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THIS QUESTIONNAIRE IS FOR THE PREPARATION OF THE FOLLOWING EIGHT (8) ESTATE PLANNING DOCUMENTS:

1. Last Will and Testament
2. Directive to Physician
3. Medical Power of Attorney
4. Statutory Durable Power of Attorney
5. Declaration of Guardian
6. Disposition of Remains
7. HIPAA Release
8. Hospital Visitation

The following pages will help guide you through the decisions necessary to complete the eight (8) basic estate planning documents you are having prepared and the basic purpose for each document. The documents which will be prepared for you are not intended for tax planning purposes. In the event you desire tax planning assistance, please let us know and we will refer you to an appropriate attorney or other professional for tax planning assistance.

Please be sure to complete each section, even though you will be asked the same or similar questions depending upon the document. When listing names, please be sure to be consistent throughout (for example: first name, middle name or initial, last name). If the questionnaire does not provide adequate space to complete your information, please use the back of the page or attach additional pages.

Any questions you may have or should you have particular estate planning needs not addressed in this questionnaire, please contact Mitchell Avila Katine at (713) 808-1001.

Please return the completed questionnaire via fax, email or postal service to Mitchell Avila Katine.

YOUR PERSONAL INFORMATION

1. Complete legal name: _____

Current Age: _____ Date of Birth: _____

Social Security Number: _____

2. Telephone Number: Daytime: _____ Evening: _____

Cell: _____ Fax: _____

Email Address: _____

3. Mailing Address: _____

Address _____

City, State, Zip _____ COUNTY _____

4. I would like to receive information by: ___email___ fax ___postal service___ no preference

How did you hear about us? _____

5. Are you: _____ single _____ married _____ divorced _____ separated

_____ widow(er) _____ in a relationship

If currently married, please provide name of spouse: _____

How long have you been married: _____

If in a relationship, please provide name of partner: _____

Are you currently living together: _____

How long have you been together: _____

6. Do you have any children? _____

If so, please provide the following information:

Child's Full Name: _____ Age: _____

Child's Full Name: _____ Age: _____

Child's Full Name: _____ Age: _____

Child's Full Name: _____ Age: _____

1. LAST WILL AND TESTAMENT

PURPOSE: A Will is intended to distribute your estate assets to your desired beneficiaries, after payment of all estate debts. "Estate assets" include real estate and personal property which you own at the time of your death which *do not already have a designated beneficiary*. (For example: house, real estate, car, personal possessions, etc.)

Examples of *assets which would typically have a designated beneficiary within the instrument and thereby would not be considered an "estate asset"* would be bank accounts, life insurance policies, retirement accounts/pensions, etc. In some instances these assets may not have a beneficiary designation and would then be included in your estate assets.

EXECUTOR DESIGNATION: The person responsible for carrying out the provisions of your Will.

1. Complete legal name of your independent executor

Answer: _____

2. Complete legal name of the FIRST ALTERNATE choice for independent executor

Answer: _____

3. Complete legal name of the SECOND ALTERNATE choice for independent executor

Answer: _____

DISTRIBUTION OF ESTATE ASSETS: There are several ways in which to distribute your estate.

ALTERNATIVE 1. GIVE ALL TO ONE PERSON OR ENTITY

I wish to distribute my entire estate to ONE person or entity:

Legal name of person: _____ Minor? _____

Complete Name and Address of Entity: _____

Legal Name of FIRST ALTERNATE _____

Legal Name of SECOND ALTERNATE _____

ALTERNATIVE 2. DIVIDE YOUR ESTATE ASSETS AMONG SEVERAL PERSONS OR ENTITIES IN EQUAL OR VARYING PORTIONS

2. I wish to leave my entire estate to the following person(s) and/or entity(ies):

Legal name of person: _____ % Minor? _____
Legal name of person: _____ % Minor? _____
Legal name of person: _____ % Minor? _____

Name and Address of Entity: _____ %

Name and Address of Entity: _____ %

Name and Address of Entity: _____ %

ALTERNATIVE 3. GIVE SPECIFIC ITEMS TO AN INDIVIDUAL(S) AND THE REMAINDER OF YOUR ESTATE TO ONE OR MORE PERSONS OR ENTITIES IN EQUAL OR VARYING PORTIONS.

3. I wish to make a specific gift of certain property to the following:

Legal name of person: _____ Minor? _____
Specific Gift: _____

Legal name of person: _____ Minor? _____
Specific Gift: _____

Legal name of person: _____ Minor? _____
Specific Gift: _____

Name and Address of Entity: _____

Specific Gift: _____

The remainder of my estate shall be distributed to:

Legal name of person: _____ % Minor? _____

Legal name of person: _____ % Minor? _____

Name and Address of Entity: _____ %

Legal Name of FIRST ALTERNATE _____

Legal Name of SECOND ALTERNATE _____

MINORS (Any person under the age of 18):

4. If you leave any portion of your estate to a minor, by law that portion must be placed in a trust until the beneficiary reaches at least the age of 18. In such event, a testamentary trust should be included in the Will and a Trustee designated.

I wish the minor beneficiary to receive his/her portion of the estate at the age of _____.

I wish to leave all or part of my estate to a minor. I wish to designate the following person(s) as **Trustee**:

Legal name of person: _____

Legal Name of FIRST ALTERNATE _____

Legal Name of SECOND ALTERNATE _____

5. If you have a child under the age of 18 (whether or not they are designated as a beneficiary), it is recommended that you designate a Guardian for the child in the event you and/or your significant other should pass before your child becomes of age.

I have children that are currently minors. I wish to designate the following person(s) as **Guardian** of my child(ren).

Legal name of person: _____

Legal Name of FIRST ALTERNATE _____

Legal Name of SECOND ALTERNATE _____

**2. DIRECTIVE TO PHYSICIAN
A/K/A “LIVING WILL”**

PURPOSE: This is an important legal document known as an Advance Directive or Living Will. It is designed to help you communicate your wishes about your choice of medical treatment at some time in the future when you are unable to make your wishes known due to an incapacitating illness or injury. These wishes are usually based on personal values. This document does not require you to provide any specific information, however, the Directive to Physician will need to be completed and signed in front of witnesses.

In executing this document, consideration should be given as to what burdens or hardships of treatment you would be willing to accept if you were seriously ill. For example: In the event you are diagnosed by your physician as suffering from a *terminal condition* or an *irreversible condition*, you may direct whether you are to be kept comfortable but allowed to die as gently as possible, or you may direct to be kept alive for as long as possible in such a condition using all available life-sustaining treatment.

I wish to have a Directive to Physician a/k/a “Living Will” prepared _____ Yes _____ No

Definitions

“**Artificial nutrition and hydration**” means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

“**Irreversible condition**” means a condition, injury, or illness:

- (1) that may be treated, but is never cured or eliminated;
- (2) that leaves a person unable to care for or make decisions for the person’s own self; and
- (3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serous brain disease such as Alzheimer’s dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

“**Life-sustaining treatment**” means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient’s pain.

“Terminal condition” means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physicians, family, or other important persons in your life.

3. MEDICAL POWER OF ATTORNEY FOR HEALTHCARE

PURPOSE: Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. "Health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. A physician must comply with your agent's instructions or allow you to be transferred to another physician. Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion.

I wish to appoint the following persons (over the age of 18) as my agent and alternate agents (over the age of 18) to make health care decisions for me:

Designated Agent

Name: _____
Address: _____
Phone: _____

First Alternate:

Name: _____
Address: _____
Phone: _____

Second Alternate

Name: _____
Address: _____
Phone: _____

I place the following limitations on the decision making authority of my agent, if any. If you place no limitations on your agent, please indicate "NONE": _____

If you choose, the original of your health care power of attorney may be kept at Katine & Nechman L.L.P. We suggest that at least one person or institution (such as your designated agent and/or your primary care physician) have a signed copy or duplicate original of your medical power of attorney for healthcare.

First person or institution: (such as your designated agent)

Name: _____

Address: _____

Phone: _____

Second person or institution: (such as your primary care physician)

Name: _____

Address: _____

Phone: _____

4. STATUTORY DURABLE POWER OF ATTORNEY

PURPOSE: Texas law provides for a statutory power of attorney for real estate transactions, business transactions, claims and litigation, personal and family maintenance, tax matters, and other types of *non-health care* decisions. This power of attorney is intended to cover all matters except health care decisions which are covered by your medical power of attorney.

Primary

Name: _____

First Alternate:

Name: _____

Second Alternate

Name: _____

5. DECLARATION OF GUARDIAN

PURPOSE: A guardianship is established for a person through a court order when it is determined that a person is no longer capable of managing their personal and/or business affairs. (Examples may be alzheimer, dementia, mental illness, incapacitating illness, etc.) This document is designed to inform the Judge of your selection of a Guardian (and alternates) in case the need for a guardianship arises.

This document designates an agent and two alternate agents to serve as guardian of your estate and of your person:

Designated Agent

Name: _____

First Alternate:

Name: _____

Second Alternate:

Name: _____

6. APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS

PURPOSE: Texas law states that a person may provide written directions for the disposition of the person's remains in a Will, a prepaid funeral contract, or a written instrument signed by such person, the designated agent and successor agent and acknowledged by a notary. This document will constitute such written instrument appointing your agent (and alternates) to handle your remains after your death.

Designated Agent

Name: _____
Address: _____
Phone: _____

First Alternate:

Name: _____
Address: _____
Phone: _____

Second Alternate

Name: _____
Address: _____
Phone: _____

Please state any special directions (i.e. cremation, special burial/memorial service, prepaid funeral contract, family cemetery plot, etc.), if any, below. If there are no special disposition directions and you would simply like the disposition of your remains to be at the discretion of your agent named above, please indicate "NONE" below.

I give my agent the following directions, instructions, limitations regarding the disposition of my remains:

**7. HIPAA AUTHORIZATION
FOR RELEASE OF MEDICAL RECORDS AND INFORMATION**

PURPOSE: Congress passed a law entitled the Health Insurance Portability and Accountability Act (“HIPAA”) that limits disclosure of protected medical information. Medical care providers are not permitted to disclose information about your medical condition, treatment or diagnosis to any person or institution unless expressly given permission to do so by you. This authorization gives your medical providers permission to give your protected medical information to the individuals designated in this authorization and allows your medical providers to discuss and obtain advice from the individuals listed below.

You may designate as many individuals as you wish. This authorization covers the following person(s):

1. Name: _____
 Address: _____
 Phone: _____

2. Name: _____
 Address: _____
 Phone: _____

3. Name: _____
 Address: _____
 Phone: _____

8. HOSPITAL VISITATION AUTHORIZATION

PURPOSE: In the event you should be hospitalized, placed in critical care or ICU, medical facilities may limit or restrict visitation based on your condition. This document informs the medical facility of persons which should be allowed to visit you.

You may designate as many individuals as you wish to be given preference to be admitted to visit you if you are confined in a hospital. The individuals you name are not limited to family members.

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____