

# **TESTATOR/TRIX INFORMATION FOR WILL PREPARATION**

## **TESTATOR/TRIX INFORMATION**

**1000** - Comp Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ D.O.B: \_\_\_\_\_ E-mail address: \_\_\_\_\_

## **INDEPENDENT EXECUTOR/TRIX INFORMATION**

**4000** - Complete Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship: \_\_\_\_\_ E-mail address: \_\_\_\_\_

## **ALTERNATE INDEPENDENT EXECUTOR/TRIX INFORMATION**

**4001** - Complete Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship: \_\_\_\_\_ E-mail address: \_\_\_\_\_

## **WHO IS GOING TO INHERIT YOUR ESTATE?** **(Beneficiaries)**

Please explain to whom and how you wish your estate to be divided:

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**STATUTORY DURABLE POWER OF ATTORNEY (POA) DOCUMENT**  
**INFORMATION**

**Document whereby you are appointing an individual/agent to handle all financial/legal affairs on your behalf if you become incapacitated.**

**Who do you want to appoint as your agent to handle all financial/legal affairs on your behalf if you become incapacitated?**

**9000** - Complete Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Who do you want to appoint as your alternative agent to handle all financial/legal affairs on your behalf if you become incapacitated?**

**9001** - Complete Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship: \_\_\_\_\_

**DURABLE POWER OF ATTORNEY (POA) FOR HEALTH CARE INFORMATION**

**The Durable Power of Attorney for Healthcare is a legal document that allows an individual (you) to appoint another person (agent) to make medical decisions on your behalf if you become unable to do so.**

**Who do you want to appoint as your agent to make any and all health care decisions for you, should you become incapacitated?**

\_\_\_\_\_ **Check this box if using the same agent and alternates appointed for Statutory Durable POA.**

**10000** - Complete Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Who do you want to appoint as your alternative agent to make any and all health care decisions for you, should you become incapacitated?**

**10001** - Complete Legal Name: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship: \_\_\_\_\_