TRAVERS • MAYES • SHELDON

Travers Law

Exceptional Standards, Personal Approach

CLIENT INFORMATION FOR PREPARATION OF A LAST WILL AND TESTAMENT

I. TESTATOR

Do you have proficient comprehension of the English language? **Yes** ○ **No** ○

Your Full Legal Name:

The name you commonly use, if different from above:

Home Address:

Telephone: (Home) (Work) (Cell)

Email Address:

Date of Birth: Citizenship:

Work Address: Occupation:

Marital Status

- Divorced: (name of ex-spouse)
- Separated: (name of spouse)
- Married: (name of spouse)
- Widowed: **Yes** ○ **No** ○
- Common Law:

  Living together for more than 3 years: (name of spouse)

  In a relationship with a shared child: (name of spouse)

If you are presently married, please provide full legal names of all children from **current** marriage:

	Name	Date of Birth
1		
2		
3		
4		

Are any children disabled and on social assistance, like the Ontario Disability Support Program (ODSP)? If so, please indicate the name or name(s) of the child/children:

Do you have a signed Cohabitation Agreement or Marriage Contract? **Yes** ○ **No** ○

(If "Yes", please provide us with a copy of either your Cohabitation Agreement or Marriage Contract, **not** your Marriage Licence.)

Were there any children of the previous marriage? **Yes** ○ **No** ○

If so, full legal names of all children from **previous** marriages:

Name	Date of Birth

Are any children disabled and on social assistance, like the Ontario Disability Support Program (ODSP)? If so, please indicate the name or name(s) of the child/children:

2. PROPOSED EXECUTOR

(who will administer your estate on your behalf and distribute your assets or manage trusts established for your beneficiaries in your Will when you pass away – you may wish to consider appointing your spouse either alone or with one or more other people)

Full Legal Name:

Address:

Telephone: (Home) (Work)

Relationship to Testator:

Sole Executor ○ OR Joint Executors ○

IF JOINT EXECUTOR

Full Legal Name:

Address:

Telephone: (Home) (Work)

Relationship to Testator:

IMPORTANT: *If you have named more than one executor and if, for example, one of the named executors predeceases you or is unwilling or unable to act, do you wish for the surviving named executor to act as executor solely?* **Yes** ○ **No** ○

ALTERNATE EXECUTOR

(in the event the appointed executor should predecease you, die within a period of twenty-nine days following your death, or is unwilling or unable to act, it is recommended that you appoint at least one alternate – this is especially important if you have only chosen ONE executor)

Full Legal Name:

Address:

Telephone: (Home) (Work)

Relationship to Testator:

Sole Executor ○ OR Joint Executors ○

IF JOINT ALTERNATE EXECUTOR

Full Legal Name:

Address:

Telephone: (Home) (Work)

Relationship to Testator:

IMPORTANT: *If you have named more than one executor and if, for example, one of the named executors predeceases you or is unwilling or unable to act, do you wish for the surviving named executor to act as executor solely?* **Yes** ○ **No** ○

3. BENEFICIARIES *(if you have specific instructions as to the distribution of the residue of your estate, please indicate in the margin of this page or on the space provided on the last page.)*

Spouse:

Full Legal Name:

Address:

Telephone: (Home) (Work)

Date of Birth: Citizenship:

Children (the residue of your estate will be held in trust until your children reach the age of eighteen (18) years – unless otherwise indicated below):

(1) Full Legal Name: Date of Birth

Address:

(2) Full Legal Name: Date of Birth

Address:

(3) Full Legal Name: Date of Birth

Address:

(4) Full Legal Name: Date of Birth

Address:

If there is insufficient space here, please attach list.

If you wish for the residue of your estate to be held in trust for your children other than until they reach the age of eighteen (18) years, please indicate the age or ages that you want it to be distributed and in what percentages or amounts:

Age	**%**	***Age***	**%**	***Age***	**%**

Is there to be a giftover to your grandchildren if a child of yours is not then alive? **Yes** ○ **No** ○

Other Beneficiaries:

(1) Full Legal Name: Date of Birth

(2) Address:

(3) Relationship to Testator:

(4) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

(3) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

(4) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

4. GUARDIANS *(should both you and the other parent of your child(ren) pass away):*

Proposed Guardian(s)

(1) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

(2) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

IMPORTANT: *If you have named more than one guardian and if, for example, one of the named guardians predeceases you or is unwilling or unable to act, do you wish for the surviving named guardian to act as guardian solely?* **Yes** ○ **No** ○

Alternate Guardian(s)

(1) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

(2) Full Legal Name: Date of Birth

Address:

Relationship to Testator:

IMPORTANT: *If you have named more than one alternate guardian and if, for example, one of the named alternate guardians predeceases you or is unwilling or unable to act, do you wish for the surviving named alternate guardian to act as alternate guardian solely?* **Yes** ○ **No** ○

5. CREMATION **Yes** ○ **No** ○

6. GIFTS OF PERSONAL PROPERTY, LEGACIES OR BEQUESTS TO INDIVIDUALS or CHARITIES *(please provide full legal names below)*

TO: I wish to leave:

TO: I wish to leave:

TO: I wish to leave:

TO: I wish to leave:

7. REAL ESTATE

Your Home Address:

Names on title:

- Joint Tenants
- Tenants in Common Percentage ownership

Other Real Estate:

Property 1 – Street address or location:

Names on title:

- Joint Tenants
- Tenants in Common Percentage ownership

Property 2 – Street address or location:

Names on title:

- Joint Tenants
- Tenants in Common Percentage ownership

If you own the above properties solely or as Tenants in Common and you wish to leave such property to a particular person or people or give someone the right to use such property during their lifetime with the provision that when they pass away the property is to go to someone else. This type of arrangement is a trust and requires you to consider matters such as who will pay ongoing expenses, such as insurance and regular maintenance costs, who will be responsible for repairs outside the course of everyday living expenses, etc.

Please describe the property you wish to deal with and set how the property is to be distributed:

8. CORPORATE INFORMATION – Do you have any shares in a private corporation? **Yes** ○ **No** ○

Full Legal Name of Corporation:

Is there a Shareholders' Agreement? **Yes** ○ **No** ○ If yes, please provide a copy.

If not, please provide the full legal name(s) of the individual(s) that you wish to leave the shares to:

In the event the above named individual(s) predecease you, please provide the full legal name(s) of the individual(s) that you wish to leave the shares to:

9. ADDITIONAL DETAILS OR COMMENTS you wish to be outlined in your Will, if any:

Continuing Power of Attorney for PROPERTY
QUESTIONNAIRE

Please Read this Section Carefully

To make a valid power of attorney, you must be 18 years of age or more and "mentally capable" of giving a continuing power of attorney for property. You should:

know what property you have and its approximate value
be aware of your obligations to those people who depend on you financially
know what your attorney has the authority to do
know that your attorney must account for all the decisions he or she makes about your property
know that, if you are capable, you may cancel your power of attorney
understand that unless your attorney manages the property prudently, its value may decline
understand that there is always the possibility that your attorney could misuse the authority.

Your Full Name:

Address:

Date of Birth:

Telephone: Home: Work:

The person you appoint could have significant power over your finances. When deciding who to appoint, consider whether the person is someone you know well, is someone you trust completely, is concerned only with your best interests, and has good judgement and financial management skills. Your attorney must be 18 years of age or more.

Power of Attorney to be granted to *(Please print)***:**

Name: Age

Address:

2nd Attorney (OPTIONAL): Age

Address:

If you appoint more than one attorney, *your attorneys will be required to make every decision together all the time,* unless you instruct that they may act "jointly and severally". In other words, they may act together and separately, so if one attorney is unavailable, the other would be able to act.

IMPORTANT: If you have named more than one attorney, do you want them to have the authority to make decisions together AND separately from one another, i.e. jointly and severally? Yes ◯ No ◯

Your appointed attorney may not be willing or able to act on your behalf because of refusal, resignation, death, mental incapacity or removal by the court. Your substitute attorney will have the same authority and powers as the attorney he or she replaces.

Substitute Attorney

Name: Age

Address:

The law allows you to limit your attorney's authority. For example, you may limit your attorney to transactions concerning specific assets, such as your bank accounts, or prohibit him or her from dealing with a particular piece of property.

THINK CAREFULLY before you limit the scope of your attorney's authority. If your attorney does not have full authority, it may be necessary for your attorney or someone else to be appointed as your guardian in order to manage the balance of your property.

Conditions and Restrictions.(OPTIONAL)

You *may* put conditions and restrictions on your power of attorney if you wish. However, *you are not required* to put anything in this section.

This document will give your attorney legal authority as soon as it is signed and witnessed unless you specify otherwise in this form. This does not prevent you from looking after your own affairs while you are still capable of doing so.

DATE OF EFFECTIVENESS

Upon signing Yes ◯ No ◯

If No, upon incapacity determined by a medical doctor.

Please note that acting as an attorney under a Continuing Power of Attorney for Property for an incapable person can involve considerable time and effort. In recognition of the time spent and the care taken to manage an incapable person's property, Ontario laws provide that compensation (or an allowance) may be payable to your attorney.

COMPENSATION

Do you wish for your attorney to receive compensation for any work done on your behalf? Yes ◯ No ◯

BEFORE YOU SIGN, be sure that:

1. You understand the authority your attorney may have;
2. You trust your attorney to act responsibly and follow any instructions you may provide
3. You are giving this power of attorney of your own free will.
4. You have carefully considered advice you may have received from trusted advisors.

Power of Attorney for PERSONAL CARE
QUESTIONNAIRE

Please Read this Section Carefully

The *Substitute Decisions Act* allows you to appoint someone you trust, in advance, to make decisions for you if you become mentally incapable. If you decide to appoint an attorney for personal care, it is important that you do so of your own free will, without pressure from anyone else. To appoint an attorney for personal care, ***you must be 16 years of age or more*** and have the mental ability to know whether your attorney truly cares about you and that he or she may make personal care decisions for you if necessary.

Certain people are NOT allowed to be your attorney. Do not appoint anyone who provides you with health care or residential, social, training, advocacy, or support services for compensation, unless that person is also your spouse, partner or relative.

Decisions about personal care involve things such as where you live, what your nutrition, and the kind of medical treatment you receive. Your attorney may become responsible for profoundly important decisions about your well-being and quality of life. The person you appoint should be someone you know very well and trust completely with your personal decisions. Your attorney must be 16 years of age or more.

Your Full Name: _____

Address: _____

Date of Birth: _____

Telephone: Home: _____ Work: _____

You can name more than one person to be your attorney for personal care, however, you are **not required** to do so.

Power of Attorney to be granted to *(Please print)***:**

Name: _____ Age _____

Address: _____

If you appoint more than one attorney, *your attorneys will be required to make every decision together all the time*, unless you instruct that they may act "jointly and severally". In other words, they may act together and separately, so if one attorney is unavailable, the other would be able to act.

2nd Attorney (OPTIONAL): _____ Age _____

Address: _____

IMPORTANT: If you have named more than one attorney, do you want them to have the authority to make decisions together AND separately from one another, i.e. jointly and severally? Yes ◯ No ◯

Your appointed attorney may not be willing or able to act on your behalf because of refusal, resignation, death, mental incapacity or removal by the court. Your substitute attorney will have the same authority and powers as the attorney he or she replaces.

Substitute Attorney

Name: _____ Age _____

Address: _____

Your attorney will have the authority to make decisions about **any** category of your personal care if you are mentally incapable. Although you may limit your attorney(s) to specific categories of personal care by stating instructions, conditions and restrictions, think carefully before you do so.
It may be necessary for the Court to appoint a guardian for a particular area if your attorney does not have the authority to decide for you.

Instructions, Conditions and Restrictions. (OPTIONAL)

You may, if you wish, give your attorney(s) instructions about specific decisions that you want made in certain circumstances. If you do not provide instructions, your attorney(s) will make decisions according to what he or she believes is in your best interest at the time. **One** type of instruction you can make concerns declining certain treatment, such as artificial life support, in the event of terminal illness. (Attach separate sheet if space below is insufficient.)

You may have already completed an organization's form in which you recorded your choices about medical treatment. You may wish to attach it to your power of attorney. If so, please indicate this in the space provided.

DATE OF EFFECTIVENESS: The Power of Attorney for Personal Care only becomes effective once you have been declared mentally incapable.

BEFORE YOU SIGN, be sure that:

1. You understand the authority your attorney may have;
2. You trust your attorney to act responsibly and follow any instructions you may provide
3. You are giving this power of attorney of your own free will.
4. You have carefully considered advice you may have received from trusted advisors.

Power of Attorney for PERSONAL CARE

Your Power of Attorney for Personal Care allows you to set out your wishes regarding refusal or consent to specific treatments and personal care.

Please refer below to clauses that you should consider inserting into your Power of Attorney for Personal Care.

Kindly indicate which clause below that you would like to have inserted into your Power of Attorney for Personal Care. If you wish to use clause 2, kindly check off your consent or refusal of each specific treatment choice that apply to you.

1. **If I am terminally ill or in a vegetative state, I do not wish to use life prolonging measures that will only delay the inevitable occurrence of my death. To me, an early, easy death is preferable to extra months of life so filled with deterioration, dependence and demeaning pain and suffering that they are not really life.**

I would like to have this clause inserted into my Power of Attorney for Personal Care

Yes ○ No ○

or

2. **If I am suffering from a terminal condition, or become permanently unconscious, or am in a persistent vegetative state, I want only treatment that will keep me as comfortable and as free from pain as possible. In particular (*check only those that apply to you; if you are aware of other specific treatment choices that are relevant to you, please add them to the list*):**

IF I AM IN A TERMINAL CONDITION:

I DO ○	I DO NOT ○	want cardiac resuscitation
I DO ○	I DO NOT ○	want mechanical respiration
I DO ○	I DO NOT ○	want nutrition (food) or hydration (water) by tubes
I DO ○	I DO NOT ○	want blood or blood products
I DO ○	I DO NOT ○	want surgery or invasive test
I DO ○	I DO NOT ○	want antibiotics

IF I AM PERMANENTLY UNCONSCIOUS:

I DO ○	I DO NOT ○	want cardiac resuscitation
I DO ○	I DO NOT ○	want mechanical respiration
I DO ○	I DO NOT ○	want nutrition (food) or hydration (water) by tubes
I DO ○	I DO NOT ○	want blood or blood products
I DO ○	I DO NOT ○	want surgery or invasive tests
I DO ○	I DO NOT ○	want antibiotics

IF I AM IN A PERSISTENT VEGETATIVE CONDITION:

I DO ○	I DO NOT ○	want cardiac resuscitation
I DO ○	I DO NOT ○	want mechanical respiration
I DO ○	I DO NOT ○	want nutrition (food) or hydration (water)
I DO ○	I DO NOT ○	want blood or blood products
I DO ○	I DO NOT ○	want surgery or invasive tests
I DO ○	I DO NOT ○	want antibiotics

I would like to have this clause inserted into my Power of Attorney for Personal Care

Yes ○ No ○

To return your completed information, please click the SAVE AS ... icon below to save the document to your system ...

... then click the SUBMIT button to return forms to our office