

KB KRUEGER BECK, PLLC
 ATTORNEYS AND COUNSELORS AT LAW
 520 KIRKLAND WAY, SUITE 202
 PO BOX 3143
 KIRKLAND, WASHINGTON 98083-3143
 425.828.7800
 WWW.KRUEGERBECKLAW.COM

ESTATE PLANNING CONFIDENTIAL QUESTIONNAIRE

Appointment: _____

FAMILY INFORMATION		
Client Full Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Client E-mail:	Client SSN:	
Citizenship:	Occupation:	

Spouse Full Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Spouse E-mail:	Spouse SSN:	
Citizenship:	Occupation:	
Place of Marriage/Commitment:	Date:	

Street Address:	Home Phone:
	Work Phone:
City:	Cell Phone:
State:	Zip:

CHILDREN		
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Please list any deceased children

Birthdate	Full Name	Current Residence

GRANDCHILDREN		
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Birthdate	Full Name	Grandchild's parents

PLEASE NAME THE PERSON OR PERSONS YOU WISH TO SERVE IN THE FOLLOWING CAPACITIES IN YOUR WILL:

Persons not qualified are those of unsound mind, minors, or persons who have been convicted to any felony or a misdemeanor involving moral turpitude, i.e., dishonesty. Consider persons who are honest and have good business judgment and the ability to communicate. For a guardian choose a caring person who will raise your child or children to your values.

Guardian:			Alternate Guardian:		
Trustee for Children:			Alternate Trustee for Children:		
Executor:			Alternate Executor:		
Attorney-in-fact for financial matters:			Alternate:		
Attorney-in-fact for health matters:			Alternate:		
Do you have a Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	Residence at Execution:	
Do you have a Trust?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	Residence at Execution:	
Do you have a community property agreement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, was it recorded?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have powers of attorney for financial management and/or healthcare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a living will, physician's directive or health care directive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a safety deposit box? If so, who is your co-signer and in what bank and branch?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Where do you keep the keys to your safety deposit box?		
Has anyone created a trust for your benefit? If so, please supply a copy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone given you a power of appointment in a will, trust, or power of attorney and has anyone named you as their attorney in fact? If so, please supply a copy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How will you communicate your passwords and pins to your executor?		
Who will own the rights to your website?		
Where are your original Will and Powers of Attorney kept?		

PREVIOUS MARRIAGES			
	Name of Previous Spouse(s)	Date of Death	Divorce
Client			
Spouse			

PRESENT ADVISORS	
Accountant	Name:
Attorney	Name:
Insurance Agent	Name:
Stock Broker	Name:
Other	Name:

ASSETS			
Real Property	Address/Description	How Title Held	Market Value
a.			\$
b.			\$
c.			\$
Secured Notes	Address/Description	How Title Held	Market Value
a.			\$
b.			\$
c.			\$

Please bring copies of all deeds (and the most recent property tax for each) and copies of any secured notes & deeds of trusts to the appointment

	Description	How Title Held	Market Value
Limited Partnerships			\$
Securities <i>(stocks, bonds, certificates of deposit, unsecured notes)</i>			\$
IRA, 401(K), etc.			\$
Cash Account <i>(checking, savings, money market, etc.)</i>			\$
Retirement Plan	Client Beneficiary:		\$
	Spouse Beneficiary:		\$

Name of Business: _____ **How Owned?** Partnership Corporation Sole Proprietorship

Life Insurance			
Company:	Beneficiary:		
Owner:	Whole life or term? <input type="checkbox"/> Whole <input type="checkbox"/> Term	Death Benefit: \$	
Company:	Beneficiary:		
Owner:	Whole life or term? <input type="checkbox"/> Whole <input type="checkbox"/> Term	Death Benefit: \$	

Other Personal Property:	\$
Jewelry, art, furnishings, wines, motor vehicles, boats, etc. Sales concerns?	\$
Other Assets: (Attach schedule)	\$
GROSS ESTATE (Total of all values)	\$

LIABILITIES			
	Description	Whose Liability (Husband/Wife/Both)	Value
Notes			\$
Mortgages			\$
Judgments			\$
TOTAL DEBTS			\$
NET TAXABLE ESTATE			\$

ANTICIPATED INHERITANCES		
	From Whom	Value
Client:		\$
Spouse:		\$

ANTICIPATED GIFTS		
	From Whom	Value
Client:		\$
Spouse		\$

Are you planning to make gifts to others or have you made gifts in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you planning to make charitable gifts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an umbrella liability & underinsured policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have long term care insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What are your home insurance policy limits?		
What are your bodily injury and underinsured motorist's coverage?		
Per person \$ _____	Per Collision \$ _____	Single Limit \$ _____

Your cooperation in completing this form is critical. It will enable us to ascertain your particular estate planning needs in the time allotted for your appointment. If you have any questions or problems in completing this form, please call our office before your appointment.