





**Alan G.  
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# Wills & Estate Planning Questionnaire

## Other Beneficiaries

| Full Legal Name | Child of: | Birth date | City/State |
|-----------------|-----------|------------|------------|
|                 |           |            |            |
|                 |           |            |            |
|                 |           |            |            |
|                 |           |            |            |

## Your Executor

Who do you want to handle your estate/financial affairs at your death? Please list in order of priority.

**Primary:**

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**Alternate(s):**

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## Your Trustee (If Applicable)

Are you creating a Trust for a minor child or other beneficiary? If so, who would you want to be Trustee for any Trusts created under your Will? Please name in order of priority.

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## Disabilities & Beneficiaries

**Disabilities** - Does anyone in your family, or any of your beneficiaries, have any special needs due to physical or mental disability? If so, please list them below.

| Full legal name | Relationship |  |
|-----------------|--------------|--|
|                 |              |  |
|                 |              |  |
|                 |              |  |
|                 |              |  |

**Beneficiaries** - Please briefly describe how you would like your property to be distributed after your death. We will go into more detail at your first consultation.

|  |
|--|
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|  |
|  |
|  |

## Guardian for Minor Children

If you have minor children (under 18 years of age) and are unable to take care of them, or you are deceased, who would you want to be legal guardian of your children?

| Desired Guardian  |                   |
|-------------------|-------------------|
| Name: _____       | Address: _____    |
| Home Phone: _____ | Cell Phone: _____ |

## Durable Power of Attorney

Who do you want to handle your financial and personal affairs if you become incapacitated? Please provide at least two persons with their full legal names.

1. Full legal name: \_\_\_\_\_

2. Full legal name: \_\_\_\_\_



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## Health Care Power of Attorney

If you are incapacitated and unable to make health care decisions for yourself, who do you want to make health care decisions for you? Please provide at least two full legal names, home addresses, and contact information in the order which you want them to serve.

### Person 1

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

### Person 2

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

## Miscellaneous

Do you presently have a will? NO YES Year: \_\_\_\_\_

Do you presently have a trust? NO YES Year: \_\_\_\_\_

Is your trust revocable or non-revocable? \_\_\_\_\_