INFORMATION FOR ESTATE PLANNING DOCUMENTS

YOUR FULL LEGAL NAME: ____

MAIDEN NAME/PRIOR NAME/ALIASES: ______________________________________

For any individual named in the form, please include their **legal name and full current mailing address**. Also include at least one **phone number for Health Care Proxy Agents**, and **date of birth for anyone under the age of 18**. Please add additional lines or sheets as needed.

Will

1. **Primary Beneficiaries** (Who will receive your property and in what percentages. You may include individuals or schools, charities, etc.)

(a) _______% to ____

(b) _______% to ____

(c) _______% to ____

(d) _______% to ____

2. **Contingent Beneficiaries** (In the unlikely event your beneficiaries named in Paragraph 1 predecease you, where you want your property distributed and in what percentages. You may include individuals or schools, charities, etc. These may be Trust beneficiaries if you have a Trust.)

(a) _______% to ____

(b) _______% to ____

(c) _______% to ____

(d) _______% to ____

3. **Secondary Contingent Beneficiaries** (If all of your named beneficiaries in Paragraphs 1 and 2 are immediate family members and/or lineal descendants, or in the unlikely event all of the beneficiaries named in Paragraphs 1 and 2 predecease you, secondary contingent beneficiaries may be recommended. You may include individuals or schools, charities, etc.)

(a) _______% to ____

(b) _______% to ____

(c) _______% to ____

4. **Personal Representatives** (Formerly "Executors," in charge of administering the estate. I recommend naming at least 3 if possible, one primary and two alternates. Spouses usually name each other as their primary nominee.)

Personal Representative name and address:

(a) ____

(b) ____

(c) ____

5. **Guardians** (Nominating individuals who would be responsible for the care of any children in need of a guardian. Please indicate, for any Co-Guardians named, if you would want one to act as sole Guardian in the event one Co-Guardian dies before or after appointment, or if they divorce, or if you have any relocation conditions or preferences. If there will be no Trust, please indicate if you want the Guardian to also act as Conservator; this will be the default.)

Guardian names, addresses, & any special provisions:

(a) ____

____

____

(b) ____

____

____

(c) ____

____

____

(d) ____

____

____

6. **Conservator** (Who will be responsible for the child's assets in the event any Trust is not in effect, only if it will be someone other than the Guardian. If the same as the nominated Trustees, write "Same as Trustees.")

Conservator name and address:

(a) ____

(b) ____

(c) ____

7. **Disposition of remains** (Choosing burial vs. cremation, location or other directives, eco-friendly options, military ceremonies if applicable, or nominating someone in charge of making these decisions.)

____

____

8. **Personal Property** (e.g. family heirlooms---You may include these items in your Will but I would instead recommend you create a separate list that is enforceable and kept with your Will and can be updated over time without having to re-execute your Will.)

____

____

<u>Power of Attorney</u>

9. **Power of Attorney Agents** (Who will have the authority to make financial decisions on your behalf in the event you are alive but incapacitated or otherwise unavailable. Spouses usually name each other as the primary agent.)

Agent Name and Address:

(a) ____

(b) ____

(c) ____

Health Care Proxy

10. **Health Care Agents** (Who will have the authority to make medical decisions on your behalf in the event you are alive but incapacitated or otherwise unable to provide informed consent. You may fill in the attached form or list your agents here. Please provide at least one telephone number for each agent. I recommend you have at least one contingent agent, or more if possible. Spouses usually name each other as the primary agent.)

A. Agent Name, Full Mailing Address, and Phone Number:

(a) ____

(b) ____

(c) ____

11. Guidance for Goals of Care: (Check one or write your own below)

_____ (a) I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of the treatment outweigh the expected benefits, I want my agent to consider the relief of suffering and the quality as well as the extent or the possible extension of my life in making decisions concerning life-sustaining treatment. I specifically consent to pain-relieving medication or treatment, even if such medication or treatment shall shorten my life, and in the event I am unable to mechanically feed myself, I direct that no intubation or feeding assistance be administered.

_____ (b) I want my life to be prolonged and I want life-sustaining treatment to be provided unless I am in a coma or vegetative state which two independent physicians reasonably believe to be irreversible. Once two physicians have reasonably concluded that I will remain unconscious for the remainder of my life, I do not want life-sustaining treatment to be provided or continued.

_____ (c) I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

_____ (d) I want ____

____

____

____

12. Special Authorities: (Check DO or DO NOT for each special authority)

(a) Inpatient Medical Services
I specifically [**DO** ______ OR **DO NOT** ______] authorize my Agent to apply for and obtain any inpatient medical services on my behalf, including, but not limited to, rehabilitation, assisted living, nursing care, specialized care, or hospice care services, as may be deemed appropriate to my diagnosis, condition and prognosis.

(b) Outpatient or At-Home Medical Services
I specifically [**DO** ______ OR **DO NOT** ______] authorize my Agent to apply for or obtain any outpatient or at-home medical services on my behalf, including, but not limited to, rehabilitation, assisted living, nursing care, specialized care, or hospice care services, regardless of my diagnosis, condition and prognosis.

(c) Do Not Rescussitate/Do Not Intubate
I specifically [**DO** ______ OR **DO NOT** ______] authorize my Agent to implement a Do Not Rescussitate and/or a Do Not Intubate order on my behalf.

(d) Administration of Antipsychotic Medications
I specifically [**DO** ______] authorize my Agent to provide consent or to contest the administration of any anti-psychotic medications as may be sought through a Rogers guardianship petition based on my diagnosis, condition and prognosis.

OR

I specifically [**DO NOT** ______] authorize my Agent to provide consent or to contest the administration of any anti-psychotic medications as may be sought through a Rogers guardianship petition based on my diagnosis, condition and prognosis, and instead prefer the Probate and Family Court to appoint an attorney to represent my interests in any Rogers guardianship action which may be filed for such purpose naming me as the subject incapacitated individual.

13. Guardian: In the event a situation arises where a guardian will be appointed for you, please nominate the Guardian ONLY IF IT IS SOMEONE DIFFERENT THAN YOUR HEALTH CARE AGENT.

Guardian name and address:

(a) ____

(b) ____

(c) ____

14. **Contribution of Anatomical Gift** (Check one and complete any selections)

_____ (a) Pursuant to the Uniform Anatomical Gift Act, I hereby give, upon my death, **[Choose one]**

______ Any needed organs or parts **OR**

______ Only these specific organs or parts: ______________________________________

AND [Choose one] Donated organs may be used:

______ for any legally authorized purpose **OR**

______ for transplant or therapeutic purposes only and not for research

_____ (b) I have already signed a written agreement regarding anatomical gifts with the following individual or institution:
____.

_____ (c) I do not want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to make such a gift of my remains.

15. **Autopsy** (Check one)

_____ (a) I hereby consent to an examination of my body after my death, to the extent necessary to determine the cause of my death.

_____ (b) My agent may not authorize an autopsy. I do not want an autopsy unless absolutely required by law.

16. **Disposition of Remains** (Check all that apply and complete any selections)

_____ (a) I direct that my remains be [_____ cremated OR _____ buried OR _____ disposed of with an eco-friendly option]

OR

_____ My agent may not direct the disposition of my remains and I would prefer that the disposition of my remains be determined by: (name and full mailing address)

____

_____ (b) I have a contract for funeral services with ___________________________________.

_____ (c) I own a cemetery plot or mausoleum space at __________________________________ and the contract identification number or plot number is _________________________.