SANFORD | PIERSON
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Estate Planning and Information Form

WHEN YOU HAVE COMPLETED THIS FORM, please return it to our office or bring it along to your office conference. We rely upon the information you provide us to be accurate and complete in all respects. If the information is not accurate and complete, the recommendations we make may not be appropriate for your situation.

1. Client.

Name _____ Date of Birth: _____

Email Address _____ U.S. Citizen? Yes ☐ No ☐

Cell Phone _____

Street Address _____ Apt _____ County _____

City _____ State _____ Zip _____

2. Beneficiary Designations.

A. Life Insurance/IRA/Bank Account:

Policy Name/Number	Face Value	Owner	Insured	Beneficiary

B. Do you have a retirement plan? Yes ☐ No ☐. If so, what is it called?

C. Does your retirement plan(s) have a death benefit? Yes ☐ No ☐. If so, who is the named beneficiary?

3. Power of Attorney. Are you interested in preparing a Power of Attorney granting another person (your "Attorney-in-Fact") the power to act on your behalf to manage your assets, pay your bills if you are unable to sign your name?

Attorney-in-Fact:

Name: _____

Address: _____

Successor Attorney-in-Fact or Co-Attorney-in-Fact:

Name: _____

Address: _____

Second Successor or Co-Attorney-in-Fact:

Name: _____

Address: _____

☐ Please check the box if you would you prefer that your Attorneys-In-Fact can only act on your behalf upon your incapacity or death?

Would you like your Attorneys-In-Fact to be able to act:

☐ Independently (action of one Attorney-In-Fact binds the other, with or without the other's consent)

☐ Jointly (actions of each Attorney-In-Fact must be made with consent of the other)

Which Attorneys-In-Fact should initially be named Co-Attorneys-in-Fact? _____

4. **Health Care Directive.** Your Agent will make health care decisions for you if you cannot make them yourself.

Health Care Agent:

Name: _____

Address: _____

Telephone Number: _____

Successor or Co-Agent:

Name: _____

Address: _____

Telephone Number: _____

Second Successor or Co-Agent:

Name: _____

Address: _____

Telephone Number: _____

B. Do you want to donate any organs upon your death? Client Yes ☐ No ☐

Have you agreed in another document, e.g., driver's license, to make the donation? Client Yes ☐ No ☐

C. Please indicate how you want the disposition of your remains after you die, e.g., cremation, regular burial, etc.

Client _____

D. ☐ Please check the box if you wish for your Health Care Agents to be Co-Health Care Agents. Co-Health Care Agents must act jointly in all decisions.

If so, which Health Care Agents should be named Co-Health Care Agents? _____

E. HIPPA Authorization: Do you want to give your health care agent(s) access to your medical information and records while you have decision making capacity. Client Yes ☐ No ☐

F. Digital Authorization: Do you want to authorize your fiduciaries, including your attorney-in-fact to access your electronically stored information while you are alive and capable of making decisions? Client Yes ☐ No ☐ Or upon incapacity or death? Client Yes ☐ No ☐