

Western Mass Estate Planning

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NOMINATIONS FOR FIDUCIARIES AND AGENTS

Will with Supplemental Needs Trust, Power of Attorney,
and Health Care Documents

1. WILL: This is the document which will direct distribution of your assets at your death. **Please list, in order, the individuals you would like to settle your estate.** Assets titled in your own name (not held jointly with anyone else, or not designating a beneficiary) will be distributed according to your Will (after going through the probate process); those assets will be available for your spouse for the rest of his or her life, but held in a sub-trust to protect the assets from the sick spouse's long-term-care expenses (these assets will not be countable for MassHealth purposes or deemed available to creditors). The individuals you list here will be responsible for distributing the assets passing through your Will, including managing the assets held for your spouse. We will be providing you with separate instructions about how to re-title your assets and/or designate beneficiaries, so that you can maximize the benefit of your Will.

• **Personal Representatives/Trustees (Please name at least 4 individuals to serve):**

1.	2.
Name: _____	_____
Relationship: _____	_____
Address: _____	_____
_____	_____
3.	4.
Name: _____	_____
Relationship: _____	_____
Address: _____	_____
_____	_____

2. DISTRIBUTION: **How would you like the assets distributed after your death?** This would include assets remaining in your spouse's sub-trust, after your spouse dies. 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:**

<p>1.</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone (H): _____</p> <p>Phone (W): _____</p> <p>Phone (cell): _____</p>	<p>2. First Alternate:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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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?**

<u>Full Name</u>	<u>Relationship to You</u>	<u>Full Name</u>	<u>Relationship to You</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 who should manage the funds 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: _____

When trust terminates: _____ death or when trust assets depleted _____