

## Presentation – Wills and Estates

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1. The Planning Process – The Questionnaire
  - a. What Documents Are Needed Based on Questionnaire
    - i. Power of Attorney
    - ii. Living Will
    - iii. Health Care Power of Attorney
    - iv. Wills
    - v. Trusts
2. What Happens After Death – Opening an Estate
  - a. With a Will
    - i. AOC-E-201
    - ii. AOC-E-304
    - iii. AOC-E-400
    - iv. AOC-E-402
  - b. Without a Will
    - i. AOC-E-202
    - ii. AOC-E-200
    - iii. AOC-E-404
    - iv. AOC-E-400
    - v. AOC-E-402
3. Contesting Will or Questioning Actors in the Estate
  - a. Caveat
  - b. Requesting an Accounting
  - c. Removal of Administrator/Executor
4. Question and Answer Session

Will/Trust Questionnaire

**The information requested below is essential in preparing your will or trust. If you need more space to answer a question, attach a separate sheet and indicate the question number to which it pertains. If both you and your spouse require estate planning documents, you will need to each fill out a separate questionnaire. (When filling out two questionnaires, long or complex directions that will be identical in both sets of documents may be written down on only one questionnaire and referred to on the second questionnaire.)**

1. State your full name:

\_\_\_\_\_

First	Middle	Last
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State all other names by which you have been known:

\_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Male      Female

2. State your current address:

\_\_\_\_\_

Street address	City	State	Zip Code
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Telephone Numbers:

\_\_\_\_\_

Home	Cell	Work
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Email: \_\_\_\_\_

3. Married? If so, Please state your spouse's full name:

\_\_\_\_\_

First	Middle	Last
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\_\_\_\_\_

Maiden	Date of Birth
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4. Have you created any trusts or made gifts to any trusts? If yes, describe:

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5. Do you have a date on which you expect to have any inheritance distributed to you? If so, state from whom and how much: \_\_\_\_\_

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6. Please indicate, by checking the appropriate option, how you want your assests to pass when die.

\_\_\_\_\_ Option A: I want my assets to pass my spouse and children as follows:

- To spouse, if surviving.
- If my spouse predeceases me, my assets will be divided in equal shares among children.
- If any of my children predecease me, that child's share shall be distributed to his or her children in equal shares.
- In the event my spouse and all of my children and descendents fail to survive me, I want assets to be distributed as follows:

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\_\_\_\_\_ Option B: I am unmarried with children and want my assets to pass:

- In equal shares to my children.
- If one or more of my children predeceases me, that child's share in my estate is distributed to his or her children in equal.
- In the event all my children and descendents fail to survive, I want my assets to be distributed as follows:

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\_\_\_\_\_ Option C: None of the above. I want my assets to pass:

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7. At what age(s) do you want the monies to be distributed to your children/beneficiaries?  
List percentages:

\_\_\_\_\_ % at \_\_\_\_\_ years old; \_\_\_\_\_ % at \_\_\_\_\_ years old; \_\_\_\_\_ % at \_\_\_\_\_ years old.

Other: \_\_\_\_\_  
\_\_\_\_\_

8. List any instructions regarding limitations on distributions (such as must finish college, etc.), or special situations (such as starting a business, getting married, etc.).

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9. Do you wish to disinherit any child, grandchild, or other person? If yes, you must list their names here:

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10. Many people make special provisions for family heirlooms, jewelry, or other items of special value to be distributed to friends or relatives. If you have such property and wish it left to a specific person, please complete the following:

*Note: If you have chosen "Option A" or "Option B" under number 11, you have indicated by your selection the items described above will pass to your spouse and/or children. Complete this number ONLY if you desire such items of specific value to be left to specific person(s).*

Item	Special Identifying Features	Recipient

Item	Special Identifying Features	Recipient

11. If your children are under age eighteen (18), state the full name, address, and relationship (if any) of the person you wish to act as their guardian (custody) in the event of your death (in the case of single parent) or in the case of the joint death of you and your spouse (if married). You should obtain the consent of the person(s) before executing your Will.
- Note: A guardian is a person lawfully invested with the power, and charged with the duty, of taking care of the person who is incapable of doing so because of age or other capacity.*

Guardian(s)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Relationship (if any) \_\_\_\_\_

*If the person or entity listed above is unwilling or unable to serve as guardian, please list an alternate:*

Successor Guardian(s)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Relationship (if any) \_\_\_\_\_

12. If you want the guardian to receive a stipend/compensation for the taking on the responsibilities of guardian, please set forth the details (e.g. monthly, annually, COLA, salary reimbursement to stay at home, etc.).

\_\_\_\_\_

13. Do you want the appointed guardian also to be the conservator of any assets inherited by the minor child/ren? **Note: A conservator is a person appointed to manage the financial affairs of one who legally incapable of doing so because of age or other capacity.**

\_\_\_\_\_ Yes \_\_\_\_\_ No

14. WILL/POUR-OVER WILL (with trust)-The person charged with administering your estate ,paying taxes and other debts, marshalling, preserving, managing and distributing estate assets and property is called personal representative (executor). State the name and address of the person you wish to serve in this role.

Spouse first? \_\_\_\_\_ Yes \_\_\_\_\_ No

Successor or if not spouse:

Primary Successor

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Relationship (if any) \_\_\_\_\_

If the person listed above is unwilling or unable to serve as a personal representative, please list an alternate:

Second Successor

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Relationship (if any) \_\_\_\_\_

Do you wish to waive the fiduciary bond requirement (usually they serve without bond)?

**Note: A fiduciary bond is a type of surety bond required by the court to be filed by executors, guardians, etc., to ensure proper performance of duties.**

\_\_\_\_ Yes

\_\_\_\_ No

- 15. Trust/Child's Trust (with a will if there is/are minor children)- The person charged with administering your estate through your trust, paying taxes and other debts, marshalling, preserving, managing and distributing estate asset and property is called a trustee. State the name and address of the person you wish to serve in this role.

First Successor Trustee

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Relationship (if any) \_\_\_\_\_

If the person listed above is unwilling or unable to serve as a trustee, please list an alternate:

Second Successor Trustee

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Relationship (if any) \_\_\_\_\_

Do you wish to waive the fiduciary bond requirement (usually they serve without bond)?

**Note: A fiduciary bond is a type of surety bond required by the court to be filed by executors, guardians, etc., to ensure proper performance of duties.**

\_\_\_\_ Yes

\_\_\_\_ No

16. In what place and manner do you wish your remains to be disposed of?

\_\_\_\_\_
\_\_\_\_\_

Execution of a Will/Trust is the best way to determine how your property will be distributed; however, it cannot address important issues regarding health care decisions. You may want to discuss the functions of a Health Care Power of Attorney and a Living Will with our office. These issues should be discussed prior to drafting these documents with the person named as agent.

17. If you become incapacitated, whom do you want to make health care decisions for you?

Spouse first? \_\_\_Yes \_\_\_No Successor if not Spouse:

Primary Successor Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_
Street City State Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

If the person listed above is unwilling or unable to serve as a trustee, please list an alternate:

Second Successor Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_
Street City State Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

18. The agent under your Health Care Power of Attorney has the ability to make a mental health care decision on your behalf. However, that agent does not have the ability to place you in a level one behavioral health care facility licensed by the Department of Health Services ( a locked facility), in the event that you need to be in this type of facility. This document is especially recommended to those who have a family history of mental illness (including Alzheimer’s disease).



Do you want a Mental Health Care Power of Attorney? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, who do you want to have the authority to make all mental health care decisions for you?

Spouse first? \_\_\_\_\_Yes \_\_\_\_\_No

Primary Successor if not Spouse:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

19. Do you want a Living Will (Life Support decisions)? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, who do you want to be responsible for the deciding to remove you from life support?

Spouse first? \_\_\_\_\_Yes \_\_\_\_\_No

Primary Successor Agent if not Spouse:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

If the person listed above is unwilling or unable to perform that duty, please list an alternate:

Second Successor Agent if not Spouse:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

20. Here are some general statements about choices you have as to health care you want at the end of your life. Put a check next to whichever choices best fit your wishes. Any combination can be used but if you choose "Direction to Prolong My Life (to the greatest extent possible)", no other choices should be checked.

\_\_\_\_\_ Comfort Care Only: If I have a terminal condition I do not want my life to be prolonged, and I do not want a life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of death. ***(NOTE: "Comfort Care" means treatment in an attempt to protect and enhance the quality of life without artificially prolonging life.)***

\_\_\_\_\_ Specific Limitations on Medical Treatments I want: (NOTE: mark one or more choices below). If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:

- \_\_\_\_\_ 1. Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
- \_\_\_\_\_ 2. Artificially administered food and fluids.
- \_\_\_\_\_ 3. To be taken to a hospital if it is as all avoidable.

\_\_\_\_\_ Pregnancy: Regardless of any other directions I have given in this Living Will, If I am known to be pregnant I do not want life sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life sustaining treatment.

\_\_\_\_\_ Treatment Until My Medical Condition is Reasonable Known: Regardless of the Directions I have made in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonable conclude that my condition is terminal or is irreversible and incurable, or I am in a persistent vegetative state.

\_\_\_\_\_ Directions to Prolong my Life: I want my life to be prolonged for (amount of time)

\_\_\_\_\_ Days                      \_\_\_\_\_ Months                      \_\_\_\_\_ Years

\_\_\_\_\_ Direction to Prolong My Life: I want my life to be prolonged to the greatest extent Possible.

\_\_\_\_\_ Other Directions: \_\_\_\_\_

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21. Do you wish to donate your organs for the following purposes?

Transplantations	_____Yes	_____No
Research	_____Yes	_____No
Studies	_____Yes	_____No

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*In addition to a Last Will and Health Care documents many individuals ask to receive a General Durable Power of Attorney that becomes "EFFECTIVE UPON INCAPACITATION". This document allows an individual's designated 'Attorney-In-Fact' to act for him/her in all financial matters during any time that the individual is incapacitated due to medical or other problems. The Attorney-In-Fact will have full control over your financial future; therefore, you need to make sure only to select trustworthy individuals to act in such an important capacity for you.*

22. Do you want a General Durable Power of Attorney? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes, then who do you wish to be your Attorney-In-Fact?

Spouse first? \_\_\_\_\_Yes \_\_\_\_\_No

Primary Attorney-In-Fact if not Spouse:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

If the person listed above is unwilling or unable to perform that duty, please list an alternate:

Successor Attorney-In-Fact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone Number: \_\_\_\_\_ Relationship (if any) \_\_\_\_\_

If there is any other information you think would be help us prepare your Will, please include below or on a separate sheet of paper and attach it to this questionnaire.

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Confirmation of information and instructions: I will confirm the information provided by me in this questionnaire is complete and accurate, and that the instructions I am providing reflect my wishes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date