

***Seymour Law Firm***

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TRUST ESTATE PACKAGE QUESTIONNAIRE

Thank you for choosing Seymour Law Firm, PLLC to assist you with your estate planning.

Please fill out the following questions and ensure that I receive them at least two business days before your appointment, so I may have sufficient time to prepare draft copies for review during your appointment.

You may send the completed forms to me via email, regular mail or by simply dropping them off at the office.

If an item does not apply to you, please put N/A next to it or cross through it.

And one last reminder: don't forget to call my office and make an appointment for your Estate Package review.

If you have any questions, do not hesitate to call or email me,

Tina

**Please provide the following information:**

1. Full Legal Name
	1. Address
	2. City, State, Zip
2. Spouse
	1. Full legal name
	2. Spouse Phone Number
3. Children:
	1. Full legal name and date of birth
	2. Full legal name and date of birth
	3. Full legal name and date of birth
	4. Full legal name and date of birth
4. Do you wish to be cremated or embalmed?
5. Where do you wish to be buried?
6. If a cemetery, do you have a place already reserved?
7. Do you have prearrangements on file with a funeral home or insurance company?
	1. If so, please provide the name of the home/insurance company and town:
8. Specific items you wish to give family members:
	1. (item) (name of person)
	2. (item) (name of person)
	3. (item) (name of person)
	4. (item) (name of person)
9. Primary home: do you wish to give this to someone or sell it?
	1. If to sell, who gets the proceeds?
10. Once your bills are paid, how do you wish to divide the rest of your estate? (land, cars, personal property, etc.)
11. If those people are not alive at the time of your death, to whom do you wish to give the items/proceeds?
12. Who do you wish to be named to handle your estate (Executor) and your backup Executor?

Executor:

* 1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Relationship

Backup Executor:

* 1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Relationship

**Trust:**

1. **Please provide the following name for the Trust:**
	1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Telephone Number
	5. Relationship
2. **If you wish to place the Trust in more than one name (for example, a married couple):**
	1. Spouse Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Telephone Number
	5. Relationship
3. **Who would you like to name as your successor, the person who takes over after your death?**
	1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Telephone Number
	5. Relationship
4. **Who would you like to name as your back up successor, in case this person cannot take over after your death?**
	1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Telephone Number
	5. Relationship
5. **Are there any minor children, or young adults, for whom you want to hold assets in the trust, until they reach a certain age?**

**Child One:**

* 1. Name (full, legal)
	2. Date of birth
	3. Relationship to you (child, grandchild)
	4. Age to reach before trust funds are released \_\_\_\_\_\_\_ (usually 18 or 21--but can be extended)
	5. Special circumstances for releasing additional funds? (ex: medical expenses, college expenses, reasonable living expenses, buying a house, buying a car)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child Two:**

1. Name (full, legal)
2. Date of birth
3. Relationship to you (child, grandchild)
4. Age to reach before trust funds are released \_\_\_\_\_\_\_ (usually 18 or 21--but can be extended)
5. Special circumstances for releasing additional funds? (ex: medical expenses, college expenses, reasonable living expenses, buying a house, buying a car)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Financial Power of Attorney:**

1. Who do you wish to handle your financial affairs if you become incapacitated:

First Choice:

* 1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Phone Number
	5. Relationship

Second Choice:

1. Name (full, legal)
2. Address
3. City, State, Zip
4. Phone Number
5. Relationship

 **Medical Power of Attorney:**

1. Who do you want to name as the person to make medical decisions if you are incapacitated?
	1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Telephone Number
	5. Relationship
2. Who is your second choice?
	1. Name (full, legal)
	2. Address
	3. City, State, Zip
	4. Telephone Number
	5. Relationship

For the purposes of the next document, the following definitions apply:

1.      **"Artificially administered food and water"** (or artificial nutrition and hydration) means the provision of nutrients or fluids by a tube inserted in vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

2.      **"Attending physician"** means the physician licensed by the state board of medicine, selected by or assigned to the patient, and who has primary responsibility for the treatment and care of the patient.

3.      **"Comfort care"** means treatment, including prescription medication, provided to the patient for the sole purpose of alleviating pain. Artificially administered food and water is not included.

4.      **"Health care provider"** or "provider" means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.

5.      **"Irreversible (Permanent) Coma"** means a profound state of unconsciousness caused by disease, injury, poison, or other means and for which it has been determined that there exists no reasonable expectation of regaining consciousness.

6.      **"Life-prolonging procedure"** (or **"life-sustaining procedure"**) means any medical procedure, treatment, or intervention which sustains, restores, or supplants a spontaneous vital function. In this document the term does not include sustenance and hydration administration, or the provision of medication or the performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

7.      **"Persistent vegetative state"** means a permanent and irreversible condition in which there is:
      a. The absence of voluntary action or cognitive behavior of any kind.
      b. An inability to communicate or interact purposefully with the environment.

8.      **"Terminal condition"** means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

**Medical Advance Directives:**

Instructions for Health Care: Please check/initial the following--**those not checked/initialed will be removed from your documents**:

1. If I have an incurable and irreversible (terminal) condition that will result in my death within a relatively short time, I direct that:
	1. I be removed from any artificial life support or any additional life-prolonging treatment. \_\_\_\_\_\_
	2. I not be artificially administered food and water, realizing this may hasten my death. \_\_\_\_\_\_
	3. I not be provided any comfort care, and relief from pain, including any pain reduction medication.  \_\_\_\_\_\_
2. If I am diagnosed as being in an irreversible coma and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that
	1. I be removed from any artificial life support or any additional life-prolonging treatment. \_\_\_\_\_\_
	2. I not be artificially administered food and water, realizing this may hasten my death. \_\_\_\_\_\_
	3. I not be provided any comfort care, and relief from pain, including any pain reduction medication.  \_\_\_\_\_\_
3. If I am diagnosed as being in a persistent vegetative state and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that:
	1. I be removed from any artificial life support or any additional life-prolonging treatment. \_\_\_\_\_\_
	2. I not be artificially administered food and water, realizing this may hasten my death. \_\_\_\_\_\_
	3. I not be provided any comfort care, and relief from pain, including any pain reduction medication.  \_\_\_\_\_\_
4. Do you have any additional instructions regarding your care?
	1. Organ donor, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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