

NETHERY & OFSEYER LLP
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PALM DESERT, CALIFORNIA 92260
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CLIENT INFORMATION: DOMESTIC PARTNER
[Strictly Confidential]

Partner I - Legal Name: _____

Other Names used by Partner I: _____

Address: _____

County: _____ E-Mail: _____

Telephone Numbers: (work) _____ (cell) _____

(home) _____ (fax) _____

Date of Birth: _____ Social Security No.: _____

US citizen? Yes No. If no, what nationality: _____

Currently Employed? Yes No. If no, Retired? Yes No. Other: _____

Business/Employment: _____

Type of Business: _____ Owner: Yes No. Number of Employees: _____

Please List Business Partners: _____

Partner II - Legal Name: _____

Other Names used by Partner II: _____

Date of Birth: _____ Social Security No.: _____

Business/Employment: _____

US citizen? Yes No. If no, what nationality: _____

Business/Employment: _____

Type of Business: _____ Owner: Yes No. Number of Employees: _____

Please List Business Partners: _____

Are you Registered Domestic Partners? Yes No

Prior Registered Domestic Partners or Marriages?

Partner I: Yes No. If yes, name of prior spouse/partner _____

How Terminated? Death Divorce Date: _____

Partner II: Yes No. If yes, name of prior spouse/partner: _____

How Terminated? Death Divorce Date: _____

CHILDREN OF THIS PARTNERSHIP	<input type="checkbox"/> None	AGE or DOB
_____		_____
_____		_____

Number of grandchildren: _____ Range of Ages: _____

CHILDREN FROM <u>PRIOR</u> MARRIAGE/PARTNERSHIP:	P I	P II	AGE
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Treat all children as if they were the children of this partnership? No Yes

	<u>YES</u>	<u>NO</u>
• Is there any reason that you need your Estate Plan created or changed quickly? If yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>

• Any deceased children?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, name: _____

If yes, survived by issue?	<input type="checkbox"/>	<input type="checkbox"/>
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• Any adopted children?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, name: _____

• Do any of your beneficiaries have a learning disability, special educational, medical or physical needs?	<input type="checkbox"/>	<input type="checkbox"/>
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- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| • Do you have any relatives (other than children) who depend on you for all or part of their support? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you think any of your beneficiaries have special problems with partner, drugs, alcohol or handling money? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to disinherit any of your children, grandchildren or any other close relative? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have an existing Partnerships Property Agreement? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do either of you expect to inherit substantial assets (\$100,000 +)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to make anatomical bequests (organ donor)? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to have a "Living Will"? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have existing Wills? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have any existing trusts? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever filed a Federal Gift Tax Return? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Should the surviving partner have the power to control the distribution of the entire estate after the first death? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you want any assets to pass to your children before the surviving partner's death? | <input type="checkbox"/> | <input type="checkbox"/> |
| • If a beneficiary dies prior to the second partner's death, do you want the assets to go to that beneficiary's issue? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you want assets passing to your beneficiaries to be held in trust until a specific age or ages? | <input type="checkbox"/> | <input type="checkbox"/> |
| • The name / address / telephone number of the person(s) other than the surviving partner that you want to be the decision maker(s) concerning your estate upon your death: | | |

Partner 1

Partner 2

- The name / address / telephone number of the person(s) that you want to raise a child that is under 18, if both partners die (if applicable):

Partner 1

Partner 2

_____	_____
_____	_____
_____	_____
_____	_____

- The name / address / telephone number of the person(s) other than the surviving partner that you want to make any major medical decisions on your behalf: (If different from above)

Partner 1

Partner 2

_____	_____
_____	_____
_____	_____
_____	_____

- In general, state how you want your estate distributed among your beneficiaries after the death of both of you?

Partner 1

Partner 2

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- State any specific concerns (not already mentioned) that you have regarding the distribution of your estate:

Partner 1

Partner 2

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- Please list below the following professionals you are currently utilizing: Financial Planners, Stockbrokers, Accountants, Personal Bankers, Insurance Agents and Family Attorney(s):

Partner 1

Partner 2

END-OF-LIFE DECISIONS

Of the four (4) statements below, initial the statement which best states your desires:

I. Default “Living Will” Provision

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. I understand that if there is a conflict between my agent’s decision and this statement, this statement shall take precedence.

For purposes of this statement:

- (A) “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.
- (B) “An irreversible coma”, means a coma from which the treating physicians have reasonably concluded I will never regain consciousness.
- (C) “Persistent vegetative state” means a state of permanent unconsciousness that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, is characterized by both of the following:
 - (i) I am irreversibly unaware of myself and my environment, and
 - (ii) There is a total loss of cerebral cortical functioning, resulting in my having no capacity to experience pain or suffering.
- (D) “Terminal condition” means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, both of the following apply:
 - (i) There can be no recovery; and
 - (ii) Death is likely to occur within a relatively short time if life sustaining treatment is not administered.

Partner I

Partner II

II. Similar to “I” But Agent Makes Final Decision

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, if in my agent’s judgment the burdens of the proposed treatment outweigh the expected benefits, then I do not want any form of life-sustaining procedures or, if life-sustaining treatment has been instituted, I ask that it be withdrawn. I desire that my agent consider relief from suffering, preservation or restoration of functioning, and the quality as well as the extent of the life being preserved when decisions are made concerning life-sustaining care, treatment, services, and procedures. I trust my agent, who knows my desires well, and in whose judgment I have absolute faith to exercise discretionary decisions in a manner that would be satisfactory to me. “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

Partner I

Partner II

III. End Treatment Only Absent Cognitive Function

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, if the extension of my life would result in a mere biological existence, devoid of cognitive function, with no reasonable hope for normal functioning, then I do not desire any form of life-sustaining procedures or, if life-sustaining treatment has been instituted, I desire that it be withdrawn. It is my desire that my agent consider relief from suffering, preservation or restoration of functioning, and the quality as well as extent of the life being preserved when decisions are made concerning life-sustaining care, treatment, services, and procedures. In making the decision to withhold or remove treatment, my agent should ask the question: “Is the proposed treatment an aid to recovery or merely a prolongation of inevitable death?” What is “reasonable,” what is “an aid to recovery,” and what is “merely a prolongation of inevitable death” shall be determined by my agent after consulting with my attending physicians. “Life-sustaining treatment” means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

Partner I

Partner II

IV. Prolong Life

I express the desire that my life be prolonged to the greatest possible extent without regard for my physical or mental condition, chance of recovery, likelihood of suffering, or expense and authorize my Agent to consent to whatever medical procedures are necessary to accomplish this end. I trust my Agent, who knows my desires well, and in whose judgment I have absolute faith to exercise discretionary decisions in a manner that would be satisfactory to me.

Partner I

Partner II

* ESTIMATED VALUE OF ESTATE

<u>TYPE OF ASSET:</u>	<u>Partner I SEP. PROP.</u>	<u>Partner II SEP. PROP.</u>	<u>COMMUNITY PROPERTY</u>
• REAL ESTATE: (fair market value, <u>less</u> loans)	\$ _____	\$ _____	\$ _____
• SECURITIES: (stocks, bonds, mutual funds)	\$ _____	\$ _____	\$ _____
• CASH TYPE ASSETS: (cash, annuities, notes due you)	\$ _____	\$ _____	\$ _____
• BUSINESS INTERESTS: (sole proprietorship, partnerships, closely held corporation, etc.)	\$ _____	\$ _____	\$ _____
• RETIREMENT PLANS: (IRA, 401k, etc. †)	\$ _____	\$ _____	\$ _____
• VEHICLES: (autos, R.V., boat)	\$ _____	\$ _____	\$ _____
• PERSONAL PROPERTY: (jewelry, furniture, antiques)	\$ _____	\$ _____	\$ _____
TOTAL:	\$ _____	\$ _____	\$ _____

* Use best guess; this can be a “ballpark” estimate.

† Do not show benefits which will terminate at death (e.g., pension, social security, etc.).

Value of Life Insurance policies will be listed separately on the next page.

LIFE INSURANCE

(do not include accidental death policies)

- “Insured” will be “P I” partner; “P II” partner; or “S” survivor
- “Owner” will be “C” community property; “P I” partner or “P II” partner
- “Cash Value” use best estimate (term policies normally have no cash value)
- “Face Value” is the amount payable at death
- “Beneficiary” will be “P I” partner; “P II” partner; “C” child, “O” other

INSURED (P I/P II/S)	OWNER (P I/P II/C)	CASH VALUE (\$ estimate)	FACE VALUE (\$ paid on death)	BENEFICIARY (P I/P II/C/O)
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____
_____	_____	\$ _____	\$ _____	_____

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WAIVER OF POTENTIAL CONFLICT OF INTEREST

We have each read the foregoing material and understand that there are potential conflicts of interest between myself and my partner in the matters about which we are consulting you. If either of us wishes to have separate counsel or desire you not to be involved at all, that partner shall notify you. We each hereby consent to having you represent both of us in the drafting of our estate planning documents, and we each hereby waive any potential or actual conflicts of interest. We understand that since you will be representing both of us on the same matter, as between ourselves and you, there are no confidential communications.

Dated: _____

Partner I's Signature

Partner II's Signature