



COMMANDER LAW

ATTORNEYS & MEDIATORS

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How did you find us: _____

WILL /TRUST/ LIVING WILL QUESTIONNAIRE

The information requested below is essential in preparing your will or trust. If you need more space to answer a question, attach a separate sheet and indicate the question number to which it pertains. If both you and your spouse require estate planning documents, you will need to each fill out a separate questionnaire. (When filling out two questionnaires, long or complex directions that will be identical in both sets of documents may be written down on only one questionnaire and referred to on the second questionnaire.)

1. State your full name:

First

Middle

Last

a. State all other names by which you have been known:

b. Age: _____ Date of birth: _____

c. Sex: Male ☐ Female ☐

d. SSN: _____

2. State your current residence:

a. Street Address:

b. City: _____ County: _____

c. State: _____ Zip code: _____

d. Contact Information:

Residence: _____ Work: _____

Cell: _____ Other: _____

Email: _____

3. If you are married, state your spouse's full name (including maiden name):

First	Middle	Last
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4. If you have children, including adopted children, state the Name, Sex, Date of Birth and the type of relationship (i.e. Biological, Step, Adopted) for each child:

Full Name	M/F	Date of Birth	Bio/Step/Adopted

5. a. Name and date of deceased child or children:

Full Name	Son/ Daughter	Date of Death

b. Name of deceased child's living children:

Full Name	Son/ Daughter	Date of Birth

6. Do you and your spouse have a Prenuptial Agreement, which identifies and disposes of separate spousal property?

YES ☐ NO ☐

(If yes, attach copy with any filing data)

7. Have you created any trusts or made gifts to any trust? If yes, describe:

8. Do you have a date on which you expect to have any inheritance distributed to you? If so, state from whom and how much:

9. Please indicate, by checking the appropriate option, how you want your assets to pass when you die.

☐

Option A: I want my assets to pass to my spouse and children 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 predeceases me, that child's share shall be distributed to his or her children in equal shares.
- In the event my spouse and all of my children and decedents fail to survive me, I want my assets to be distributed as follows:

☐

Option B: I am unmarried with children and want my assets to pass:

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

☐

Option C: None of the above. I want my assets to pass:

10. At what age(s) do you want the monies to be distributed to your children/beneficiaries?

List percentages:

_____ % at _____ years old; _____ % at _____ years old; _____ % at _____ years old

Other:

11. List any instructions regarding limitations on distributions (such as must finish college, etc.), or special instructions (such as starting a business, getting married, etc.).

12. Do you wish to disinherit any child, grandchild, or other person?

If yes, you must list their names here.

13. 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.

NOTE: If you have chosen “Option A” or “Option B” under number 11, you have indicated by your selection the items described above will pass to your spouse and/or children. Complete this number ONLY if you desire such items of specific value to be left to specific person(s).

ITEM	SPECIAL IDENTIFYING FEATURES	RECIPIENT

Execution of a Will/Trust is the best way to determine how your property will be distributed; however, it cannot address important issues regarding health care decisions. You may want to discuss the functions of a Health Care Power of Attorney and a Living Will with our office. These issues should be discussed prior to drafting these documents with the person named as agent.

14. If you become incapacitated, whom do you want to make health care decisions for you?

Spouse first? Yes ☐ No ☐

Successor or if not spouse:

PRIMARY SUCCESSOR AGENT

a. Name(s):

b. Address:

c. City: _____ County: _____

d. State: _____ Zip code: _____

e. Relationship (if any): _____

If the person listed above is unwilling or unable to perform these duties, please list an alternate:

SUCCESSOR AGENT

a. Name(s):

b. Address:

c. City: _____ County: _____

d. State: _____ Zip code: _____

e. Relationship (if any): _____

15. Do you want a Living Will (life support decision)?

Yes ☐ No ☐

If **yes**, who do you want to be responsible for deciding to remove you from life support?

Spouse first? Yes ☐ No ☐

Successor or if not spouse:

PRIMARY SUCCESSOR AGENT

a. Name(s):

b. Address:

c. City: _____ County: _____

d. State: _____ Zip code: _____

e. Relationship (if any): _____

If the person listed above is unwilling or unable to perform this duty, please list an alternate:

SUCCESSOR AGENT

a. Name(s):

b. Address:

c. City: _____ County: _____

d. State: _____ Zip code: _____

e. Relationship (if any): _____

16. Here are some general statements about choices you have as to health care you want at the end of your life. Put a check next to whichever choices best fit your wishes. Any combination can be used but if you choose “Direction to Prolong My Life (to the greatest extent possible)”, no other choices should be checked.

☐ **Comfort Care Only:** If I have a terminal condition, I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. (NOTE: “Comfort care” means treatment in an attempt to protect and enhance quality of life without artificially prolonging life.)

☐ **Specific Limitations on Medical Treatment I Want:** (NOTE: mark one or more choices below.) If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but **I do not want the following:**

- ☐ 1.) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
- ☐ 2.) Artificially administering food and fluids.
- ☐ 3.) To be taken to a hospital if it is at all avoidable.

☐ **Pregnancy:** Regardless of any other directions I have given in this Living Will, if I am known to be pregnant I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

☐ **Treatment Until My Medical Condition is Reasonably Known:** Regardless of the directions I have made in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable, or I am in a persistent vegetative state.

☐ **Direction to Prolong My Life:** I want my life prolonged for _____ (amount of time).

☐ **Direction To Prolong My Life:** I want my life prolonged to the greatest extent possible.

☐ **Other Directions:**

17. Do you wish to donate your organs for the following purposes?

Transplantations	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Research	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Studies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

In addition to a Last Will and Health Care documents many individuals ask to receive a General Durable Power of Attorney that becomes “EFFECTIVE UPON INCAPACITATION”. This document allows an individual’s designated ‘Attorney-In-Fact’ to act for him in all financial matters during any time that the individual is incapacitated due to medical or other problems. The Attorney-In-Fact will have full control over your financial future; therefore, you need to make sure only to select trustworthy individuals to act in such an important capacity for you.

18. Do you want a General Durable Power of Attorney?

Yes ☐ No ☐

If yes, then who do you wish to be your Attorney-In-Fact?

Spouse first? Yes ☐ No ☐

Successor or if not spouse:

PRIMARY SUCCESSOR AGENT

a. Name(s):

b. Address:

c. City: _____ County: _____

d. State: _____ Zip code: _____

e. Relationship (if any): _____

If the person listed above is unwilling or unable to perform these duties, please list an alternate:

SUCCESSOR AGENT

a. Name(s):

b. Address:

c. City: _____ County: _____

d. State: _____ Zip code: _____

e. Relationship (if any): _____

If there is any other information you think would help us prepare your Will, please include below or on a separate sheet of paper and attach it to this questionnaire.

Confirmation of information and instructions: I confirm the information provided by me in this questionnaire is complete and accurate, and that the instructions I am providing reflect my wishes.

Signature

Date