Name: _____

REVOCABLE TRUST

Trust name: _____

Successor Trustees (in chronological order):

1. Name(s): _____ Relation(s): _____
2. Name(s): _____ Relation(s): _____
3. Name(s): _____ Relation(s): _____
4. Name(s): _____ Relation(s): _____

Notes:

Beneficiaries:

1. Name: _____ Relation: _____ Percentage: _____
2. Name: _____ Relation: _____ Percentage: _____
3. Name: _____ Relation: _____ Percentage: _____
4. Name: _____ Relation: _____ Percentage: _____

Notes:

Contingent Beneficiaries:

1. Name: _____ Relation: _____ Percentage: _____
2. Name: _____ Relation: _____ Percentage: _____
3. Name: _____ Relation: _____ Percentage: _____
4. Name: _____ Relation: _____ Percentage: _____

Notes:

Age(s) of Distribution(s) for Beneficiaries and Contingent Beneficiaries:

Age of first distribution: _____ Amount/percentage: _____ Additional requirement: _____

Age of second distribution: _____ Amount/percentage: _____ Additional requirement: _____

Age of third distribution: _____ Amount/percentage: _____ Additional requirement: _____

Notes:

Pet Guardian(s), if applicable (in chronological order):

1. Name(s): _____ Relation(s): _____
2. Name(s): _____ Relation(s): _____
3. Name(s): _____ Relation(s): _____

Notes:

LAST WILL AND TESTAMENT

Guardian(s) of minor children, if applicable (in order of priority):

1. Name(s): _____ Relation(s): _____
2. Name(s): _____ Relation(s): _____
3. Name(s): _____ Relation(s): _____
4. Name(s): _____ Relation(s): _____

Notes:

Interim/Temporary Guardian(s) of minor children, if applicable (in order of priority):

1. Name(s): _____ Relation(s): _____
2. Name(s): _____ Relation(s): _____

3. Name(s): _____ Relation(s): _____

4. Name(s): _____ Relation(s): _____

Notes:

Executors/Personal Representatives (in order of priority):

1. Name(s): _____ Relation(s): _____

2. Name(s): _____ Relation(s): _____

3. Name(s): _____ Relation(s): _____

4. Name(s): _____ Relation(s): _____

Notes:

FINANCIAL POWER OF ATTORNEY

Effective upon: ☐ signing ☐ written determination of incapacity by your physician

Agents (in order of priority):

1. Name: _____ Relation: _____

   Address: _____ Phone: _____

2. Name: _____ Relation: _____

   Address: _____ Phone: _____

3. Name: _____ Relation: _____

   Address: _____ Phone: _____

4. Name: _____ Relation: _____

   Address: _____ Phone: _____

HEALTH CARE POWER OF ATTORNEY

Agents (in order of priority):

1. Name: _____ Relation: _____

   Address: _____ Phone: _____

2. Name: _____ Relation: _____

   Address: _____ Phone: _____

3. Name: _____ Relation: _____

   Address: _____ Phone: _____

4. Name: _____ Relation: _____

   Address: _____ Phone: _____

ADDITIONAL INFORMATION