

ESTATE PLANNING ANALYSIS

Please complete your *Estate Planning Analysis* form and return it to our office with your retainer in the amount \$275.00. Once we receive your request, we will contact you within 7 days to schedule your appointment in our office. There is no need to organize your financial assets at this time. This is done *after* you complete and return this form.

The balance of your professional fees and costs will be due at your final signing scheduled in our office.

SEND FORM TO:

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ESTATE PLANNING ANALYSIS

This *Estate Planning Analysis* is designed to be a tool to help you organize all aspects of your estate and help us prepare your *Estate Plan* documents which will contain all of the following:

LIVING TRUST

This legal document allows your family estate to be administered quickly and privately, provides prenuptial protection, removes assets from your name, and protects your assets from the cost and time of the probate court system.

POUR-OVER WILL

Its purpose is to transfer or "pour-over" any assets outside the *Living Trust* at the time of death so that all assets are distributed according to a common plan.

POWER OF ATTORNEY

Allows you to name a person to act on your behalf and transfer assets into your *Living Trust*, should you become disabled or are unable to make the transfer yourself.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This document states your desires regarding life support and health care decisions.

CERTIFICATE OF TRUST

A notarized *Certificate of Trust* does not disclose financial or estate planning information. This allows you to provide proof of the *Living Trust* to selected individuals or investment sources without having to reveal information you want to keep confidential.

IMPORTANT

Please fill out the information on the following pages. If an item does not pertain to your situation then skip that item and continue with the next applicable item. This information is confidential and will not be disclosed to any person or organization without your prior written approval.

OUR TRUST TEAM

1. BACK-UP TRUSTEE OF YOUR TRUST

This is the person who will manage your assets if you are disabled, and distribute them according to your *Living Trust* at your death. Write spouse if you wish your spouse to be your first *Back-Up Trustee*.

Name

2. ALTERNATE BACK-UP TRUSTEE OF YOUR TRUST

This is the person that would take over at the death, incapacity, or resignation of your *Back-Up Trustee*.

Name

3. EXECUTOR OF YOUR WILL

This is the person that makes sure your instructions as set forth in your *Will* are carried out. (Often this is the same person as your *Back-Up Trustee*).

Name

4. ALTERNATE EXECUTOR OF YOUR WILL

This is the person that takes over if your first executor resigns, dies, or becomes incapacitated. (Often this is the same person as your *Alternate Back-Up Trustee*).

Name

5. EXECUTOR OF YOUR SPOUSE'S WILL

Name

6. ALTERNATE EXECUTOR OF YOUR SPOUSE'S WILL

Name

7. GUARDIAN OF YOUR MINOR CHILDREN

This is the person you choose to be legally responsible for your children under the age of 18.

Name

Address

8. ALTERNATE GUARDIAN FOR YOUR MINOR CHILDREN

Name *Address*

9. GUARDIAN OF YOUR MINOR CHILDREN'S ESTATE
This is the person that is responsible for the estate of your children under the age of 18.

Name *Address*

10. ALTERNATE GUARDIAN FOR YOUR MINOR CHILDREN'S ESTATE

Name *Address*

11. AGENT FOR YOUR POWER OF ATTORNEY
This person acts on your behalf if you become incapacitated. If married it is often your spouse.

Name

Address

City *State* *Zip*

Phone: _____

12. ALTERNATE AGENT FOR YOUR POWER OF ATTORNEY

Name

Address

City *State* *Zip*

Phone: _____

13. AGENT FOR YOUR SPOUSE'S POWER OF ATTORNEY

Name

Address

City *State* *Zip*

Phone: _____

14. ALTERNATE AGENT FOR YOUR SPOUSE 'S POWER OF ATTORNEY

Name

Address

City *State* *Zip*

Phone: _____

15. AGENT FOR YOUR POWER OF ATTORNEY FOR HEALTH CARE

This person will legally have the right, authority, and duty of making life-support decisions in the event of your inability to make decisions concerning your personal health (for reasons such as severe injury, unconsciousness, mental incapacity, etc.). This is usually the same as the back-up trustee and/or agent for Power of Attorney.

Name

16. ALTERNATE AGENT FOR YOUR POWER OF ATTORNEY FOR HEALTH CARE

Name

Address

City *State* *Zip*

Phone: _____

17. AGENT FOR YOUR SPOUSE 'S POWER OF ATTORNEY FOR HEALTH CARE

Name

18. ALTERNATE AGENT FOR YOUR SPOUSE 'S POWER OF ATTORNEY FOR HEALTH CARE

Name

Address

City *State* *Zip*

Phone: _____

19. AGE OF FINAL DISTRIBUTION TO THE BENEFICIARIES

At what age do you want the beneficiaries of your *Living Trust* to receive their share. If none listed, the age of 18 will be used.

Age(s)

21. YOUR OPTIONS IN THE EVENT OF A DECEASED BENEFICIARY

If one of your beneficiaries dies before you, to whom do you wish this share to be distributed?

~ OPTION 1

If you wish such share to go to the beneficiary's children only (your grandchildren, if beneficiary is your child), use this option.

~ OPTION 2

If you wish such share to go to the beneficiary's children and/or spouse, use this option.

~ OPTION 3

If you wish such share to be divided proportionately among the other named beneficiaries use this option.

~ OPTION 4

If neither of the above three options is suitable for your situation, you may indicate an alternate recipient of the share of a deceased beneficiary, such as a third party or a charitable organization. Just write in the name of the organization or individual in the space provided below.

FULL LEGAL NAME	PERCENTAGE
_____	_____
_____	_____
_____	_____
_____	_____

22. LIST YOUR CHILDREN

FULL LEGAL NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____

