

*The Law Office of*  
**Michael J. Girardi**

## **Estate Planning Questionnaire**

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**THE PERSONAL AND CONFIDENTIAL FILE**

OF

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If you have any questions or need assistance in completing this questionnaire, please do not hesitate to call 724-339-1062. Make sure to complete this questionnaire and bring it with you to our initial meeting.

**ALL THE INFORMATION YOU PROVIDE IN THIS QUESTIONNAIRE IS STRICTLY  
CONFIDENTIAL.**

PLEASE NOTE that no attorney-client relationship has been formed by receiving or completing this questionnaire. If you do not return your completed questionnaire within **THIRTY (30) DAYS** from the date of receipt, your file will be closed and the Law Office of Michael J. Girardi will take no further actions in this matter.



## **INTRODUCTION**

This initial estate planning questionnaire is designed to give the Law Office of Michael J. Girardi an accurate understanding of your current estate situation so that we can better advise you on your estate planning needs. Please be as complete as possible when answering this questionnaire; however do not delay an appointment for lack of answers to these questions. If any of the requested information does not apply or is not readily available, leave those sections blank. Feel free to attach any additional information you would like to provide us.



**PART I. PERSONAL INFORMATION**

**A. Client**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
U.S. Citizen: \_\_\_\_ Yes \_\_\_\_ No Veteran: \_\_\_\_ Yes \_\_\_\_ No  
Soc. Sec. No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Discharge: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Marital Status: \_\_\_\_\_

**B. Former Spouse (if applicable)**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
U.S. Citizen: \_\_\_\_ Yes \_\_\_\_ No Veteran: \_\_\_\_ Yes \_\_\_\_ No  
Soc. Sec. No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Discharge: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**C. Residence**

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Date of Marriage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**D. Children & Grandchildren**

Name of Child: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Children (Y/N): \_\_\_\_\_

Name of Child: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Children (Y/N): \_\_\_\_\_

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**F. Other Beneficiaries** (people / organizations you want to benefit from your estate)

Name

Relationship to You

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. Miscellaneous**

Do you have pets?  Yes  No

Does anyone live in your home with you?  Yes  No

Please rate the following, from 1 (lowest) to 10 (highest)

Your Mental Health \_\_\_\_\_

Your Physical Health \_\_\_\_\_

**PART II. CURRENT ESTATE PLAN & ADVISORS**

**A. Current Estate Plan**

Do you have any of the following:

Last Will & Testament  Yes  No

Financial / General Durable Power of Attorney  Yes  No

Health Care Power of Attorney / Living Will  Yes  No

Trust  Yes  No

Prenuptial Agreement  Yes  No

Do you have a safe deposit box?  Yes  No

If yes, please provide the location: \_\_\_\_\_

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**B. Advisors**

Position	Name	Phone Number
Investment Advisor	_____	_____
Accountant	_____	_____
Life Insurance Agent	_____	_____
Other Attorney	_____	_____
Primary Physician	_____	_____

**PART III. INSURANCE**

**A. Life Insurance**

Name of Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Type of Policy: \_\_\_\_\_ Owner: \_\_\_\_\_  
Insured: \_\_\_\_\_ Face Value: \_\_\_\_\_  
Death Benefit: \_\_\_\_\_ Cash Value: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_

Name of Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Type of Policy: \_\_\_\_\_ Owner: \_\_\_\_\_  
Insured: \_\_\_\_\_ Face Value: \_\_\_\_\_  
Death Benefit: \_\_\_\_\_ Cash Value: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_

Name of Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Type of Policy: \_\_\_\_\_ Owner: \_\_\_\_\_  
Insured: \_\_\_\_\_ Face Value: \_\_\_\_\_  
Death Benefit: \_\_\_\_\_ Cash Value: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_

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Name of Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Type of Policy: \_\_\_\_\_ Owner: \_\_\_\_\_  
Insured: \_\_\_\_\_ Face Value: \_\_\_\_\_  
Death Benefit: \_\_\_\_\_ Cash Value: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_

**B. Long Term Care Insurance**

Name of Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Type of Policy: \_\_\_\_\_ Owner: \_\_\_\_\_  
Insured: \_\_\_\_\_ Is spouse insured under policy (Y/N) \_\_\_\_\_  
Beneficiary: \_\_\_\_\_  
Daily Rate: \_\_\_\_\_ Maximum Payment \_\_\_\_\_ Duration of Policy: \_\_\_\_\_

**PART IV GIFTS**

1. Have you ever filed a Federal Gift Tax Return? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If so, for what calendar year(s)? \_\_\_\_\_
  2. Have you ever made gifts in excess of \$10,000? \_\_\_\_\_ Yes \_\_\_\_\_ No
  3. Have you made gifts in excess of \$500 in any one month to an individual, group of individuals or trusts within the past 60 months? \_\_\_\_\_ Yes \_\_\_\_\_ No
  4. Were names added to or removed from any bank, investment, or financial account held jointly with another individual in the past 60 months? \_\_\_\_\_ Yes \_\_\_\_\_ No
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If yes to 2, 3 or 4 above, please list the recipients below:

Name	Date	Amount
_____	___ / ___ / ____	_____
_____	___ / ___ / ____	_____
_____	___ / ___ / ____	_____
_____	___ / ___ / ____	_____
_____	___ / ___ / ____	_____
_____	___ / ___ / ____	_____

**PART V FIDUCIARIES**

**A. Personal Representatives**

List the individuals you want to serve as the Personal Representatives (Executor) of your estate. Your Personal Representative will be responsible for administering your estate and carrying out the directions in your will. Please name at least one primary and one alternative.

Primary: \_\_\_\_\_  
Alt #1 : \_\_\_\_\_  
Alt #2 : \_\_\_\_\_  
Alt #3 : \_\_\_\_\_

**B. Trustees**

List the individuals you would like to serve as your Trustee under either a Testamentary Trust, to manage your assets on behalf of your beneficiaries after your passing, or a Revocable Living Trust, if you wish to avoid probate. Please name at least one primary and one alternative.

Primary: \_\_\_\_\_  
Alt #1 : \_\_\_\_\_  
Alt #2 : \_\_\_\_\_  
Alt #3 : \_\_\_\_\_

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**C. Guardians for Minor Children**

If you should pass leaving minor children, please list the individuals you would want to provide the day-to-day care for your children. Please name at least one primary and one alterative.

Primary: \_\_\_\_\_  
Alt #1 : \_\_\_\_\_  
Alt #2 : \_\_\_\_\_  
Alt #3 : \_\_\_\_\_

**D. Financial Power of Attorney Agent**

Your agent under your Financial Power of Attorney will be able to manage your financial affairs if you are unable to do so. Typically, the primary agent is the spouse. Please name at least one primary and one alterative.

Primary: \_\_\_\_\_  
Alt #1 : \_\_\_\_\_  
Alt #2 : \_\_\_\_\_  
Alt #3 : \_\_\_\_\_

**PART VI. LIABILITIES**

Please list any significant creditors you may have, the current balance, and whether the liability is owed solely by you or jointly with another.

Creditor	Current Balance	Sole / Joint
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any legal issues we should be aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

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**PART VII. ASSETS**

Please provide the value of each asset in the appropriate space. Pay particular attention to how the asset is owned or titled.

**A. General Assets**

ASSET	OWNED INDIVIDUALLY	OWNED JOINTLY WITH ANOTHER
Personal Effects		
Jewelry		
Furnishings & Art		
Collectibles		
Checking Account		
Savings Account		
Money Market Account		
Certificates of Deposit		
Residence Property		
Other Real Estate		
Closely Held Business Ownership Interest		
Automobiles		
Other Vehicles		
Stocks		
Bonds		
Mutual Funds		
Annuities		
IRA / Roth		
401K / 403B, etc.		
Other		
Other		
Other		
Total		

**B. Miscellaneous**

Do you own any firearms? \_\_\_\_\_ Yes    \_\_\_\_\_ No

Do you anticipate a large inheritance? \_\_\_\_\_ Yes    \_\_\_\_\_ No

**PART VIII. ESTATE PLANNING GOALS**

**A. Specific Gifts**

List any specific items or dollar amounts you wish to leave to a particular person or persons.

Name	Relation	Item
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**B. Charitable Gifts**

Please list any charitable gifts (such as to a charity, institution, or church) you wish to make.

Organization	Item
_____	_____
_____	_____
_____	_____
_____	_____

**C. Distribution Goals**

Please briefly describe your distribution goals for your estate.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. Miscellaneous**

Are you interested in avoiding probate? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you interested in planning for Medicaid Eligibility? \_\_\_\_\_ Yes \_\_\_\_\_ No

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How did you hear about the Law Office of Michael J. Girardi?

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**Certification**

The undersigned hereby represent to the Law Office of Michael J. Girardi that the information contained in this questionnaire is accurate and complete, and that the undersigned understand that the Law Office will rely on this information. We understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the Law Office may not be appropriate.

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Signature of Client or Client Representative

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Date