VARNER & PEACOCK
ATTORNEYS AT LAW

CONFIDENTIAL ESTATE PLANNING & WILL INFORMATION SHEET

Our firm's Estate Planning Questionnaire has been created to assist us in gathering all the essential information needed to complete an estate plan for our client. Please do not spend an inordinate amount of time gathering the information requested on the form. However, we have found that having this data available at an initial attorney/client meeting will aid both you and our firm in focusing on estate planning issues specific to your situation. Of particular importance is the family information and at least rough estimates of the requested financial information, including the specific ownership of each asset (joint, individual or trust). Although this covers a lot of information, it is necessary to the planning process and, perhaps more importantly, its completion at the outset enables us to keep costs down for you.

Many of our estate planning clients are married and want to conduct their planning jointly. In those circumstances, and unless told otherwise, I will assume that you want the representation to be joint. I further assume that information provided by one spouse may be shared with the other spouse. If you want this representation to be separate, please inform me of that at the beginning of our discussions, so I can proceed appropriately.

Your information will be kept confidential by your Attorney unless you authorize or request its release to others.

If you have any questions about the form, please call our office; otherwise, please complete as much of it as possible and return it to us either by email or regular mail.

General Timeline: Our timeline for the preparation and completion of your personalized plan will most likely follow the format below:

- **Initial Consultation**: Review and discuss estate planning questionnaire, as well as discuss the appropriate documents to meet your estate plan goals. Please plan on about an hour for this meeting.
- **Review Meeting**. Immediately following your initial consultation, a review meeting is scheduled approximately two to three weeks from the date of your initial meeting. This meeting will be spent reviewing drafts of your estate plan documents as well as answering any questions or concerns you might have. In some cases, the review meeting can be done via email or by phone.
- **Execution Meeting**. Within a week or two of your review meeting, an execution meeting will be scheduled. Once you sign your estate plan documents, they become legally effective.

We look forward to assisting you with your estate planning needs.

CLIENT(S)

CLIENT 1:

Name _____ DOB: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Social Security Number: _____

Are you a U.S. Citizen? ☐ Yes ☐ No; if not, country of citizenship: _____

Employer Name: _____ Position: _____

Business address: _____

☐ Married: Date of Marriage: _____ ☐ Divorced ☐ Widowed ☐ Single

If married, what is your spouse's name? _____ DOB: _____

Spouse's address; if different from yours. _____

If married, is the spouse disabled, incapacitated or incompetent? ☐ Yes ☐ No ☐ N/A

If married, was a pre-nuptial or post-nuptial agreement signed? ☐ Yes ☐ No ☐ N/A

If divorced, please provide the name of the ex-spouse(s) and the date(s) of the divorce(s):
_____ DATE: _____

_____ DATE: _____

If widowed, please provide the name of the deceased spouse(s) and the date(s) of the death(s):
_____ DATE: _____

_____ DATE: _____

Are you a veteran? ☐ Yes ☐ No; If so, which branch of service: _____

Do you receive any veteran' benefits? ☐ Yes ☐ No ☐ N/A

Are you a partner or shareholder in a business? ☐ Yes ☐ No ☐ N/A

If so, please provide the name of the company: _____

Is there a Buy-Sell Agreement regarding any of the business interests? ☐ Yes ☐ No ☐ N/A

If yes, do you have a copy of the Agreement? ☐ Yes ☐ No ☐ N/A

Do you currently have a Will? ☐ Yes ☐ No Date of Will: _____

If you are also asking our office to prepare a will for your spouse, please complete this information:

CLIENT 2:

Name _____ DOB: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Social Security Number: _____

Are you a U.S. Citizen? ☐ Yes ☐ No; if not, country of citizenship: _____

Employer Name: _____ Position: _____

Business address: _____

☐ Married: Date of Marriage: _____ ☐ Divorced ☐ Widowed ☐ Single

If married, what is your spouse's name? _____ DOB: _____

Spouse's address; if different from yours. _____

If married, is the spouse disabled, incapacitated or incompetent? ☐ Yes ☐ No ☐ N/A

If married, was a pre-nuptial or post-nuptial agreement signed? ☐ Yes ☐ No ☐ N/A

If divorced, please provide the name of the ex-spouse(s) and the date(s) of the divorce(s):
_____ DATE: _____

_____ DATE: _____

If widowed, please provide the name of the deceased spouse(s) and the date(s) of the death(s):
_____ DATE: _____

_____ DATE: _____

Are you a veteran? ☐ Yes ☐ No; If so, which branch of service: _____

Do you receive any veteran' benefits? ☐ Yes ☐ No ☐ N/A

Are you a partner or shareholder in a business? ☐ Yes ☐ No ☐ N/A

If so, please provide the name of the company: _____

Is there a Buy-Sell Agreement regarding any of the business interests? ☐ Yes ☐ No ☐ N/A

If yes, do you have a copy of the Agreement? ☐ Yes ☐ No ☐ N/A

Do you currently have a Will? ☐ Yes ☐ No Date of Will: _____

CHILDREN

Name all children and the children of each deceased child, including those who will not receive anything under your will. Please indicate if there are any of your children or other beneficiaries under this will that have special needs. Reminder: Omitted children can contest a will.

Children: (please use full legal names and attach additional pages as necessary)

1. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Is this child alive ☐ or deceased ☐; if deceased, please list their date of death: _____

Is this child from this marriage ☐ or a former marriage ☐?

Is this child married? ☐Yes ☐ No; if yes, spouse's name: _____

Do you have any grandchildren from this child? ☐ Yes ☐ No; If yes, include names and date of birth:

1. Name: _____ Date of Birth _____
2. Name: _____ Date of Birth _____
3. Name: _____ Date of Birth _____
4. Name: _____ Date of Birth _____

Is this child or any member of his or her family disabled, incapacitated or incompetent? ☐YES ☐ NO
If so, please asterisk name above.

2. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Is this child alive ☐ or deceased ☐; if deceased, please list their date of death: _____

Is this child from this marriage ☐ or a former marriage ☐?

Is this child married? ☐Yes ☐ No; if yes, spouse's name: _____

Do you have any grandchildren from this child? ☐ Yes ☐ No; If yes, include names and date of birth:

1. Name: _____ Date of Birth _____
2. Name: _____ Date of Birth _____
3. Name: _____ Date of Birth _____
4. Name: _____ Date of Birth _____

Is this child or any member of his or her family disabled, incapacitated or incompetent? ☐YES ☐ NO
If so, please asterisk name above.

3. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Is this child alive ☐ or deceased ☐; if deceased, please list their date of death: _____

Is this child from this marriage ☐ or a former marriage ☐?

Is this child married? ☐Yes ☐ No; if yes, spouse's name: _____

Do you have any grandchildren from this child? ☐ Yes ☐ No; If yes, include names and date of birth:

1. Name: _____ Date of Birth _____
2. Name: _____ Date of Birth _____
3. Name: _____ Date of Birth _____
4. Name: _____ Date of Birth _____

Is this child or any member of his or her family disabled, incapacitated or incompetent? ☐YES ☐ NO
If so, please asterisk name above.

4. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Is this child alive ☐ or deceased ☐; if deceased, please list their date of death: _____

Is this child from this marriage ☐ or a former marriage ☐?

Is this child married? ☐Yes ☐ No; if yes, spouse's name: _____

Do you have any grandchildren from this child? ☐ Yes ☐ No; If yes, include names and date of birth:

1. Name: _____ Date of Birth _____
2. Name: _____ Date of Birth _____
3. Name: _____ Date of Birth _____
4. Name: _____ Date of Birth _____

Is this child or any member of his or her family disabled, incapacitated or incompetent? ☐YES ☐ NO
If so, please asterisk name above.

5. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Is this child alive ☐ or deceased ☐; if deceased, please list their date of death: _____

Is this child from this marriage ☐ or a former marriage ☐?

Is this child married? ☐Yes ☐ No; if yes, spouse's name: _____

Do you have any grandchildren from this child? ☐ Yes ☐ No; If yes, include names and date of birth:

1. Name: _____ Date of Birth _____
2. Name: _____ Date of Birth _____
3. Name: _____ Date of Birth _____
4. Name: _____ Date of Birth _____

Is this child or any member of his or her family disabled, incapacitated or incompetent? ☐YES ☐ NO
If so, please asterisk name above.

If there are additional children, please attach additional pages as necessary. If there are additional pages, please check here to indicate: ☐

PARENTS, BROTHERS, SISTERS, OTHERS

Client 1's Parents:

Father's Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is your father alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is your father disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

Mother's Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is your mother alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is your mother disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

Client 1's Siblings:

1. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this sibling alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is this sibling disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

2. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this sibling alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is this sibling disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

3. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this sibling alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is this sibling disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

If there are additional siblings, please attach additional pages as necessary. If there are additional pages, please check here to indicate: ☐

Client 2's Parents:

Father's Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is your father alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is your father disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

Mother's Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is your mother alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is your mother disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

Client 2's Siblings:

1. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this sibling alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is this sibling disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

2. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this sibling alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is this sibling disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

3. Name: _____ Date of Birth _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this sibling alive ☐ or deceased ☐ If deceased, please list their date of death: _____

Is this sibling disabled, incapacitated or incompetent or resides in a skilled nursing facility? ☐YES ☐ NO

If there are additional siblings, please attach additional pages as necessary. If there are additional pages, please check here to indicate: ☐

WILL PROVISIONS

One of the most important parts of a Will is the Testator naming their beneficiaries. The beneficiaries are the people who will inherit the contents of the Testator's estate**,** all of their belongings and property, after the Testator's death. The Testator may make specific gifts in their Will, naming specific people to inherit specific possessions**,** property, or cash assets. For example, a mother might make a specific gift leaving her engagement ring to her eldest daughter or a father might make a specific gift leaving $5,000 to each of their children to help them pay for their college education.

In addition to specific gifts, the Testator will also name who will inherit the residue, or remainder, of their estate. The residue includes anything that they have not given away in a specific gift. The Testator will name beneficiaries as well as alternate beneficiaries in case the people they have initially named die before them and are therefore unable to inherit. The Testator can name multiple people to inherit the residue of their estate and may **s**pecify what percentage or fraction of the estate each beneficiary will get**.**

There are generally 2 types of Assets: PROBATE and NON-PROBATE. The NON-PROBATE assets are generally not subject to the terms of the Will, nor to the statutes that decree the heirs to whom an intestate (one who dies without a will) decedent's property will pass. The most common arrangements that result in NON-PROBATE Transfers of assets are: life insurance policies, retirement plans, joint tenancy ownership of property, payable on death bank accounts and trust accounts, transferable on death security registration, and inter vivos trusts. These non-probate assets will **NOT** pass through your will or trust, but will pass automatically to the surviving joint owner(s) or to the designated beneficiary.

For purposes of this questionnaire, we will categorize your disposition of assets as follows:

1. **SPECIFIC BEQUESTS:** You do not need to describe every item of your personal or real property in your Will. However, if there is some specific item, sum of money or piece of land that you want to go to a certain individual, please list it.

2. **CHARITABLE BEQUESTS:** if there is some specific item, sum of money or piece of land that you want to go to a certain non-profit entity, please list it.

3. **GENERAL BEQUESTS:** The distribution of the balance of property (rest & residue) in the estate.

Is the value of your estate excluding retirement plans and/or insurance policies in excess of $**5,000,000.00**? ☐YES ☐ NO

(The official estate and gift tax limits for 2021: The estate and gift tax exemption is $11.7 million per individual, up from $11.58 million in 2020. That means an individual could leave $11.7 million to heirs and pay no federal estate or gift tax, while a married couple could shield $23.4 million.)

If **YES** we need to discuss possible tax consequences and/or estate planning needs. If **NO**, the size of your estate will not exceed the current allowable deduction and based upon that fact ALONE, probably will not incur tax liability.

DISINHERITANCE: Do you have any person or persons whom you wish to make a special point of **excluding** from your Will. For example, if you have a child or stepchild who might normally be considered a person who would be a beneficiary of your body that you wish to exclude, it is normally better to make a point of excluding that person so that it does not appear that they were excluded by accident? If so, please list their names:

_____

_____

FUNERAL ARRANGEMENTS: I wish to be ☐ buried OR ☐ cremated

Specific Arrangements: _____

_____

_____

_____

PERSONAL EFFECTS to be distributed as follows:

- ☐ by separate list attached to will
- ☐ to spouse
- ☐ to children
- ☐ at the discretion of the personal representative
- ☐ other: please list below

_____

_____

REAL ESTATE:

1. Address of Property be given: _____

City: _____ State: _____ Zip: _____

County: _____ FMV Value: _____

How Titled: _____

Name of Beneficiary: _____ Age: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

If this person does not survive you, then should this specific item be given to another individual? ☐YES ☐ NO
If this person does not survive you, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

2. Address of Property be given: _____

City: _____ State: _____ Zip: _____

County: _____ FMV Value: _____

How Titled: _____

Name of Beneficiary: _____ Age: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

If this person does not survive you, then should this specific item be given to another individual? ☐YES ☐ NO
If this person does not survive you, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

If there are additional pages, please check here to indicate: ☐

SPECIFIC BEQUESTS: ☐YES ☐ NO. Many people make special provisions for family heirlooms, jewelry, or other items of special value to be distributed to friends or relatives. If you have such property and wish it left to a specific person, please complete the following:

Name of Item(s): ____

Name of Beneficiary: ______________________________ Age: ______________

Address: ______________________________ Apt. #______________

City: ______________________ State: ________ Zip: ______________

Home Phone: (________) ______________ Work Phone: (________) ______________

Cell Phone: (________) ______________ Other Phone: (________) ______________

E-Mail Address: ____

If this person does not survive you, then should this specific item be given to another individual? ☐YES ☐ NO
If this person does not survive you, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

Name of Item(s): ____

Name of Beneficiary: ______________________________ Age: ______________

Address: ______________________________ Apt. #______________

City: ______________________ State: ________ Zip: ______________

Home Phone: (________) ______________ Work Phone: (________) ______________

Cell Phone: (________) ______________ Other Phone: (________) ______________

E-Mail Address: ____

If this person does not survive you, then should this specific item be given to another individual? ☐YES ☐ NO
If this person does not survive you, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

Name of Item(s): ____

Name of Beneficiary: ______________________________ Age: ______________

Address: ______________________________ Apt. #______________

City: ______________________ State: ________ Zip: ______________

Home Phone: (________) ______________ Work Phone: (________) ______________

Cell Phone: (________) ______________ Other Phone: (________) ______________

E-Mail Address: ____

If this person does not survive you, then should this specific item be given to another individual? ☐YES ☐ NO
If this person does not survive you, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

If there are additional pages, please check here to indicate: ☐

CHARITABLE BEQUESTS: ☐YES ☐ NO. Many people make special provisions for their church, a specific ministry or a specific charitable organization as a gift at their death.

Name of Item(s): _____

Name of Beneficiary: _____ Age: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

If this entity is no longer in existence at the time of your death, then should this specific item be given to another entity?
☐YES ☐ NO

If this entity is no longer in existence at the time of your death, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

Name of Item(s): _____

Name of Beneficiary: _____ Age: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

If this entity is no longer in existence at the time of your death, then should this specific item be given to another entity?
☐YES ☐ NO

If this entity is no longer in existence at the time of your death, then should this specific item pass along with the balance of your estate? ☐YES ☐ NO

If there are additional pages, please check here to indicate: ☐

GENERAL BEQUESTS

☐ **OUTRIGHT TO SPOUSE**: I/we want to leave property outright to the surviving Spouse.

I/we recognize that this offers no protection from creditors or predators. Allows surviving spouse to leave property to whomever he or she wants. Also allows a new spouse to possibly make claim on property in case of death or divorce.

Typically, the estate assets will pass as follows:
• To spouse, if surviving.
• If my spouse predeceases me, my assets will be divided in equal shares among my children.
• If any of my children predecease me, that child' share shall be distributed to his or her children in equal shares.
• In the event my spouse and all of my children and descendants fail to survive me, I want assets to be distributed as follows:

_____

_____

☐ **OUTRIGHT TO CHILDREN**: If your spouse dies before you, I/we want to leave property outright to my surviving children.

Typically, the estate assets will pass as follows
• In equal shares to my children or percentages.

☐ Equal shares or ☐ percentages; if percentages, please place below.

_____

_____

• If one or more of my children predeceases me, that child's share in my estate is distributed to his or her children in equal shares.
• In the event all my children and descendants fail to survive me, I want my assets to be distributed as follows:

_____

_____

In the event that your estate is to be divided among your children and if they are minors at the time of your death do you want their interest to be placed in a trust for their benefit? ☐YES ☐ NO

☐ **SEPARATE TRUST**: Distribution to children into separate trust, given outright at the age of: _____

☐ **FAMILY POT TRUST**: Distribution to children into "family pot" trust until youngest child reaches the age of: _____

When youngest child reached age, division into separate trusts at that time? ☐YES ☐ NO

If any beneficiary dies before you, do you wish their share to go ☐ to their lineal descendants OR
☐ to other beneficiaries in that group

The trustee must distribute the principal of the trust at one or more times in the future. How would you like the trust to be finally distributed?

____ distribute all to the child / grandchild at age _____, OR

____ distribute _____% at age _____, then distribute _____% at age _____, then distribute _____% at age _____, then

distribute the remaining balance at age _____

Other: _____

_____

_____

Indicate the types of things you would like the trustee to pay for that child:

____ for the child's general health, education and support,

[OR select from the following]

____ pay medical expenses not covered by other insurance

____ pay education expenses, including college / vocational / graduate school

____ provide summer trips, camps or other cultural experiences

____ purchase a car at certain ages or up to a certain purchase price

____ pay a monthly / quarterly income to the child / grandchild starting at age 21 / age _____

____ other: _____

OTHER FACTORS / PROVISIONS: Describe or list here any facts that do not seem covered by the other sections of this questionnaire and that you believe may be important for your Attorney to know. For example, does a member of your family have a serious long-term medical or physical problem that will require special care or attention in the future? Some provision that a beneficiary may receive as an inheritance might jeopardize their benefits, such as SSI or Medicaid.

_____

_____

_____

FIDUCIARIES

PERSONAL REPRESENTATIVE / EXECUTOR: The Executor is in charge of making sure that the people the Testator has named as beneficiaries get the portion of the estate described by the Testator. An Executor is one appointed by you to carry out the terms of your Will. Your Executor has the responsibility to wind up your affairs at your death, see to it that your assets are collected, that claims, expenses, and estate and inheritance taxes are paid, if any, and then distribute your property to who you have named. If you do not name an Executor in your Will, the Court will appoint an Administrator. He or she may not be the one that you would have appointed, so exercise the right to name the person or bank you want. Due to unforeseen circumstances it would be wise to name alternates.

PRIMARY:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Are the above executors the same for Client 2? ☐YES ☐ NO; if no, please complete this page separately.

TRUSTEE: If you establish a trust in your will, a Trustee must be named. The Trustee has the responsibility for the long-range management of property that is to be held in trust for the benefit of the beneficiaries of trust you may create. In general, choose a trustee with the following qualities: integrity, mature judgment, fiscal responsibility, and reasonable business and investment acumen.

PRIMARY:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Are the above trustees the same for Client 2? ☐YES ☐ NO; if no, please complete this page separately.

GUARDIAN: In most cases, a surviving parent assumes the role of sole guardian. However, it is important to name a guardian for minor children in your will in case neither you nor your spouse is able and willing to act. This person will have physical custody and care of your children.

PRIMARY:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Are the above guardians the same for Client 2? ☐YES ☐ NO; if no, please complete this page separately.

OTHER ESTATE PLANNING DOCUMENTS NEEDED:

☐ **Advance Directive for Health Care**: is the primary legal tool for any health care decision made when you cannot speak for yourself. "Health Care advance directive" is the general term for any written statement you make while competent concerning your future health care wishes.

GENERAL POWERS OF A HEALTH CARE AGENT: My health care agent will make health care decisions for me when I am unable to communicate my health care decisions, or I choose to have my health care agent communicate my health care decisions. My health care agent will have the same authority to make any health care decision that I could make. My health care agent´s authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly;
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

PRIMARY:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Are the above agents the same for Client 2? ☐YES ☐ NO; if no, please complete this page separately.

After my death, my Agent will have the power to authorize:

	An autopsy
☐YES ☐ NO	Organ donation
☐YES ☐ NO	Donate my body for medical study
☐YES ☐ NO	Final disposition of my body

Decisions concerning last illness situation:

1. A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

2. A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

Specific Decisions:

☐ Extend my life as long as possible, using all medication and medical procedures.

☐ Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

☐ I do not want any medications, machines, or other medical procedures, except as follows:
- ☐ Nutrition by tube or other means;
- ☐ Fluids by tube or other means;
- ☐ Ventilator
- ☐ CPR

Specific guidance (e.g. personal and religious values about treatment; preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis, etc.)

_____

_____

_____

☐ **Statutory Power of Attorney OR General Power of Attorney**: is a legal document that authorizes another person---called an agent---to act on behalf of the person who created the power of attorney---known as the principal---in the event that the principal cannot make those decision his or herself.

PRIMARY:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

ALTERNATE:

Name: _____ Over 18? ☐YES ☐ NO

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

E-Mail Address: _____

Are the above agents the same for Client 2? ☐YES ☐ NO; if no, please complete this page separately.

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Please furnish copies of each of the following documents that are in existence and to which you have access. If a document exists and you are unable to obtain a copy of it, please so indicate.

1. Your Present will and all codicils thereto.
2. All trusts created by you or your spouse.
3. All trusts of which you or your spouse is a beneficiary.
4. All separation or property settlement agreements or divorce decrees to which you or your spouse is a party.
5. All prenuptial agreements or marriage contracts to which you or your spouse is a party.
6. Deeds, mortgages & recent appraisals for each parcel of real estate owned by you or your spouse.
7. Copies or summaries of all individual or group life insurance policies insuring you or your spouse.
8. Current reports on all retirement, pension, or other employee benefit plans to which you or your spouse have contributed or of which you or your spouse is a beneficiary.
9. Current summaries of all IRA's owned by you or your spouse or of which is a beneficiary.
10. Current reports or summaries on all savings accounts, money market accounts, or certificates of deposit owned by you or your spouse.
11. If you or your spouse have an ownership interest in a small or closely held business, copies of the following documents: Partnership Agreements, Operation Agreements of Limited Liability Company, Shareholder's Agreements, Articles of Incorporation and By-Laws of Corporation

The information contained in this Estate Planning Information Packet is being disclosed to Varner & Peacock, LLC, attorneys, for the purpose of drafting a will for myself and is intended to be confidential information between my attorney and myself. The undersigned represents that the information contained in this packet is accurate and complete, and that the undersigned understands that the attorney will rely on this information which I am furnishing. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made the attorney may not be appropriate.

☐ I request that I may be able to review drafts of my estate planning documents via email. Please email the document to the following email address(es):

_____

☐ I request that I may be able to review drafts of my estate planning documents via mail. Please mail the document to the following email address(es):

_____

☐ I request that I may be able to review drafts of my estate planning documents in a review meeting with the attorney. Please call me at the following number to schedule an appointment with the attorney:

_____

Dated this _____ day of _____, 2021.

_____ _____

CLIENT 1: **CLIENT 2:**

QUOTE: _____

VARNER & PEACOCK
ATTORNEYS AT LAW

ASSET INFORMATION CHECKLIST

This Asset Information checklist is designed to help you list all the property you own and what it is worth. If you do not own property under a particular heading, just leave that section blank. Under certain headings you may own more property than can be listed on this checklist. If so, use extra sheets of paper to list your additional property.

SAFE DEPOSIT BOX: YES: _____ NO: _____

LOCATION: _____

BANK ACCOUNTS:

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

REAL ESTATE: Any interest in real estate including your family residence, vacation home, time share, vacant land, etc.

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ CURRENT FMV VALUE: _____

HOW TITLED: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ CURRENT FMV VALUE: _____

HOW TITLED: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ CURRENT FMV VALUE: _____

HOW TITLED: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ CURRENT FMV VALUE: _____

HOW TITLED: _____

FURNITURE AND PERSONAL EFFECTS: List separately only major personal effects such as jewelry, collections, antiques, furs, and all other valuable non-business personal property (indicate type below and give a lump sum value for miscellaneous, less valuable items.).

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

TYPE: _____ CURRENT FMV VALUE: _____

STOCKS AND BONDS: List any and all stocks and bonds you own. If held in a brokerage account, lump them together under each account.

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

CURRENT VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

CURRENT VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

CURRENT VALUE: _____

MONEY MARKET ACCOUNTS OR CERTIFICATES OF DEPOSIT:

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

CURRENT VALUE: _____

U.S. GOVERNMENT SAVINGS BONDS (E, EE, H):

HOW TITLED: _____

LOCATION OF BONDS: _____

TO BE CASHED: YES _____ NO _____

IF YES, NAME OF TRANSFEREE: _____

CURRENT VALUE: _____

MORTGAGES AND NOTES (RECEIVABLE):

MORTGAGOR 1: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

CURRENT VALUE: _____

MORTGAGOR 2: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

CURRENT VALUE: _____

INSURANCE ON DECEDENT'S LIFE:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

FACE AMOUNT: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

FACE AMOUNT: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

FACE AMOUNT VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

FACE AMOUNT VALUE: _____

ANNUITIES:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

FACE AMOUNT VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

FACE AMOUNT VALUE: _____

VEHICLES: For each motor vehicle, boat, RV, etc. please list the following: description, how titled, market value and encumbrance.

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

CURRENT VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

CURRENT VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

CURRENT VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

CURRENT VALUE: _____

BUSINESS INTERESTS: General and Limited Partnerships, Sole Proprietorships, privately owned corporations, professional corporations, oil interests, farm and ranch interests. **ADDITIONAL INFORMATION:** Give a description of the interests, who has the interest, your ownership in the interests, and the estimated value of the interests.

_____

_____

_____

_____

ANTICIPATED INHERITANCE, GIFT, OR LAWSUIT JUDGMENT: Gifts or inheritances that you expect to receive at some time in the future; or moneys that you anticipate receiving through a judgment in a lawsuit.

_____

_____

_____

_____

INTELLECTUAL PROPERTY INTERESTS: Please list all REGISTERED copyright, trademark, patent & royalty interests. (Type: Registered Copyright (©), Registered Trademark (T), Registered Patent (P), or Royalty Agreement (R).)

_____

_____

_____

_____

BURIAL PLOTS: Please list all burial plots or contracts with cemeteries for burial, and include the address to which to change ownership should you be directed. If you have a deed to the actual land, please provide us with a copy. (Type: Owns the actual land (O), Contract with cemetery (C))

_____

_____

_____

_____

OTHER ASSETS: Other property is any property that you have that does not fit into any listed category.

_____

_____

_____

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

By: **JOHN DOE** Date of Birth: _____
(Print Name) *(Month/Day/Year)*

This advance directive for health care has four parts:

PART ONE—Health Care Agent. *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*

PART TWO—Treatment Preferences. *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*

PART THREE—Guardianship. *This part allows you to nominate a person to be your guardian should one ever be needed.*

PART FOUR—Effectiveness and Signatures. *This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.*

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE—Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.

1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

2. Back-Up Health Care Agent

This section is optional. PART ONE will be effective even if this section is left blank.

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent´s authority includes, for example, the power to:

- **Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;**
- **Request, consent to, withhold, or withdraw any type of health care; and**
- **Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).**

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- **My health care agent may refuse to act as my health care agent;**
- **A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and**
- **My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.**

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. Powers of Health Care Agent After Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent´s power by initialing below.

_____ *(Initials)* **My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).**

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent´s power by initialing below.

Initial each statement that you want to apply.

_____ *(Initials)* **My health care agent will not have the power to make a disposition of my body for use in a medical study program.**

_____ *(Initials)* **My health care agent will not have the power to donate any of my organs.**

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ *(Initials)* **I want the following person to make decisions about the final disposition of my body:**

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

I wish for my body to be:

_____ *(Initials)* **Buried**

OR

_____ *(Initials)* **Cremated**

PART TWO—Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_____ *(Initials)* **A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.**

_____ *(Initials)* **A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.**

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ *(Initials)* **Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.**

OR

(B) _____ *(Initials)* **Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.**

OR

(C) _____ *(Initials)* **I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:**

Initial each statement that you want to apply to option (C).

_____ *(Initials)* **If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.**

_____ *(Initials)* **If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.**

_____ *(Initials)* **If I need assistance to breathe, I want to have a ventilator used.**

_____ *(Initials)* **If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.**

8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

9. In Case of Pregnancy

PART TWO will be effective even if this section is left blank.

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ *(Initials)* **I want PART TWO to be carried out if my fetus is not viable.**

PART THREE—Guardianship

10. Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

(A) _____ *(Initials)* **I nominate the person serving as my health care agent under PART ONE to serve as my guardian.**

OR

(B) _____ *(Initials)* **I nominate the following person to serve as my guardian:**

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

PART FOUR—Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ *(Initials)* **This advance directive for health care will become effective on or upon _____ and will terminate on or upon _____.**

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- *Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;*
- *Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *Cannot be a person who is directly involved in your health care.*

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____

JOHN DOE *(Date)*

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____

(Signature of First Witness) *(Date)*

Print Name: _____

Address: **1719 Russell Parkway, Building 200, Warner Robins, GA 31088**

_____ _____

(Signature of Second Witness) *(Date)*

Print Name: _____

Address: **1719 Russell Parkway, Building 200, Warner Robins, GA 31088**

This form does not need to be notarized.

STATE OF GEORGIA
COUNTY OF HOUSTON

STATUTORY FORM POWER OF ATTORNEY

This power of attorney authorizes another person (**your agent**) to make decisions concerning your property for you (**the principal**). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in O.C.G.A. Chapter 6B of Title 10.

This power of attorney does not authorize the agent to make health care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you. If you revoke the power of attorney, you must communicate your revocation by notice to the agent in writing by certified mail and file such notice with the clerk of superior court in your county of domicile.

Your agent is not entitled to any compensation unless you state otherwise in the Special Instructions. Your agent shall be entitled to reimbursement of reasonable expenses incurred in performing the acts required by you in your power of attorney.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a successor agent or name a co-agent in the Special Instructions. Co-agents will not be required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney shall be durable unless you state otherwise in the Special Instructions.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

DESIGNATION OF AGENT

I, _____, name the following person as my agent:

Name of agent: _____

Agent's address: _____

Agent's telephone number: _____

Agent's email address: _____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of successor agent: _____

Successor agent's address; _____

Successor agent's telephone number: _____

Successor agent's email address: _____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined O.C.G.A. Chapter 6B of Title 10:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "all preceding subjects" instead of initialing each subject).

( ) Real property
( ) Tangible personal property
( ) Stocks and bonds
( ) Commodities and options
( ) Banks and other financial institutions
( ) Operation of entity or business
( ) Insurance and annuities
( ) Estates, trusts, and other beneficial interests
( ) Claims and litigation
( ) Personal and family maintenance
( ) Benefits from governmental programs or civil or military service
( ) Retirement plans
( ) Taxes
( ) All preceding subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent SHALL NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent. You should give your agent specific instructions in the Special Instructions when you authorize your agent to make gifts).

( ) Create, amend, revoke, or terminate an inter vivos trust
( ) Make a gift, subject to the limitations of O.C.G.A. § 10-6B-56 and any Special Instructions in this power of attorney
( ) Create or change rights of survivorship
( ) Create or change a beneficiary designation
( ) Authorize another person to exercise the authority granted under this power of attorney
( ) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
( ) Access the content of electronic communications
( ) Exercise fiduciary powers that the principal has authority to delegate
( ) Disclaim or refuse an interest in property, including a power of appointment

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant SHALL NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines (you may add lines or place your special instructions in a separate document and attach it to the power of attorney):

_____

_____

_____

_____

_____

_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF CONSERVATOR (OPTIONAL)

If it becomes necessary for a court to appoint a conservator of my estate, I nominate the following person(s) for appointment:

Name of Nominee for Conservator: _____

Nominee's address: _____

Nominee's telephone number: _____

Nominee's email address: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person has actual knowledge it has terminated or is invalid.

[SIGNATURES ON FOLLOWING PAGE]

SIGNATURE AND ACKNOWLEDGMENT

_____ _____
Signature Date

_____
Your name printed

_____ _____
Telephone number

_____ _____
Address Email address

This document was signed in my presence on _____ by _____.

_____
Witness's Signature

_____
Witness's name printed

_____ _____
Telephone number

_____ _____
Witness's Address Email address

State of Georgia
County of _____

This document was signed in my presence on _____ by _____.
DATE NAME OF PRINCIPAL

_____
Signature of notary (Seal)

My commission expires: