Western Mass Estate Planning

Kate Downes, Esq. **Deirdre Gleason, Esq.**
Of Counsel

NOMINATIONS FORM

Will, Durable Power of Attorney, and Health Care Documents

How my complete, legal name should appear in the documents (how I will be signing my name, as well as any "aka"):

_____

The information below will be used to prepare your estate planning documents. If, after you have returned this document to our office, you wish to make changes to any of the names or order of names, or any of the named individuals change addresses or telephone numbers, you must notify us no later than five (5) days prior to the date of the scheduled signing. It is extremely difficult to make changes at the signing. We will be sending you a summary of the documents in advance, reflecting the information below, which will give you another chance to review your decisions and make changes.

1. WILL: This is the document which will direct distribution of your assets. Please list, in order, the individuals you would like to settle your estate. *After your death, your assets will go through the probate process and be distributed according to the terms of your Will. Your Personal Representative will be responsible for identifying assets requiring probate, liquidating them, if appropriate, and distributing them to your designated beneficiaries.*

- **Personal Representatives (*Please name at least 4 individuals to serve)*:**

	1.	2.
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____

	3.	4.
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____

2. DISTRIBUTION: How would you would like your assets distributed after your death? *For example, if you have children, would you want your estate distributed equally among them? If you do not have children, who would you want to inherit your estate? Other family members or charities? What happens to a share of a deceased beneficiary – does it pass to the deceased beneficiary's children, otherwise to your surviving children/beneficiaries? If not, to whom?* You may use percentages or a dollar amount (which we will convert to a capped percentage). **For each**

beneficiary listed, please provide their complete name, their relationship to you, and the town and state where they live:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(You may attach a separate piece of paper if you need more space)

Sub-Trust for Younger Beneficiaries.

2(a) Age. If there is a chance that a grandchild or other beneficiary might inherit before or during early adulthood, either because you have named them as a primary beneficiary of your estate or because they would inherit if another beneficiary predeceased you (for example, if a beneficiary predeceased you, and that person's children are entitled to their share), We recommend that the beneficiary be given control over those funds only after they reach a certain age (which you must designate). We further recommend that this age be no younger than age 25 (but older may be appropriate), so that the beneficiary will be of sufficient maturity to handle the funds when they receive them outright, and the funds are protected from creditors and financial aid considerations. Whatever age you select, the Trustee may make distributions to the beneficiary prior to that age, but in the Trustee's discretion (in other words, the beneficiary may not demand funds).

At what age would you want beneficiaries to be eligible to inherit? _____

2(b) Trustees of Sub-Trust. The Trustee of this sub-trust will be responsible for holding the funds and disbursing them as appropriate, keeping in mind the child's maturity level and need for funds for college or living expenses. Note that**,** in general, it is not advisable to name a beneficiary's surviving parent, since some distributions they make could be viewed by the IRS as income to the parent. This is not the case if someone other than the parent serves as Trustee. **Kindly list four (4) individuals you would trust in this capacity, in order of preference:**

	1.	2.
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____

	3.	4.
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____

3. POWER OF ATTORNEY: This document names the individuals (called your Attorneys-in-Fact, or Agents) who you would trust to handle business transactions for you, whether you are incapacitated, on vacation, or just wanting/needing assistance with banking or other financial issues. Note that these individuals will each have equal authority to act (there is no hierarchy) which means we can call on each, as needed and appropriate. None may act, however, without access to the document, which gives you control over who can exercise the power. **Please name at least three (3) individuals who you would like to serve as your Attorneys-in-Fact to handle business matters for you:**

1. Name:_____ 2. _____

Relationship:_____ _____

Town/State: _____ _____

3. Name:_____

Relationship:_____

Town/State: _____

4. HEALTH CARE PROXY: This document designates the individuals (called your Health Care Agents) who may make medical decisions for you if your physician has declared that you are unable to make or communicate a medical decision. **Please name three (3) individuals, in order of preference, who you would like to serve as your Health Care Agents:**

	1.	2. First Alternate:
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____
Phone (H):	_____	_____
Phone (W):	_____	_____
Phone (cell):	_____	_____

3. Second Alternate:

Name: _____

Relationship: _____

Address: _____

_____

Phone (H): _____

Phone (W): _____

Phone (cell): _____

5. LIVING WILL: This document says that you would not want to remain on life support indefinitely and gives your medical professionals and family members permission/encouragement to terminate life support if appropriate. **Would you like a Living Will?**

_____ YES _____ NO

6. HIPAA AUTHORIZATION FOR RELEASE form: This form lists the individuals who you authorize to access your medical information and talk with your doctors. We will list the same individuals who you listed as Health Care Agents above. **In addition, would you like anyone else listed?**

Full Name	**Relationship to You**	**Full Name**	**Relationship to You**

7. PRIMARY CARE PHYSICIAN: Please provide the name, practice, and address of your Primary Care Physician, so that our office may send copies of your signed Health Care Proxy, Living Will, and HIPAA Authorization for Release form for your records:

Physician: _____

Practice: _____

Address: _____

_____

_____

8. Sub-trust for any beneficiary not inheriting directly. (IF RELEVANT)

If there is any actual or potential beneficiary of your estate, regardless of age, who should not receive his or her share outright, due to disability, divorce, medical issues, poor money management, or other reasons, you may want to have someone else manage these funds. Note that, if funds will be held for the term of a beneficiary's life, you should name some Trustees who are the same age or younger than the beneficiary. **ONLY IF THIS IS RELEVANT TO YOUR SITUATION, please tell us which beneficiary should not inherit directly:**

_____

Please tell us <u>who should manage the funds</u> and make decisions about distributions (be sure to list at least four (4) individuals, in order of preference):

	1.	2.
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____

	3.	4.
Name:	_____	_____
Relationship:	_____	_____
Address:	_____	_____
	_____	_____