

**NETHERY & OFSEYER LLP**  
**74000 COUNTRY CLUB DRIVE, SUITE H-1**  
**PALM DESERT, CALIFORNIA 92260**  
**PHONE: (760) 346-3355 FAX: (760) 346-7057**  
**www.nollp.com**

**CLIENT INFORMATION [Strictly Confidential]**

Legal Name: \_\_\_\_\_

Other Names used: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Telephone Numbers: (work) \_\_\_\_\_ (cell) \_\_\_\_\_

(home) \_\_\_\_\_ (fax) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Marital Status:  Never married  Divorced  Widowed  Married

If married, name of Spouse: \_\_\_\_\_

US citizen?  Yes  No. If no, what nationality: \_\_\_\_\_

Currently Employed?  Yes  No. If no, Retired?  Yes  No. Other: \_\_\_\_\_

Business/Employer: \_\_\_\_\_

Type of Business: \_\_\_\_\_ Owner:  Yes  No. Number of Employees: \_\_\_\_\_

Please List Business Partners: \_\_\_\_\_

CHILDREN:	<input type="checkbox"/> None	AGE or DOB
_____		_____
_____		_____
_____		_____
_____		_____

• Number of grandchildren: \_\_\_\_\_ Range of Ages: \_\_\_\_\_

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| • Any deceased children?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, name: _____  |                          |                          |
| If yes, survived by issue?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, name(s): _____   |                          |                          |
| _____  |                          |                          |
| _____  |                          |                          |
| • Is there any reason that you need your Estate Plan created or changed quickly? If yes, please explain:       | <input type="checkbox"/> | <input type="checkbox"/> |
| _____  |                          |                          |
| _____  |                          |                          |
| • Do any of your beneficiaries have a learning disability, special educational, medical or physical needs?     | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have any relatives (other than children) who depend on you for all or part of their support?          | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you think any of your beneficiaries have special problems with spouses, drugs, alcohol or handling money? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to disinherit any of your children, grandchildren or any other close relative?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| • If a named beneficiary dies before you, do you want the assets to go to that beneficiary's issue?            | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you want assets passing to your beneficiaries to be held in trust until a specific age or ages?           | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you expect to inherit substantial assets (\$100,000 +)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have an existing Will?  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever executed a trust (either revocable or irrevocable)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever filed a Federal Gift Tax Return?   | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have an existing General Power of Attorney?   | <input type="checkbox"/> | <input type="checkbox"/> |

YES                      NO

- Do you currently hold any assets in Joint Tenancy with another person?
  
- Do you wish to make anatomical bequests (organ donor)?
  
- Do you wish to have a “Living Will”?

- The name / address / telephone number of the person(s) that you want to be the decision maker(s) concerning your estate upon your death:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- The name / address / telephone number of the person(s) that you want to raise a child that is under 18 (if applicable):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- The name / address / telephone number of the person(s) that you want to make any major medical decisions on your behalf (if different from above):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- In general, state how you want your estate distributed among your beneficiaries?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# END-OF-LIFE DECISIONS

Initial the statement which best states your desires:

## I. Default “Living Will” Provision

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, I do not want efforts made to prolong my life 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 use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. I understand that if there is a conflict between my agent’s decision and this statement, this statement shall take precedence.

For purposes of this statement:

- (A) “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.
- (B) “An irreversible coma”, means a coma from which the treating physicians have reasonably concluded I will never regain consciousness.
- (C) “Persistent vegetative state” means a state of permanent unconsciousness that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, is characterized by both of the following:
  - (i) I am irreversibly unaware of myself and my environment, and
  - (ii) There is a total loss of cerebral cortical functioning, resulting in my having no capacity to experience pain or suffering.
- (D) “Terminal condition” means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, both of the following apply:
  - (i) There can be no recovery; and
  - (ii) Death is likely to occur within a relatively short time if life sustaining treatment is not administered.

## **II. Similar to “I” But Agent Makes Final Decision**

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, if in my agent’s judgment the burdens of the proposed treatment outweigh the expected benefits, then I do not want any form of life-sustaining procedures or, if life-sustaining treatment has been instituted, I ask that it be withdrawn. I desire that my agent consider relief from suffering, preservation or restoration of functioning, and the quality as well as the extent of the life being preserved when decisions are made concerning life-sustaining care, treatment, services, and procedures. I trust my agent, who knows my desires well, and in whose judgment I have absolute faith to exercise discretionary decisions in a manner that would be satisfactory to me. “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

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## **III. End Treatment Only Absent Cognitive Function**

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, if the extension of my life would result in a mere biological existence, devoid of cognitive function, with no reasonable hope for normal functioning, then I do not desire any form of life-sustaining procedures or, if life-sustaining treatment has been instituted, I desire that it be withdrawn. It is my desire that my agent consider relief from suffering, preservation or restoration of functioning, and the quality as well as extent of the life being preserved when decisions are made concerning life-sustaining care, treatment, services, and procedures. In making the decision to withhold or remove treatment, my agent should ask the question: “Is the proposed treatment an aid to recovery or merely a prolongation of inevitable death?” What is “reasonable,” what is “an aid to recovery,” and what is “merely a prolongation of inevitable death” shall be determined by my agent after consulting with my attending physicians. “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

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#### **IV. Prolong Life**

I express the desire that my life be prolonged to the greatest possible extent without regard for my physical or mental condition, chance of recovery, likelihood of suffering, or expense and authorize my agent to consent to whatever medical procedures are necessary to accomplish this end. I trust my agent, who knows my desires well, and in whose judgment I have absolute faith to exercise discretionary decisions in a manner that would be satisfactory to me.

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# ESTIMATED\* VALUE OF ESTATE

<u>TYPE OF ASSET:</u>	<u>ESTIMATED VALUE</u>
• REAL ESTATE: (fair market value, <u>less</u> loans)	\$ _____
• SECURITIES: (stocks, bonds, mutual funds)	\$ _____
• CASH TYPE ASSETS: (cash, annuities, notes due you)	\$ _____
• BUSINESS INTERESTS: (sole proprietorship, partnerships, closely held corporation, etc.)	\$ _____
• RETIREMENT PLANS: (IRA, 401k, etc.**)	\$ _____
• VEHICLES: (autos, R.V., boat)	\$ _____
• PERSONAL PROPERTY: (jewelry, furniture, antiques)	\$ _____
<b>TOTAL:</b>	\$ _____

\* Use best guess; this can be a “ballpark” estimate.

\*\* Do not show benefits which will terminate at death (e.g., pension, social security, etc.).

Value of Life Insurance policies will be listed separately on the next page.

# LIFE INSURANCE

(do not include accidental death policies)

- “Cash Value” use best estimate (term policies normally have no cash value)
- “Face Value” is the amount payable at death

<u>COMPANY</u>	<u>CASH VALUE</u>	<u>FACE VALUE</u>	<u>BENEFICIARY</u>
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____