ _____ Frequency _____

6. Bank Accounts:

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

7. Life Insurance:

HUSBAND

WIFE

Name of Owner _____
Name of Insured _____
Name of Insurer _____
Policy #: _____
Face Value: _____
Cash Surrender Value: _____
Term or whole life: _____
Beneficiary (ies): _____

Name of Owner _____
Name of Insured _____
Name of Insurer _____
Policy #: _____
Face Value: _____
Cash Surrender Value: _____
Term or whole life: _____
Beneficiary (ies): _____

8. Annuities:

Asset: _____ Value: _____ Account #: _____
Name & Address of Co. _____
How is it titled: _____ When does it come due and interest rate: _____
Are there survivorship benefits and who is the beneficiary: _____

Asset: _____ Value: _____ Account #: _____
Name & Address of Co. _____
How is it titled: _____ When does it come due and interest rate: _____
Are there survivorship benefits and who is the beneficiary: _____

9. Other Assets (Debts owed by others to you including description of debt, name of debtor, current unpaid balance, identify document which evidences debt):

Business interest in corporation or partnership (include name, address, percent of stock owned, book value and fair market value of stock, whether you have a Buy/Sell Agreement, Stock Option Agreement, Deferred Compensation Agreement, or other employee benefit plans) : _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

Mortgages: _____

Promissory notes: _____

Inheritance (Are you receiving or do you expect to receive an inheritance in the near future), Powers of Appointment: _____

TOTAL OF ALL PROPERTY: \$ _____

VII. GROSS MONTHLY INCOME: THIS MUST INCLUDE INCOME FROM ALL SOURCES, EVEN IF REINVESTED, AS WELL AS ANY DEDUCTIONS FROM SOCIAL SECURITY OR PENSIONS. IF YOU RECEIVE A PENSION, BRING THE BOTTOM OF YOUR MOST RECENT CHECK.

	HUSBAND	WIFE	JOINT
<u>Social Security</u>	\$ _____	\$ _____	
<u>VA Disability</u>	\$ _____	\$ _____	
<u>VA DIC</u>	\$ _____	\$ _____	
<u>Employment</u>	\$ _____	\$ _____	
<u>Pensions</u>	\$ _____	\$ _____	
From: _____		From: _____	
	\$ _____	\$ _____	
From: _____		From: _____	
<u>IRA's</u>	\$ _____	\$ _____	
<u>Annuities</u>	\$ _____	\$ _____	
<u>Interest on Bank Accounts, Savings Accounts, C.D.'s:</u>			
	\$ _____	\$ _____	\$ _____
<u>Dividends on Stocks and Bonds:</u>			
	\$ _____	\$ _____	\$ _____
<u>Other (i.e. rent)</u>	\$ _____	\$ _____	\$ _____
<u>TOTALS:</u>			
	\$ _____	\$ _____	\$ _____

Which sources of income have a benefit for a surviving spouse? _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

VIII. MONTHLY ESTIMATED BUDGET

Rent/Mortgage Payment/Facility \$ _____
Utilities: \$ _____
Car Payment/Maintenance: \$ _____
Clothing: \$ _____
Food/Personal Household: \$ _____
Insurance: \$ _____
Medical Expenses (incl. Prescriptions) \$ _____
Taxes: \$ _____
Vacation/Entertainment: \$ _____
Emergency Fund: \$ _____
Other: \$ _____
TOTAL MONTHLY EXPENSES: \$ _____

IX. MONTHLY LIABILITIES

Mortgages: \$ _____
Notes to banks: \$ _____
Notes to others: \$ _____
Unpaid medical: \$ _____
Charge card bills: \$ _____
Other: \$ _____
TOTAL MONTHLY LIABILITIES: \$ _____

X. UNREIMBURSED MEDICAL EXPENSES. Identify those expenses you have already paid that are not covered by insurance. Focus on expenses that are recurring (indicate those that are infrequent). Identify the amount paid and to whom.

1. Health insurance premiums (Medicare; long term care): _____

2. Over the counter medicines taken at doctor's direction: _____

3. Mechanical & electronic devices: _____

4. Adult day care center (i.e. Alzheimer's program): _____

5. Nursing home or other facility: _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

- 6. In home attendant (aide) that provides some medical or nursing services: _____

- 7. Assisted living facility: _____

- 8. Prescriptions: _____

XI. TRANSFERS OF ASSETS. THIS INFORMATION MUST BE COMPLETED IN FULL.

Have you or your spouse made any gifts or transfers, of any amount, to any individuals or charities other than to a spouse within the last sixty (60) months? Yes _____ No _____ If yes, complete the following:

HUSBAND

WIFE

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

XII. What is the name, address and phone number of your primary care physician? _____

XIII. Do you have any professional advisors who you wish us to work with? Please provide us with their names, addresses and telephone number. If you are not currently working with any of the following professionals, would you like our office to provide you with a recommendation? ___ Yes ___ No

Accountant: _____

Financial Planner: _____

Insurance Advisor: _____

LEGAL DOCUMENTS

A. Last Will & Testament of Husband:

- 1. Name of Personal Representative: _____
Address of Personal Representative: _____
Name of Successor Personal Representative: _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

Address of Successor Personal Representative: _____

2. Name(s) of beneficiary(ies), their address and their respective share of the estate (indicate beneficiaries who are minors and at what age they are to receive part or all of their share):

Name\Age _____ Relationship _____
Address _____ Phone # _____

If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____

If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____

If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____

If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____

If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Charity Name _____
Address _____ Phone # _____

Charity Name _____
Address _____ Phone # _____

3. Is there a pre or post-nuptial agreement? _____

4. If you have minor children, do you wish to name a pre-need guardian? Yes ___. I wish to name: _____
No ___

5. Do you wish to name a preneed guardian for yourself? Yes ___. I wish to name: _____
No ___

B. Last Will & Testament of Wife:

1. Name of Personal Representative: _____
Address of Personal Representative: _____
Name of Successor Personal Representative: _____
Address of Successor Personal Representative: _____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-MARRIED

2. Name(s) of beneficiary(ies), their address and their respective share of the estate (indicate beneficiaries who are minors and at what age they are to receive part or all of their share):

Name\Age _____ Relationship _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Name\Age _____ Relationship _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____.

Charity Name _____
Address _____ Phone # _____

Charity Name _____
Address _____ Phone # _____

3. Is there a pre or post-nuptial agreement? _____

4. If you have minor children, do you wish to name a pre-need guardian? Yes ___. I wish to name: _____
_____. No __

5. Do you wish to name a preneed guardian for yourself? Yes ___. I wish to name: _____
_____. No ____

C. Durable Power of Attorney for Husband: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

1. Name: _____
Address: _____
Relationship to you: _____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

2. Name: _____
 Address: _____
 Relationship to you: _____

3. Indicate with a check mark (✓) whether you wish to give your agent the authority to handle the following matters:

Yes	No	Legal Authority
		Create an inter vivos trust (i.e., revocable living trust)
		Make a gift (subject to restrictions)
		Create or change a beneficiary designation on life insurance
		Create or change a beneficiary designation on other assets
		Disclaim property to which you may be entitled

Yes	No	Legal Authority
		Amend, modify, revoke or terminate a trust (trust must give agent this authority also)
		Create or change rights of survivorship
		Waive your right to be a beneficiary of a joint and survivor annuity, including under a retirement plan
		Disclaim powers of appointment

4. An agent is entitled to reimbursement of expenses reasonably incurred on your behalf. A qualified agent (spouse, heir, financial institution with trust powers, attorney, Certified Public Accountant) is entitled to reasonable compensation unless you decide otherwise.

Do you want your agent to be compensated? _____ Yes _____ No

5. The Durable Power of Attorney is effective when signed. This means if your agent gets the original or a photocopy, he/she can begin making financial decisions for you immediately even if you are healthy and not incapacitated.

Do you want to keep the original Durable Power of Attorney? _____ Yes _____ No

Do you want our law firm to hold the original document as your escrow agent? _____ Yes _____ No

D. Durable Power of Attorney for Wife: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

1. Name: _____
 Address: _____
 Relationship to you: _____

2. Name: _____
 Address: _____
 Relationship to you: _____

3. Indicate with a check mark (✓) whether you wish to give your agent the authority to handle the following matters:

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

Yes	No	Legal Authority
		Create an inter vivos trust (i.e., revocable living trust)
		Make a gift (subject to restrictions)
		Create or change a beneficiary designation on life insurance
		Create or change a beneficiary designation on other assets
		Disclaim property to which you may be entitled

Yes	No	Legal Authority
		Amend, modify, revoke or terminate a trust (trust must give agent this authority also)
		Create or change rights of survivorship
		Waive your right to be a beneficiary of a joint and survivor annuity, including under a retirement plan
		Disclaim powers of appointment

4. An agent is entitled to reimbursement of expenses reasonably incurred on your behalf. A qualified agent (spouse, heir, financial institution with trust powers, attorney, Certified Public Accountant) is entitled to reasonable compensation unless you decide otherwise.

Do you want your agent to be compensated? _____ Yes _____ No

5. The Durable Power of Attorney is effective when signed. This means if your agent gets the original or a photocopy, he/she can begin making financial decisions for you immediately even if you are healthy and not incapacitated.

Do you want to keep the original Durable Power of Attorney? _____ Yes _____ No

Do you want our law firm to hold the original document as your escrow agent? _____ Yes _____ No

E. Designation of Health Care Surrogate for Husband: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate: _____
 Address: _____
 Telephone: Office _____ Home _____
 Relationship: _____

2. Name of Alternate Surrogate: _____
 Address: _____
 Telephone: Office _____ Home _____
 Relationship: _____

3. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member): _____

F. Designation of Health Care Surrogate for Wife: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate: _____
 Address: _____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

Telephone: Office _____ Home _____
Relationship: _____

2. Name of Alternate Surrogate: _____
Address: _____
Telephone: Office _____ Home _____
Relationship: _____

3. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member): _____

G. Living Will for Husband: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes ____ No ____

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes ____ No ____

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes ____ No ____

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes ____ No ____

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)? Yes ____ No ____

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated? Yes ____ No ____

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes ____ No ____

If you answer "Yes" please complete the following:

a) I wish to give _____ any needed organs or parts _____ only the following organs or parts:

Specify the organ(s) or part(s)

for the purpose of transplantation, therapy, medical research, or education;

b) _____ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows: _____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

H. Living Will for Wife: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes _____ No _____

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes _____ No _____

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes _____ No _____

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes _____ No _____

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)? Yes _____ No _____

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated? Yes _____ No _____

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes _____ No _____

If you answer "Yes" please complete the following:

a) I wish to give _____ any needed organs or parts _____ only the following organs or parts:

Specify the organ(s) or part(s)

for the purpose of transplantation, therapy, medical research, or education;

b) _____ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows: _____

I. Living Trust for Husband (a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes _____ No _____

2. Name & address of Trustee or Co-Trustees: _____

3. Name & address of first successor trustee: _____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

4. Name & address of second successor trustee: _____

5. Disposition upon death of second spouse: _____

6. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share: _____

7. Credit shelter trust: _____

8. Marital deduction trust: _____

J. Living Trust for Wife (a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes _____ No _____

2. Name & address of Trustee or Co-Trustees: _____

3. Name & address of first successor trustee: _____

4. Name & address of second successor trustee: _____

5. Disposition upon death of second spouse: _____

6. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share: _____

7. Credit shelter trust: _____

8. Marital deduction trust: _____

K. DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (Husband):

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes _____ No _____

This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

Name: _____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

c. If yes, identify the successor authorized representative:

Name: _____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

d. What is your preference for final arrangements? Burial _____ Cremation _____

e. Detail any restrictions you want to place on the representative's authority: _____

L. DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (Wife):

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes _____ No _____
This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:

Name: _____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

c. If yes, identify the successor authorized representative:

Name: _____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

d. What is your preference for final arrangements? Burial _____ Cremation _____

e. Detail any restrictions you want to place on the representative's authority: _____

M. Do you have any professional advisors who you wish us to work with? Please provide us with their names, addresses and telephone number. If you are not currently working with any of the following professionals, would you like our office to provide you with a recommendation? ___ Yes ___ No

Accountant: _____
Financial Planner: _____
Insurance Advisor: _____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Print Name: _____
Date: _____

Print Name: _____
Date: _____

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