LIVING TRUST PREPARATION AND FILING SERVICE AGREEMENT

I/We____ the Client(s), hereby apply to CAPA to purchase a _____REVOCABLE LIVING TRUST SERVICE or a _____IRREVOCABLE LIVING TRUST SERVICE.

Client(s) understand that CAPA will prepare a _____SINGLE TRUST, a _____HUSBAND AND WIFE TRUST.

OTHER TRUST____, _______________________________________

Insert type of OTHER TRUST   Insert name of LIVING TRUST

CAPA LIVING TRUST SERVICE consist of preparing the following trust documents, POUR-OVER WILL, DURABLE POWER OF ATTORNEY FOR HEALTH CARE, DURABLE POWER OF ATTORNEY FOR FINANCIAL DECISIONS, CERTIFICATION OF TRUST, OR ABSTRACT OF TRUST, SUCCESSOR TRUSTEE'S FINAL INSTRUCTION, SUCCESSOR TRUSTEE(S) STEPS IN SETTLING THE ESTATE.

Client(s) acknowledges that CAPA will prepare Trust Transfer Deed(s) and assist in transferring Client(s) properties (assets) into Clients(s) trust, Client(s) may be required to furnish his own transfer deed or transfer instrument, depending on the availability of the instrument, state laws or complications in transferring such instrument. CAPA will transfer only those properties in which the client(s) has cleared title or ownership interest and for which Client(s) has requested a transfer. Transferring out-of-state properties is the responsibility of the Clients(s) unless arrangements are made to the contrary. Service does not include filing fees, state fees, notary fees or any other fees.

Client(s) understand and agree that financial counseling is limited to answering question pertaining to the above service. All other financial counseling and financial services offered by CAPA are Optional Services to Client(s) and will require additional fees. The above service shall be completed within (45) days after CAPA receives full payment (15) if it is expedited. Upon completion of the above service CAPA will deliver the Trust by mail to the address provided by Client(s). Client(s) is responsible for validating all signatures required by law including witnesses.

Client(s) agree to pay CAPA for the above service according to the fees and terms of the invoice attached hereto and made a part of this agreement. Client(s) understand and agree that all transactions are final and there are no refunds. Client(s) also understand and agree that if all fees are not paid within 90 days of the terms of the attached invoice, Client(s) services will be terminated and will require all new fees if Client(s) wish to acquire new services.

Client(s) further understands that any deposits paid to CAPA are non-refundable. Should Client(s) default in any balance due and owing to CAPA, Client(s) shall pay any additional charges in addition to the balance owing, including any interest charges thereon incurred, any legal fees which may be incurred in the process of CAPA collecting on said balance with may be due and owing.

Client(s) understand that CAPA may retain outside agents to process the above services. CAPA and its agent is acting on Client's(s) behalf, only for preparing and filing the above Living Trust documents and not in a legal capacity. An attorney should be consulted for legal matters. Client(s) understand that the person negotiating this document is an Independent Contractor and not an Agent or Representative of CAPA.

CLIENT(S) IS ADVISED TO PAY BY CHECK, CREDIT CARD OR ELECTRONIC FUNDS TRANSFER ONLY, MADE PAYABLE TO CAPA.

Client(s) will hold CAPA and its Agent harmless from any suits and all litigation and indemnify them from any loss whatsoever kind, directly or indirectly sustained through legal process of the above Living Trust services.

_______________________________________   _______________________________________

CLIENT   DATE

_______________________________________   __________________________/____________

CAPA: CORPORATE AMERICAN PLANNING ASSOCIATION

Living Trust Package Clients Information

Section 1. General Trust Information

Full Name____ SSN._______________________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Spouse Name____ SSN._______________________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Single_____ Married_____ Widowed_____ Divorced_____

List Children (if any):

Name____ M____ F____ Date of Birth_______________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Name____ M____ F____ Date of Birth_______________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Name____ M____ F____ Date of Birth_______________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Name____ M____ F____ Date of Birth_______________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Name____ M____ F____ Date of Birth_______________________________
Address____ City____
State___________________________ Zip code___________________ Phone #._________________________________

Section 2. Specific Trust Information

HOW DO YOU WANT YOUR ESTATE (PROPERTY) DISTRIBUTED?

1. Name__________________________________ Relationship_______________ Property_____________________________
____

2. Name__________________________________ Relationship_______________ Property_____________________________
____

3. Name__________________________________ Relationship_______________ Property_____________________________
____

4. Name__________________________________ Relationship_______________ Property_____________________________
____

5. Name__________________________________ Relationship_______________ Property_____________________________
____

6. Name__________________________________ Relationship_______________ Property_____________________________
____

7. Name__________________________________ Relationship_______________ Property_____________________________
____

8. Name__________________________________ Relationship_______________ Property_____________________________
____

Section 3. Name of Initial Trustee(s) (list only if you and/or your spouse will not be the Trustees)

____

Section 4. Names of Successor Trustees

Successor Trustee(s) #1____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will be responsible for carrying out your wishes, manage and distribute your estate when you are gone.)

Successor Trustee(s) #2____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will replace the First Successor Trustee, if the First Successor Trustee is unable or unwilling to carry out your wishes.)

Successor Trustee(s) #3____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will replace the Second Successor Trustee, if the Second Successor Trustee is unable or unwilling to carry out your wishes.)

Successor Trustee(s) #4____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will replace the Third Successor Trustee, if the Third Successor Trustee is unable or unwilling to carry out your wishes.)

Section 5. Executor for Pour-Over Will (Husband or Single)

Executor #1____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will be responsible for carrying out your wishes, as stated in your will, manage and distribute your estate when you are gone.)

Executor #2____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will replace the First Executor, if the First Executor is unable or unwilling to carry out your wishes.)

Executor #3____

Address______________________________ City_________________ State_____ Zip code__________

Relationship___________________________________ Phone #._____________________________

(This person will replace the Second Executor, if the Second Executor is unable or unwilling to carry out your wishes.)

Section 5 II. Executor for Pour-Over Will (Wife)

Executor #1____

Address________________________________ City__________________ State_____ Zip code_________

Relationship______________________________________ Phone #.______________________________

(This person will be responsible for carrying out your wishes, as stated in your will, manage and distribute your estate when you are gone.)

Executor #2____

Address________________________________ City__________________ State_____ Zip code_________

Relationship______________________________________ Phone #.______________________________

(This person will replace the First Executor, if the First Executor is unable or unwilling to carry out your wishes.)

Executor #3____

Address________________________________ City__________________ State_____ Zip code_________

Relationship______________________________________ Phone #.______________________________

(This person will replace the Second Executor, if the Second Executor is unable or unwilling to carry out your wishes.)

Section 6 A. Durable Power of Attorney for Health Care Decisions (Husband or Single)

Life Support: Yes____ No____

Agent #1____

Address________________________________ City__________________ State_____ Zip code_________

Relationship______________________________________ Phone #.______________________________

(This person will make your health care decisions on your behalf should you become unable to take care of yourself.)

Agent #2____

Address________________________________ City__________________ State_____ Zip code_________

Relationship______________________________________ Phone #.______________________________

(This person will replace the First Agent, if the First Agent is unable or unwilling to carry out your wishes.)

Agent #3____

Address________________________________ City__________________ State_____ Zip code_________

Relationship______________________________________ Phone #.______________________________

(This person will replace the Second Agent, if the Second Agent is unable or unwilling to carry out your wishes.)

Section 6 B. Durable Power of Attorney for Health Care Decisions (Wife)

Life Support: Yes____ No____

Agent #1____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #._______________________________________

(This person will make your health care decisions on your behalf should you become unable to take care of yourself.)

Agent #2____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #._______________________________________

(This person will replace the First Agent, if the First Agent is unable or unwilling to carry out your wishes.)

Agent #3____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #._______________________________________

(This person will replace the Second Agent, if the Second Agent is unable or unwilling to carry out your wishes.)

Section 7 A. Durable Power of Attorney for Financial Decisions (Husband or Single)

Attorney in Fact #1____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #._______________________________________

(This person will make your financial decisions on your behalf should you become unable to take care of yourself and manage your property.)

Attorney in Fact #2____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #._______________________________________

(This person will replace the First Attorney in Fact, if the First Attorney in Fact is unable or unwilling to carry out your wishes.)

Attorney in Fact #3____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #._______________________________________

(This person will replace the Second Attorney in Fact, if the Second Attorney in Fact is unable or unwilling to carry out your wishes.)

Section 7 B. Durable Power of Attorney for Financial Decisions (Wife)

Attorney in Fact #1____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #.______________________________________

(This person will make your financial decisions on your behalf should you become unable to take care of yourself and manage your property.)

Attorney in Fact #2____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #.______________________________________

(This person will replace the First Attorney in Fact, if the First Attorney in Fact is unable or unwilling to carry out your wishes.)

Attorney in Fact #3____

Address____ City______________________ State______ Zip code_____________

Relationship____ Phone #.______________________________________

(This person will replace the Second Attorney in Fact, if the Second Attorney in Fact is unable or unwilling to carry out your wishes.)

Section 8. Stocks and Bonds (Government or Other)

Company or Agency Name____

Address____ City______________________ State______ Zip code_____________

Stocks__________________________ Bonds________________________ Number of Shares or Bonds__________________

Certificate Numbers____

Company or Agency Name____

Address____ City______________________ State______ Zip code_____________

Stocks__________________________ Bonds________________________ Number of Shares or Bonds__________________

Certificate Numbers____

Company or Agency Name____

Address____ City______________________ State______ Zip code_____________

Stocks__________________________ Bonds________________________ Number of Shares or Bonds__________________

Certificate Numbers____

Company or Agency Name____

Address____ City______________________ State______ Zip code_____________

Stocks__________________________ Bonds________________________ Number of Shares or Bonds__________________

Certificate Numbers____

Section 9. Money Invested in Mortgages and Personal Loans You Made (Money Someone Owes You)

Mortgage________________ Personal Loan________________ Amount Invested and/or Loaned______________________

Name of Person Owing You____

Address____ City______________________ State______ Zip code_____________

Stocks_________________________ Bonds________________________ Number of Shares or Bonds_________________

Mortgage________________ Personal Loan________________ Amount Invested and/or Loaned______________________

Name of Person Owing You____

Address____ City______________________ State______ Zip code_____________

Stocks_________________________ Bonds________________________ Number of Shares or Bonds_________________

Mortgage________________ Personal Loan________________ Amount Invested and/or Loaned______________________

Name of Person Owing You____

Address____ City______________________ State______ Zip code_____________

Stocks_________________________ Bonds________________________ Number of Shares or Bonds_________________

Section 10. Cash (Checking & Saving Accounts)

Bank Name____

Address____ City______________________ State______ Zip code_____________

Account Number____

If Joint Account, With Whom____

Bank Name____

Address____ City______________________ State______ Zip code_____________

Account Number____

If Joint Account, With Whom____

Bank Name____

Address____ City______________________ State______ Zip code_____________

Account Number____

If Joint Account, With Whom____

Bank Name____

Address____ City______________________ State______ Zip code_____________

Account Number____

If Joint Account, With Whom____

Bank Name____

Address____ City______________________ State______ Zip code_____________

Account Number____

If Joint Account, With Whom____

Section 11. Special Needs Trust Provision

Name/Relationship	Percent of Estate To be Held in Trust	Special Need
______________________________	__________	________________________
______________________________	__________	________________________
______________________________	__________	________________________

Section 12. Child's Trust Provision

Name/Relationship	Percent of Estate To be Held in Trust	Special Need
______________________________	__________	________________________
______________________________	__________	________________________
______________________________	__________	________________________

Section 13. Miscellaneous Instruction

____

____

____

____

____

____

____

____

______________________________ ______________________

Signature Date

______________________________ ______________________

Signature Date

ATTACHMENT TO TRUST QUESTIONER

Medical Decision

1. Granting Powers to Your Health Care Agent:

Would you like your agent to have the power to direct that artificially administered food and water be withdrawn or withheld? Yes_____ or No_____

2. Organ, Tissue or Body Donation:

Do you want to give your agent the authority to carry out your wishes for organ, tissue or body donation after your death? Yes_____ or No_____

3. Authorizing an Autopsy:

Choose the statement that best expresses your wishes

_____I consent to an autopsy
_____I do not consent to an autopsy
_____My agent may give or refuse consent to an autopsy

4. Burial or Cremation:

Choose the statement that best expresses your preference.

_____I have already made arrangement on my burial or cremation.
_____I want my agent to decide on by burial or cremation.
_____I do not authorize my agent to make decision about my burial or cremation.

5. Specifying Your Health Care Wishes:

I want to specify my wishes for medical treatment.

_____I want to specify my wishes for medical treatment.
_____I understand that my agent will make decisions for me on matters I do not address.
_____I want my agent to make all treatment decisions for me.

6. Making Treatment Choices:

If you are sure that your wishes are simple you may select either of the following.

_____I do not want my life prolonged in either of these situations.
_____I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

If you are not sure what types of care you want, or if your wishes differ depending on the circumstances select the following:

_____I would like to express my treatment choices for each situation separately.

7. FOOD AND WATER:

IF YOU CHOOSE THAT YOU DO NOT WANT YOUR LIFE PROLONGED IF YOU ARE CLOSE TO DEATH FROM A MEDICAL CONDITION, OR PERMANENTLY UNCONSCIOUS, YOU MAY INDICATE WHETHER OR NOT YOU WANT TO RECEIVE ARTIFICIALLY ADMINISTERED FOOD AND WATER UNDER THESE CIRCUMSTANCES.

CHOOSE THE OPTION THAT BEST MATCHES YOUR WISHES:

_____I DO NOT WANT ARTIFICIALLY ADMINISTERED FOOD AND WATER

_____I WANT ARTIFICIALLY ADMINISTERED FOOD AND WATER

8. OTHER WISHES:

IF YOU DO NOT WANT TO ADD ANY FURTHER INSTRUCTIONS, LEAVE THE BOXES UNCHECKED.

_____LOCATION OF CARE

_____PALLIATIVE CARE

_____PAIN RELIEF EXCEPTIONS

_____PERSONAL OR RELIGIOUS VALUES

_____ANY OTHER WISHES OR STATEMENTS

IF YOU CHECK NUMBER FIVE, YOU MUST SPECIFY YOUR OTHER WISHES.

9. ORGAN DONATION:

CHOOSE THE STATEMENT BELOW THAT BEST EXPRESSES YOUR PREFERENCES.

_____I HAVE ALREADY MADE ARRANGEMENT FOR ORGANS, TISSUE OR BODY DONATION.

_____I WANT TO LEAVE INSTRUCTIONS REGARDING MY ORGANS, TISSUE OR BODY DONATION. I DO NOT WANT TO DONATE MY ORGANS, TISSUE OR BODY AFTER MY DEATH.

_____I WANT MY AGENT TO DECIDE WHETHER OR NOT TO DONATE MY ORGANS, TISSUE OR BODY AFTER MY DEATH.

IF YOU CHECK NUMBER ONE, YOU MUST SPECIFY YOUR DONATION ARRANGEMENT.

10. FINALIZING YOUR HEALTH CARE DOCUMENT:

WHO WILL SIGN THE HEALTH CARE DOCUMENTS? ____

SELECT THE METHOD OF FINALIZATION YOU WANT TO USE.

_____I WILL HAVE THE DOCUMENT NOTARIZED.

_____I WILL HAVE TWO WITNESS SIGN THE DOCUMENT.

ATTORNEY-IN-FACT FINANCIAL DECISION

1. DO YOU WANT TO GIVE YOUR ATTORNEY-IN-FACT THE POWER OVER THE FOLLOWING?

*CONDUCT REAL ESTATE TRANSACTION FOR YOU?

______YES ______YES, BUT MY ATTORNEY-IN-FACT MAY NOT SELL MY HOME ______NO

*YOUR TANGIBLE PERSONAL PROPERTY: ______YES ______NO

*SECURITIES TRANSACTIONS: ______YES ______NO

*BANKING TRANSACTION: ______YES ______NO

*MAKE BUSINESS DECISIONS FOR YOU: ______YES ______NO

*HANDLE INSURANCE AND ANNUITY MATTERS: ______YES ______NO

*CONDUCT ESTATE, TRUST AND OTHER BENEFICIARY TRANSACTIONS ON YOUR BEHALF: ______YES ______NO

*TRANSFER IT EMS OF YOUR PROPERTY INTO YOUR LIVING TRUST: ______YES ______NO

*HANDLE LEGAL ACTIONS FOR YOU: ______YES ______NO

*PERMISSION TO SPEND MONEY TO TAKE CARE OF YOU AND YOUR FAMILY: ______YE ______NO

*CONDUCT TRANSACTIONS INVOLVING GOVERNMENT BENEFITS: ______YES ______NO

*CONDUCT RETIREMENT PLAN TRANSACTIONS: ______YES ______NO

*DEAL WITH YOUR TAXES: ______YES ______NO

*MAKE GIFTS:

______YES, I WANT TO GIVE MY ATTORNEY-IN-FACT TIE POWER TO MAKE GIFTS OF MY PROPERTY, AS I SPECIFY NEXT.

______NO, I DO NOT WANT MY ATTORNEY-IN-FACT TO MAKE GIFTS OF MY PROPERTY

*DO YOU WANT TO AUTHORIZE YOUR ATTORNEY-IN-FACT TO MAKE GIFTS TO HIMSELF OR HERSELF? ______YES ______NO

IF YOU CHECK YES SPECIFY A DOLLAR AMOUNT. ________________

*DO YOU ALSO WANT TO AUTHORIZE YOUR ALTERNATE ATTORNEY-IN-FACT TO MAKE GIFTS OF YOUR PROPERTY TO HLMSELF OR HERSELF? IF YOU NAMED MORE THAN ONE ATTORNEY-IN-FACT, YOUR ANSWER WILL APPLY TO EACH OF THEM:

______YES ______NO

2. AUTHORIZING GIFTS TO OTHER PEOPLE.

DO YOU AUTHORIZE YOUR ATTORNEY-IN-FACT TO GIVE YOUR PROPERTY TO OTHER PEOPLE AND/ORGANIZATION?

______YES, TO ANYONE MY ATTORNEY-IN-FACT CHOOSES.

______YES, BUT ONLY TO THE PEOPLE AND ORGANIZATION I NAME.

______No