

The **POCKET LAWYER**[®] Document Preparation Service

COMPLETE Revocable Living Trust Agreement Client Questionnaire

<p>INSTRUCTIONS: Answer All questions with an answer or a N/A. Today's date (mm/dd/yyyy) _____ If more space is needed, use the space below or attach blank pages.</p>				
1	Select one of the following Trust situations that best fits your needs (<i>select only one</i>)			
2	<input type="checkbox"/> Husband and wife as grantors and co-trustees, for their lifetime use, then to others (regular trust)			
3	<input type="checkbox"/> Husband and wife as grantors and co-trustees, for their lifetime use, then two trusts created until surviving spouse's death (AB trust)			
4	<input type="checkbox"/> Grantor as trustee, for lifetime use by grantor, then to others			
5	<input type="checkbox"/> Grantor and third party as co-trustees, for lifetime use of grantor, then to others			
6	<input type="checkbox"/> Grantor to third party as trustee, for lifetime use by grantor, then to others			
7	Trust creator's first name	Middle	Last	
8	Street address	City	State	Zip
9	Contact Phone	Fax	E-mail	
10	Trust creator spouse's first name	Middle	Last	
11	Street address	City	State	Zip
12	1 st Co-trustee's first name	Middle	Last	
13	Street address	City	State	Zip
14	2 nd Co-trustee's first name	Middle	Last	
15	Street address	City	State	Zip
16	1 st Successor trustee's first name	Middle	Last	
17	Street address	City	State	Zip
18	2 nd Successor trustee's first name	Middle	Last	
19	Street address	City	State	Zip
If additional space is needed, number and insert below.				

Revocable Living Trust Agreement (continued)			
20	<i>List the name(s), address(es), relationship and description and amount or percentage of property to be given to each beneficiary. Attach additional sheet(s) if needed.</i>		
21	1 st Beneficiary's first name	Middle	Last
22	Street address		
23	City		State Zip
24	Relationship	Property description and amount or percentage	
25	2 nd Beneficiary's first name	Middle	Last
26	Street address		
27	City		State Zip
28	Relationship	Property description and amount or percentage	
29	3 rd Beneficiary's first name	Middle	Last
30	Street address		
31	City		State Zip
32	Relationship	Property description and amount or percentage	
33	4 th Beneficiary's first name	Middle	Last
34	Street address		
35	City		State Zip
36	Relationship	Property description and amount or percentage	
37	5 th Beneficiary's first name	Middle	Last
38	Street address		
39	City		State Zip
40	Relationship	Property description and amount or percentage	
41	6 th Beneficiary's first name	Middle	Last
42	Street address		
43	City		State Zip
44	Relationship	Property description and amount or percentage	

Revocable Living Trust Agreement (continued)		
45a	The following is a list of the items or property that are to be incorporated into this Living Trust:	
45b	DESCRIPTION	LOCATION
45c	(Complete <u>Appendix "A"</u> , <i>Asset Inventory table</i>)	
46	Do you want beneficiaries under a certain age to have their property held in trust until they reach a specified age? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what age must they attain:	
47	Do you want the trustees to serve without bond? <input type="checkbox"/> No <input type="checkbox"/> Yes	
POUR-OVER WILL INFORMATION		
48	<i>A Pour-Over will is used to put property that was not transferred into the Trust while a Trustor was alive, into the Trust after the Trustor's death, and to appoint a Guardian for your minor children.</i>	
49	Are there current Wills for:	a) Trustor <input type="checkbox"/> Yes <input type="checkbox"/> No b) Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
50	If so, where are they located?	a) (H) b) (W)
51	Sole Trustor's (or Husband's) Will Information:	
52	Do you wish to have your property that may <u>not</u> have been transferred into your Living Trust while you were alive, transferred into your Living Trust after your death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
53	Who do you want to be your <u>Personal Representative</u> (executor) or joint personal representatives?	
54	1) Name	Address
55	2) Name	Address
56	Alternate person(s) if one of the above is unable to serve as your personal representative?	
57	1) Name	Address
58	2) Name	Address
59	Who do you want to be the Guardian or joint guardians of your minor child(ren)?	
60	1) Name	Address
61	2) Name	Address
62	Alternate person(s) if one of the above is unable to serve as the guardian of your minor children?	
63	1) Name	Address
64	2) Name	Address
65	Spouse's Will Information:	
66	Do you wish to have your property that may <u>not</u> have been transferred into your Living Trust while you were alive, transferred into your Living Trust after your death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
67	Who do you want to be your <u>Personal Representative</u> (executor) or joint personal representatives?	
68	1) Name	Address
69	2) Name	Address

Revocable Living Trust Agreement (continued)			
70	Alternate person(s) if one of the above is unable to serve as your personal representative?		
71	1) Name	Address	
72	2) Name	Address	
73	Who do you want to be the Guardian or joint guardians of your minor child(ren)?		
74	1) Name	Address	
75	2) Name	Address	
76	Alternate person(s) if one of the above is unable to serve as the guardian of your minor children?		
77	1) Name	Address	
78	2) Name	Address	
79	GENERAL POWER OF ATTORNEY INFORMATION		
80	Sole Trustor's (or Husband's) power of attorney information		
81	Designation of Agent (Attorney in Fact) <i>(Information about the person who will act for you as your agent in financial and other matters)</i>		
82	First name	Middle	Last
83	Street address		
84	City	State	Zip
85	First Alternate Agent <i>(Information about the person who will serve as your agent if your first choice is unable to serve)</i>		
86	First name	Middle	Last
87	Street address		
88	City	State	Zip
89	Second Alternate Agent <i>(Information about the person who will serve as your agent if your first and second choice are unable to serve)</i>		
90	First name	Middle	Last
91	Street address		
92	City	State	Zip
93	Designation of Powers <i>(Check each power you would like to give your agent; check the first box if you want ALL of them)</i>		
94	<input type="checkbox"/> ALL OF THE POWERS LISTED BELOW		
95	<input type="checkbox"/> Real estate matters		
96	<input type="checkbox"/> Tangible personal property transactions		
97	<input type="checkbox"/> Stock and bond transactions		

Revocable Living Trust Agreement (continued)		
98	<input type="checkbox"/> Commodity and option transactions	
99	<input type="checkbox"/> Banking and other financial institution transactions	
100	<input type="checkbox"/> Business operating transactions	
101	<input type="checkbox"/> Insurance and annuity transactions	
102	<input type="checkbox"/> Estate, trust, and other beneficiary transactions	
103	<input type="checkbox"/> Claims and litigation	
104	<input type="checkbox"/> Personal and family maintenance	
105	<input type="checkbox"/> Benefits from social security, Medicare, Medicaid, or other governmental programs, or civil or military service	
106	<input type="checkbox"/> Retirement plan transactions	
107	<input type="checkbox"/> Tax matters	
108	Additional Powers <i>(List any special instructions limiting or extending the powers granted to your agent)</i>	
109	Normally, your agent is required by law to keep his or her money separate from yours. If your agent is your spouse or other close family member, and your finances are <u>already</u> commingled (mixed), do you want your agent to be able to <u>continue</u> to commingle (mix) your funds with his or her own? <input type="checkbox"/> Yes <input type="checkbox"/> No	
110	Normally, your agent is not permitted to financially benefit from any actions taken on your behalf. If your agent is your spouse or other close family member, and your financial interests are <u>already</u> intertwined with yours, do you want your agent to be able to financially benefit from any transactions taken on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	
111	Do you want your agent to be compensated for acting as your attorney-in-fact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
112	Would you like to protect your agent and others from liability when they are acting on this Power of Attorney, as long as they are acting in good faith? <input type="checkbox"/> Yes <input type="checkbox"/> No	
113	Do you want this Power of Attorney to remain in force and be effective even though you become incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
114	If you appointed more than one agent, do you want them to be able to act alone (<u>separately</u>) without the other agent joining, or do you want all of your agents to act or sign together (<u>jointly</u>)? <input type="checkbox"/> Separately <input type="checkbox"/> Jointly	
115	I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party has actual knowledge of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney. <input type="checkbox"/> Yes <input type="checkbox"/> No	
116	<input type="checkbox"/> Other (<i>specify</i>)	
117	Duration	
118	When do you want this Power of Attorney to become effective: <input type="checkbox"/> Immediately upon signing by me. <input type="checkbox"/> Only if I become mentally incapacitated.	
119	How long do you want this Power of Attorney to be in force: <input type="checkbox"/> Until revoked by me in writing. <input type="checkbox"/> For the following period of time only (<i>specify</i>):	
120	Spouse's power of attorney information	
121	Designation of Agent (Attorney in Fact) <i>(Information about the person who will act for you as your agent in financial and other matters)</i>	
122	First name	Middle
		Last

Revocable Living Trust Agreement (continued)			
123	Street address		
124	City	State	Zip
125	First Alternate Agent <i>(Information about the person who will serve as your agent if your first choice is unable to serve)</i>		
126	First name	Middle	Last
127	Street address		
128	City	State	Zip
129	Second Alternate Agent <i>(Information about the person who will serve as your agent if your first and second choice are unable to serve)</i>		
130	First name	Middle	Last
131	Street address		
132	City	State	Zip
133	Designation of Powers <i>(Check each power you would like to give your agent; check the first box if you want ALL of them)</i>		
134	<input type="checkbox"/> ALL OF THE POWERS LISTED BELOW		
135	<input type="checkbox"/> Real estate matters		
136	<input type="checkbox"/> Stock and bond transactions		
137	<input type="checkbox"/> Commodity and option transactions		
138	<input type="checkbox"/> Banking and other financial institution transactions		
139	<input type="checkbox"/> Business operating transactions		
140	<input type="checkbox"/> Insurance and annuity transactions		
141	<input type="checkbox"/> Estate, trust, and other beneficiary transactions		
142	<input type="checkbox"/> Claims and litigation		
143	<input type="checkbox"/> Personal and family maintenance		
144	<input type="checkbox"/> Benefits from social security, Medicare, Medicaid, or other governmental programs, or civil or military service		
145	<input type="checkbox"/> Retirement plan transactions		
146	<input type="checkbox"/> Tax matters		
147	Additional Powers <i>(List any special instructions limiting or extending the powers granted to your agent)</i>		
148	Normally, your agent is required by law to keep his or her money separate from yours. If your agent is your spouse or other close family member, and your finances are <u>already</u> commingled (mixed), do you want your agent to be able to <u>continue</u> to commingle (mix) your funds with his or her own? <input type="checkbox"/> Yes <input type="checkbox"/> No		
149	HEALTH CARE DIRECTIVE INFORMATION (LIVING WILL)		
150	Sole Trustor's (or Husband's) health care directive information		
151	Name of sole trustor (or Husband)		

Revocable Living Trust Agreement (continued)			
152	Social Security	Birth date (mm/dd/yyyy)	
153	<i>List information about the person you wish to designation as your Agent to Make Health Care Decisions (Attorney in Fact), when you are unable to make your own decisions:</i>		
154	Name of Agent		
155	Address		
156	City	State	Zip
157	Name of Alternate Agent		
158	Address		
159	City	State	Zip
160	<i>Choose the powers your AGENT has in dealing with your health care decisions:</i>		
161	<input type="checkbox"/> Authorized to make ALL health care decisions, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.		
162	<input type="checkbox"/> Authorized to make ALL health care decisions <u>except</u> the following: 		
163	<i>Choose the Powers your AGENT has in dealing with your medical records:</i>		
164	<input type="checkbox"/> To receive information regarding my physical and mental health, including access to my medical and hospital records.		
165	<input type="checkbox"/> To execute releases to obtain medical and hospital records and information.		
166	<input type="checkbox"/> To consent to the disclosure of this information.		
167	<i>Choose the powers your AGENT has in dealing with waivers and releases:</i>		
168	<input type="checkbox"/> To sign documents entitled “Refusal to permit treatment” and “Leaving hospital against medical advise”, or similar.		
168	<input type="checkbox"/> To sign any necessary waiver or release from liability required by a hospital or physician.		
170	<i>Choose the powers your AGENT has in dealing with the following:</i>		
171	<input type="checkbox"/> Authorize an autopsy.		
172	<input type="checkbox"/> Make a disposition of a part or parts of my body as an Anatomical Gift for use in another.		
173	<input type="checkbox"/> Make a disposition of a part or parts of my body as an Anatomical Gift for educational or scientific purposes.		
174	<input type="checkbox"/> Direct the disposition of my remains (burial, cremation, etc.).		
175	<i>Specify the length of this Health Care Power of Attorney:</i>		
176	<input type="checkbox"/> Unlimited Duration, until revoked by me at a later date.		
177	<input type="checkbox"/> This Power of Attorney expires on: My death or Date: _____		
178	<i>Specify when your AGENT's authority becomes effective:</i>		

Revocable Living Trust Agreement (continued)	
179	<input type="checkbox"/> My AGENT's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.
180	<input type="checkbox"/> My AGENT's authority to make health care decisions for me takes effect immediately.
181	Desires Regarding Life Sustaining Treatment
182	<i>Choose ONE of the following paragraphs; 183, 184, 185 or 186. If 183 is selected, mark each sub-paragraph that applies.</i>
183	Choose <u>all</u> that apply: <input type="checkbox"/> I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if I have an incurable and irreversible condition that will result in my death within a relatively short time. <input type="checkbox"/> I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness. <input type="checkbox"/> I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if the risks and burdens of treatment would outweigh the expected benefits. <input type="checkbox"/> I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.
184	<input type="checkbox"/> I want my life to be prolonged as long as possible within the limits of generally accepted health care standards, even though the burdens of the treatment outweigh the expected benefits.
185	<input type="checkbox"/> I do not want any medical treatment except what is necessary to provide feeding and hydration and what is necessary to relieve pain and discomfort.
186	<input type="checkbox"/> I do not want any medical treatment (including artificial feeding and hydration), except what is necessary to relieve pain and discomfort.
187	<input type="checkbox"/> I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatments.
188	<input type="checkbox"/> In addition to the above, I want: (If you have additional desires, complete in your own words). (attach additional sheets if needed).
189	Donation of Organs at Death
190	<input type="checkbox"/> Upon my death, I do <u>NOT</u> wish to donate my organs.
191	<input type="checkbox"/> Upon my death, I give any needed organs, tissues, or parts.
192	<input type="checkbox"/> Upon my death, I give the following organs, tissues, or parts only:
193	My anatomical gift is for the following purposes: (select ALL that apply) <input type="checkbox"/> Transplant <input type="checkbox"/> Therapy <input type="checkbox"/> Research <input type="checkbox"/> Education
	Final Requests
194	Final Arrangements (Choose ALL that apply):
195	<input type="checkbox"/> I want to be cremated at: (Location)

Revocable Living Trust Agreement (continued)		
196	<input type="checkbox"/> I want to be buried at: (Location)	
197	<input type="checkbox"/> I want to be embalmed	
198	<input type="checkbox"/> Type of Casket	
199	<input type="checkbox"/> Type of marker	
200	<input type="checkbox"/> Epitaph	
201	Flowers <input type="checkbox"/> YES <input type="checkbox"/> NO	
202	<input type="checkbox"/> Type of ceremony and size:	
203	Primary Physician	
204	I designate the following physician as my primary physician: Name Address City, State, Zip Phone	
205	If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician: Name Address City, State, Zip Phone	
If additional space is needed, number and insert below.		
	OTHER WISHES	
206	Spouse's health care directive information	
207	Name of spouse trustor	
208	Social Security Number	Birth date (mm/dd/yyyy)

Revocable Living Trust Agreement (continued)			
209	<i>List information about the person you wish to designation as your Agent to Make Health Care Decisions (Attorney in Fact), when you are unable to make your own decisions:</i>		
210	Name of Agent		
211	Address		
212	City	State	Zip
213	Name of Alternate Agent		
214	Address		
215	City	State	Zip
216	<i>Choose the powers your AGENT has in dealing with your health care decisions:</i>		
217	<input type="checkbox"/> Authorized to make ALL health care decisions, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.		
218	<input type="checkbox"/> Authorized to make ALL health care decisions <u>except</u> the following:		
219	<i>Choose the Powers your AGENT has in dealing with your medical records:</i>		
220	<input type="checkbox"/> To receive information regarding my physical and mental health, including access to my medical and hospital records.		
221	<input type="checkbox"/> To execute releases to obtain medical and hospital records and information.		
222	<input type="checkbox"/> To consent to the disclosure of this information.		
223	<i>Choose the powers your AGENT has in dealing with waivers and releases:</i>		
224	<input type="checkbox"/> To sign documents entitled "Refusal to permit treatment" and "Leaving hospital against medical advise", or similar.		
225	<input type="checkbox"/> To sign any necessary waiver or release from liability required by a hospital or physician.		
226	<i>Choose the powers your AGENT has in dealing with the following:</i>		
227	<input type="checkbox"/> Authorize an autopsy.		
228	<input type="checkbox"/> Make a disposition of a part or parts of my body as an Anatomical Gift for use in another.		
229	<input type="checkbox"/> Make a disposition of a part or parts of my body as an Anatomical Gift for educational or scientific purposes.		
230	<input type="checkbox"/> Direct the disposition of my remains (burial, cremation, etc.).		
231	<i>Specify the length of this Health Care Power of Attorney:</i>		
232	<input type="checkbox"/> Unlimited Duration, until revoked by me at a later date.		
233	<input type="checkbox"/> This Power of Attorney expires on _____. (Fill in date)		
234	<i>Specify when your AGENT's authority becomes effective:</i>		

Revocable Living Trust Agreement (continued)	
235	<input type="checkbox"/> My AGENT's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.
236	<input type="checkbox"/> My AGENT's authority to make health care decisions for me takes effect immediately.
237	Desires Regarding Life Sustaining Treatment
238	<i>Choose ONE of the following paragraphs: 239, 240, 241 or 242. If 239 is selected, mark each sub-paragraph that applies.</i>
239	Choose <u>all</u> that apply: <input type="checkbox"/> I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if I have an incurable and irreversible condition that will result in my death within a relatively short time. <input type="checkbox"/> I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness. <input type="checkbox"/> I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if the risks and burdens of treatment would outweigh the expected benefits. <input type="checkbox"/> I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.
240	<input type="checkbox"/> I want my life to be prolonged as long as possible within the limits of generally accepted health care standards, even though the burdens of the treatment outweigh the expected benefits.
241	<input type="checkbox"/> I do not want any medical treatment except what is necessary to provide feeding and hydration and what is necessary to relieve pain and discomfort.
242	<input type="checkbox"/> I do not want any medical treatment (including artificial feeding and hydration), except what is necessary to relieve pain and discomfort.
243	<input type="checkbox"/> I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatments.
244	<input type="checkbox"/> In addition to the above, I want: (If you have additional desires, complete in your own words). (attach additional sheets if needed).
245	Donation of Organs at Death
246	<input type="checkbox"/> Upon my death, I do <u>NOT</u> wish to donate my organs.
247	<input type="checkbox"/> Upon my death, I give any needed organs, tissues, or parts.
248	<input type="checkbox"/> Upon my death, I give the following organs, tissues, or parts only:
249	My anatomical gift is for the following purposes: (select ALL that apply) <input type="checkbox"/> Transplant <input type="checkbox"/> Therapy <input type="checkbox"/> Research <input type="checkbox"/> Education
250	Final Requests
251	Final Arrangements (Choose ALL that apply):
252	<input type="checkbox"/> I want to be cremated at: (Location)

Revocable Living Trust Agreement (continued)	
253	<input type="checkbox"/> I want to be buried at: (Location)
254	<input type="checkbox"/> I want to be embalmed
255	<input type="checkbox"/> Type of Casket
256	<input type="checkbox"/> Type of marker
257	<input type="checkbox"/> Epitaph
258	Flowers <input type="checkbox"/> YES <input type="checkbox"/> NO
259	<input type="checkbox"/> Type of ceremony and size:
260	Primary Physician
261	I designate the following physician as my primary physician: Name Address City, State, Zip Phone
262	If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician: Name Address City, State, Zip Phone
If additional space is needed, number and insert below.	
263	OTHER WISHES
ACKNOWLEDGEMENT and SIGNATURE	
264	Do you want us to prepare your Revocable Living Trust papers? <input type="checkbox"/> YES <input type="checkbox"/> NO
265	Do you want us to make copies and conform the papers for filing or recording? <input type="checkbox"/> YES <input type="checkbox"/> NO
266	Date Living Trust is to become effective <input type="checkbox"/> Upon signing <input type="checkbox"/> On (date)

This Acknowledgement must be signed by Grantor (and Joint Grantor, if any).

I (We), acknowledge that the information provided by me in this Workbook is true and accurate to the best of my knowledge. I further acknowledge that I am going to do my own living trust agreement and want the **POCKET LAWYER**® Document Preparation Service to assist me by performing certain document preparation services, according to my instructions. I will be solely responsible for the information contained in these documents and will have the opportunity to review the completed documents before they are filed, recorded, etc. I understand that the **POCKET LAWYER** Document Preparation Service does not render legal advice or legal services and is acting solely at my direction and pursuant to my decisions. I further understand that I have the right to handle my own legal matters and act as my own attorney, but that the advice of an attorney may be necessary. The **POCKET LAWYER** encourages attorney participation and will provide a list of attorney referrals, at my request. I hereby relieve the **POCKET LAWYER** from any liability whatsoever, regarding preparation of these documents, and agree to hold them harmless from any damages I may suffer and understand that my sole relief is limited to the return of any fee paid for the preparation of these documents.

By typing my name, I declare that I have read and agree with the above paragraphs.

Signature

Date

Print name

Signature

Date

Print name