

Name(s): _____

LAST WILL AND TESTAMENT

Guardian(s) of minor children, if applicable:

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:

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 order):

1. Name(s): _____

Relation(s): _____

2. Name(s): _____

Relation(s): _____

3. Name(s): _____

Relation(s): _____

4. Name(s): _____

Relation(s): _____

Notes:

Trustees (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:

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:

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 order of priority):

1. Name(s): _____

Relation(s): _____

2. Name(s): _____

Relation(s): _____

3. 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 POWERS 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: _____