WILL INFORMATION WORKSHEET

Please complete the attached form and return it to Jeffrey P. Ferrier by mail, email or fax (732) 946-8599.

NAME _____ SPOUSE's NAME_____

ADDRESS_____

TELEPHONE _____ Email address: _____

CHILDREN's Names and Date of Birth: (If none, please indicate. If you have step children please advise as there are other considerations we will need to discuss).

Child 1_____ DOB:

Child 2 _____ DOB:

Child 3_____ DOB:

Child 4_____ DOB:

Please list the people that will receive the assets of your estate and in what percentages. If you are married with children, this is often your spouse if they are alive, and then to your children equally. However, the people and percentages can be anyone and in any percentages you wish (10% to my niece, 5% to my friend Mary etc.).

1_____

2_____

3_____

4_____

5_____

List below any specific bequests/gifts that you would like to make (for example: 5% of my estate to Aunt Mary; or my prized stamp collection to my nephew Joey, or 10% to The American Red Cross etc.)

1 _____

2 _____

3 _____

4 _____

EXECUTOR (name and address). This is the person that will administer your estate. For married couples this is typically your spouse or your adult child/ren.

_____

_____

ALTERNATE EXECUTOR (this is the person that will act as Executor if the person you have identified as your initial Executor is deceased or otherwise unable to act). _____

_____

GUARDIAN. This usually only applies if you have children under the age of 18 or a child that is need of special care. This is the person(s) that will physically care for the children if you and your spouse (or the children's other parent) are both deceased. Include name and address._____

_____

ALTERNATE GUARDIAN _____

TRUSTEE. If you have minor children you will need to appoint a trustee to manage the children's money if something happens to you and your spouse. Please provide name and address of the trustee_____

_____

ALTERNATE TRUSTEE_____

If you have minor children, what age do you want the trust to terminate and your children to receive their money (this is normally between 21-25 but some people prefer that the trust be distributed in parts (e.g. 1/3 at age 25; 1/3 at age 30 and the balance at age 35)? _____

IF YOR ASSETS EXCEED $1,000,000 COMPLETE THE FOLLOWING:

1. Please provide an approximate value of your assets (this list should include real estate, cash, stocks, investment accounts, unusually expensive automobiles, valuable collectibles, IRA's, 401(k)). You do not need to provide too much detail; for example, the following is sufficient: ($1,000,000 in life term insurance on Mr. Smith; a jointly owned house worth $500,000 with a $250,000 mortgage owed; stocks and mutual funds worth $25,000; cash of $10,000; car, boat, jewels and other personal items worth $15,000; $135,000 in IRA or 401(k) assets left to my spouse). THIS IS USED TO DETERMINE IF YOU MIGHT BENEFIT FROM MORE EXTENSIVE ESTATE PLANNING.

LIVING WILL WORKSHEET

A medical or health care directive is used to advise medical persons what decisions you have made regarding medical care if you are not able to make your own health care decisions. In this document you are appointing someone to make medical decisions on your behalf and you are also advising your decision maker and medical professionals what your wishes are in the event you become incapacitated and unable to make medical decisions on your own.

HEALTHCARE DIRECTIVE OPTIONS

I. Options regarding life-sustaining treatment: Below are three common options that most people choose for their medical directive. You are not limited to these 3 choices and can state whatever you desire in option D.

A. I do NOT want my life to be prolonged, and I do NOT want any life-sustaining treatment to be provided or continued, IF in the opinion of my health care decision maker the burdens of the treatment outweigh the expected benefits. I want my Representative to consider the relief of suffering and the quality as well as the length of the possible extension of my life in making decisions concerning life-sustaining treatment. IF my health care decision maker determines that the benefits of treatment outweigh the burdens then I wish to continue to live.

B. I want my life to be prolonged and I want life-sustaining treatment to be provided **unless I am in a persistent vegetative condition** which my doctors reasonably believe to be irreversible. Once my doctors have reasonably concluded that I am in such a condition, 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. Other: If you have any specific instructions that you prefer please write them out and we will incorporate them into the document._____
_____
_____

II. Options regarding food and fluids:

CHOOSE ONE

A: I direct that fluids and or feeding tubes be provided until I die.

B. I direct that fluids, food and feeding tubes be withheld and withdrawn in accordance with my choice in option I above.

C. I direct that, fluids and or feeding tubes/food be continued unless I am in a persistent vegetative condition at which point I direct that they be withheld and or withdrawn and I be allowed to die.

Options regarding Organ Donation:

CHOOSE ONE

A. Pursuant to the Uniform Anatomical Gift Act, effective upon my death I wish to donate any needed organs or parts of my body that may be of further use.

B. Pursuant to the Uniform Anatomical Gift Act, effective upon my death I wish to donate only the following organs or parts of my body (list specifics):

C I do **not** wish to make any gift under the Uniform Anatomical Gift Act, nor do I wish my family of my Representative to do so.

V. AUTOPSY AND DISPOSITION OF MY REMAINS

CHOOSE ONE

A. I understand that my Representative will be able to authorize an examination of my body after my death to' determine the cause of my death, and to direct the disposition of my remains unless I limit that authority in this document. I also understand that my Representative or any other person who directs the disposition of my remains must follow any instructions I have given in a written contract for funeral services or by some other method.

B. I consent to an examination of my body after my death to determine the cause of death.

C. My Representative shall **not** authorize an autopsy.

D. My Representative **may not** direct the disposition of my remains. I prefer that _____ whose mailing address and telephone number are _____ direct the disposition of my remains.

E. DESIGNATION OF HEALTH CARE REPRESENTATIVES

Please indicate the home, address and phone number of the person that you want to act as your health care representative. This .is the person that will carry out the wishes you have expressed in your document. This will typically be your spouse, parent, adult, or child but can be any adult that you select. You can identify more than one or two person if that is your preference.

Name:

Address:

Phone #:

Please indicate an alternative person or persons that will act as your health care representative if for some reason the first person cannot act.

Name:
Address:
Phone #

Others

POWER OF ATTORNEY:

A Power of Attorney document authorizes and allows another person to act in your place in case you are unable to do so due to incapacity, illness, travel or other reason. This is particularly important in elderly persons or people who travel often.

Most people appoint their spouse or close family member (parent, grown child, brother, sister) as their POA; however you can appoint anyone that you trust.

If you wish to appoint someone as your Power of Attorney please indicate that persons name, address and phone number below.

If you wish to limit the powers of the POA in any respect please specify what specifically the person you have appointed is NOT authorized to do. For example, the POA is NOT authorized to sell any real estate that I own.

Name of person I wish to appoint as my POA:_____

Address of POA:_____

Phone number of POA_____