Trust Personal Information for an Individual Trust

Please provide the following information so we can prepare your Estate Planning Portfolio and legal documents.

PLEASE PRINT YOUR NAME AS YOU WISH IT TO APPEAR IN THE TRUST DOCUMENTS
AND **EXACTLY** AS YOUR DRIVER LICENSE, SENIOR IDENTIFICATION CARD OR PASSPORT (FOR NOTARIZATION)
ANY "ALSO KNOWN AS" NAME(S) YOU HAVE USED
SOCIAL SECURITY NUMBERS **ARE NOT REQUIRED** BUT LISTING THEM MAY FACILITATE SUBSEQUENT DEALINGS WITH FINANCIAL INSTITUTIONS, E.G. BANKS AND BROKERAGE FIRMS.
Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____
YOUR CONTACT INFORMATION
Address: _____ Home Telephone(s) (_____) _____ - _____ Work Telephone(s) (_____) _____ - _____ Cell Telephone(s) (_____) _____ - _____ Email _____

YOUR CHILDREN

Please provide your children's full names as you wish them listed in Trust documents, their Date-of-Birth and Sex.	
(C1) Name: _____ Address:_____ City, State, Zip: _____ Telephone: (_____) _____ - _____ Sex (M/F) _____ Date of Birth: ____ / ____ / _____	**(C4)** Name: _____ Address:_____ City, State, Zip: _____ Telephone: (_____) _____ - _____ Sex (M/F) _____ Date of Birth: ____ / ____ / _____
(C2) Name: _____ Address:_____ City, State, Zip: _____ Telephone: (_____) _____ - _____ Sex (M/F) _____ Date of Birth: ____ / ____ / _____	**(C5)** Name: _____ Address:_____ City, State, Zip: _____ Telephone: (_____) _____ - _____ Sex (M/F) _____ Date of Birth: ____ / ____ / _____
(C3) Name: _____ Address:_____ City, State, Zip: _____ Telephone: (_____) _____ - _____ Sex (M/F) _____ Date of Birth: ____ / ____ / _____	**(C6)** Name: _____ Address:_____ City, State, Zip: _____ Telephone: (_____) _____ - _____ Sex (M/F) _____ Date of Birth: ____ / ____ / _____

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OTHER INDIVIDUALS NAMED IN YOUR ESTATE PLAN (PLEASE PRINT)

For individuals (not your children) named in your estate plan, please provide their full name, or as you wish them listed in your estate plan. Please indicate whether they are male or female. We also request that you provide the individual's relationship to you. For **Charities**, please provide the Federal Employer Identification Number (FEIN).

(7) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(14)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____
(8) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(15)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____
(9) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(16)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____
(10) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(17)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____
(11) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(18)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____
(12) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(19)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____
(13) Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____	**(20)** Name: _____ Sex (M/F): _____ Relationship to you / Charity FEIN: _____

TRUST HEALTH CARE INFORMATION

HEALTH CARE POWER OF ATTORNEY

Your Health Care Power of Attorney communicates some of your health wishes. These may include your wishes for medical treatment, end-of-life decisions, relief from pain, and organ donations.
To assist us in preparing your Health Care Power of Attorney please carefully read the following two pages, and if you wish, complete any of the sections which communicate your wishes.

1. WOULD YOUR HEALTHCARE POWER OF ATTORNEY'S AUTHORITY BE RESTRICTED?

My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or later in this form:

_____

_____ (Add additional sheets if needed.)

2. WHAT ARE YOUR END-OF-LIFE DECISIONS?

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

❑ **(a) Choice Not To Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

❑ **(b) Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

3. WHAT INSTRUCTION DO YOU WANT TO MAKE REGARDING RELIEF FROM PAIN?

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____ (Add additional sheets if needed.)

4. ARE THERE ANY OTHER WISHES YOU WANT TO HAVE KNOWN?

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____ (Add additional sheets if needed.)

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5. WHAT ARE YOUR WISHES REGARDING DONATION OF ORGANS UPON YOUR DEATH:

Upon my death (mark applicable box): By checking (a) or (b), below, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation

❑ (a) I give any needed organs, tissues, or parts, OR

❑ (b) I give the following organs, tissues, or parts only.

_____

❑ (c) My gift is for the following purposes (Initial any of the following that you do want):

(1) Transplant _____
(2) Therapy _____
(3) Research _____
(4) Education _____

❑ (d) I do NOT want any organs, tissues or parts donated.

If I leave Part 5 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf.

6. DO YOU WANT TO DESIGNATE YOUR PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

PRIMARY PHYSICIAN

_____
PHYSICIAN'S NAME

_____
MEDICAL GROUP (EXAMPLE: KAISER)

_____
PHYSICIAN'S STREET ADDRESS

_____
PHYSICIAN'S CITY, STATE, ZIP

_____
PHYSICIAN'S TELEPHONE

HIPAA
AUTHORIZATION FORM

To assist us in preparing your HIPAA Authorization Form which authorizes the release of your medical information, please complete the form below.

When completing this section, please list those people whom you would want to authorize to call the hospital if anything happened to you, to find out what room you are in and how you are doing.

<u>Please print legibly</u>.

In the spaces provided below, please write the names of people you wish to authorize to receive your medical information. If a box is provided, please mark that box if you wish that language to appear on your HIPPA Authorization.	
□ My Spouse	
□ My Children	
List persons you want authorized below:	