

EZ LIVING TRUST

Paper Questionnaire

How to complete this form

- Please print clearly in blue or black ink.
- Mark your choices with an **X** in the box ☐.
- If a question does not apply to you, or you are not sure, leave it blank — our staff will review your answers with you.
- When complete, email to **help@strategicchoices.com** or fax to **888-940-4015**.

Date completed: _____ Advisor / referred by (if any): _____

SECTION 1 INFORMATION TO CREATE THE TRUST

A. Type of Trust

☐ New Living Trust ☐ Replacing (restating) an existing Living Trust

If replacing — name of existing trust: _____ Date signed: _____

B. Name of Your Trust

Usually your last name(s). Example: "The Smith Family Living Trust" or "The Garcia-Lee Living Trust".

The _____ Living Trust

C. Marital Status

☐ Married
☐ Legally married ☐ Registered domestic partner

☐ Single
☐ Never married ☐ Divorced ☐ Widowed

If divorced:

Ex-spouse full name: _____ Date of divorce: _____

If widowed:

Deceased spouse full name: _____ Date of death: _____

SECTION 2 TRUST OWNERS (TRUSTEES)*The people creating the trust. If married, list both spouses / partners.***OWNER 1 (Primary Trustee)**

Full legal name: _____

Other names used (a.k.a.): _____

Date of birth: _____ Gender: _____

Street address: _____

City / State / ZIP: _____

County: _____

Cell phone: _____

Email: _____

OWNER 2 (Spouse / Partner, if any)

Full legal name: _____

Other names used (a.k.a.): _____

Date of birth: _____ Gender: _____

☐ Same address as Owner 1

Street address: _____

City / State / ZIP: _____

County: _____

Cell phone: _____

Email: _____

SECTION 3 CHILDREN / BENEFICIARIES*List all children, living or deceased. Use the box after #6 if you have more.***1. Full legal name:** _____ **Date of birth:** _____**Relationship:** ☐ Son ☐ Daughter ☐ Adopted child ☐ Child **Living:** ☐ Yes ☐ No**Address:** _____**Phone:** _____ **Email:** _____**2. Full legal name:** _____ **Date of birth:** _____**Relationship:** ☐ Son ☐ Daughter ☐ Adopted child ☐ Child **Living:** ☐ Yes ☐ No**Address:** _____**Phone:** _____ **Email:** _____

3. Full legal name: _____ Date of birth: _____

Relationship: ☐ Son ☐ Daughter ☐ Adopted child ☐ Child Living: ☐ Yes ☐ No

Address: _____

Phone: _____ Email: _____

4. Full legal name: _____ Date of birth: _____

Relationship: ☐ Son ☐ Daughter ☐ Adopted child ☐ Child Living: ☐ Yes ☐ No

Address: _____

Phone: _____ Email: _____

5. Full legal name: _____ Date of birth: _____

Relationship: ☐ Son ☐ Daughter ☐ Adopted child ☐ Child Living: ☐ Yes ☐ No

Address: _____

Phone: _____ Email: _____

6. Full legal name: _____ Date of birth: _____

Relationship: ☐ Son ☐ Daughter ☐ Adopted child ☐ Child Living: ☐ Yes ☐ No

Address: _____

Phone: _____ Email: _____

Additional children (#7 and up)

Name • Relationship (Son / Daughter / Adopted child / Child) • Date of birth • Living? • Phone / Email

SECTION 4 SUCCESSOR TRUSTEES*The person who will take over managing your trust if you pass away or become incapacitated.*

PRIMARY SUCCESSOR TRUSTEE	ALTERNATE (BACK-UP) SUCCESSOR
Full legal name: _____	Full legal name: _____
Relationship to you: _____	Relationship to you: _____
Date of birth: _____	Date of birth: _____
Address: _____	Address: _____
City / State / ZIP: _____	City / State / ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Use these same two people for your other documents?Financial Power of Attorney — same people as your agents? ☐ Yes ☐ NoHealth Care Agent (medical decisions) — same people as your agents? ☐ Yes ☐ NoIf you have any minor children (under 18) — same people as Guardians? ☐ Yes ☐ No**If you answered “No” to any question above, please enter your custom designations here:***Document (Power of Attorney / Health Agent / Guardian) • Name • Relationship • Phone • Primary or Back-up*

SECTION 5 FINANCIAL POWER OF ATTORNEY*Your agents are named in Section 4. Choose when their authority begins.***OWNER 1****When does the authority begin?**

- ☐ Immediately
- ☐ Only if I become incapacitated
(as declared by a medical professional)

OWNER 2 (if any)**When does the authority begin?**

- ☐ Immediately
- ☐ Only if I become incapacitated
(as declared by a medical professional)

SECTION 6 MEDICAL INSTRUCTIONS**OWNER 1****If in an irreversible vegetative state:**

- ☐ Allow natural death
- ☐ Prolong life

Organ donation:

- ☐ Yes ☐ No

Autopsy:

- ☐ Yes ☐ Only if required by law

Final arrangements:

- ☐ Burial ☐ Cremation ☐ Not sure

Memorial / special wishes: _____

OWNER 2 (if any)**If in an irreversible vegetative state:**

- ☐ Allow natural death
- ☐ Prolong life

Organ donation:

- ☐ Yes ☐ No

Autopsy:

- ☐ Yes ☐ Only if required by law

Final arrangements:

- ☐ Burial ☐ Cremation ☐ Not sure

Memorial / special wishes: _____

SECTION 7 YOUR LIVING TRUST WISHES

Our Living Trust staff will contact you to help you further here — but sharing your initial wishes now helps.

A. Community Property (if a couple)

- ☐ Treat all property as Community Property
- ☐ Some property is separate (describe below)

Separate property

B. Dividing Your Home & Properties

How would you like your properties gifted after death?

Example: "Divide equally among our children" or "Home to our daughter Maria; rental property sold and split between our sons."

C. Retirement & Insurance Plans

Briefly describe your 401(k), IRA, life insurance and savings plans. Share today's value, the company, and who the beneficiaries are.

Type of plan	Company / institution	Today's value	Beneficiaries
401(k)			
IRA			
Life insurance			
Savings			

D. Final Words to Share with Family

Optional — a personal message, values or wishes you would like your family to know.

SECTION 8 REAL ESTATE TO PLACE IN THE TRUST

Enter the properties you own and want to protect from probate.

Primary residence (included)

Address: _____

City / State / ZIP: _____ County: _____

Investment / additional properties (\$100 extra each)

1) Address: _____

City / State / ZIP: _____ County: _____

2) Address: _____

City / State / ZIP: _____ County: _____

3) Address: _____

City / State / ZIP: _____ County: _____

Other properties

Address • City / State / ZIP • County

SECTION 9 WITNESSES*Two adults who are NOT related to you and are NOT named in your trust.*

WITNESS #1	WITNESS #2
Full name: _____	Full name: _____
Address: _____	Address: _____
City / State / ZIP: _____	City / State / ZIP: _____
Phone: _____	Phone: _____

SECTION 10 NOTARY PUBLIC & SHIPPING*Notary is paid separately.***Notary**

- ☐ I have my own Notary
- ☐ I want to notarize at the South Pasadena office
- ☐ Please recommend a Mobile Notary

Shipping — how should we deliver your completed trust?

- ☐ Ship to me ☐ I will pick up ☐ Ship to my advisor

Ship-to name (if different): _____**Ship-to address:** _____**City / State / ZIP:** _____**Thank you! When complete, please send this questionnaire to us:**Email: **help@strategicchoices.com** or Fax: **888-940-4015**