

DATE: _____, 20____

FILE NO.: _____

GRANT OF PROBATE QUESTIONNAIRE

APPLYING PERSONAL REPRESENTATIVE(S)/EXECUTOR(S)	
Full Name(s) *	
Address	
Phone Number	
Email Address	
Relationship to deceased	
Full Name(s) *	
Address	
Phone Number	
Email Address	
Relationship to deceased	

* If any of the above listed Personal Representative(s)/Executor(s) are known by any other name(s), please list all name(s) of that Personal Representative(s)/Executor(s) in the space provided.

THE DECEASED			
Full Name(s) *			
Last Place of Residence			
Date of Birth		Place of Birth	
Date of Death		Place of Death	
Marital Status at the Time of Death	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Adult Interdependent Partner (AIP)**		
Prior to the deceased's death was an Enduring Power of Attorney in effect for the deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please fill in the following information regarding the Attorney appointed under the Enduring Power of Attorney:			
Full Name of the Attorney			
Address of the Attorney			
Phone Number of the Attorney			

* If the Deceased was known by any other name(s), please list all name(s) of the Deceased in the space provided.

** Adult Interdependent Partner is a person that had:

- (a) been in a relationship of interdependence with the Deceased for a continuous period of not less than three (3) years; *** or
- (b) been in a relationship of interdependence of some permanence with the Deceased of which there is a child born; *** or
- (c) executed an Adult Interdependent Partnership Agreement with the Deceased.

*** A relationship of interdependence means a relationship outside marriage in which any two (2) persons:

- (a) share one another’s lives,
- (b) are emotionally committed to one another, and
- (c) function as an economic and domestic unit.

SPOUSE OF THE DECEASED AT TIME OF DEATH			
Full Name(s) *			
Address			
Email Address		Phone No.	
Date of Birth		Date of Death	
Mentally Capable? **	<input type="checkbox"/> Yes <input type="checkbox"/> No		
FORMER SPOUSE OF THE DECEASED			
Full Name(s) *			
Address			
Email Address		Phone No.	
Date of Birth		Date of Death	
Date of Divorce		<input type="checkbox"/> Divorce Judgment/Separation Agreement	
ADULT INTERDEPENDENT PARTNER (AIP) OF THE DECEASED **			
Full Name(s) *			
Address			
Email Address		Phone No.	
Date of Birth		Date of Death	
Date Relationship Began		Date Relationship Ended	
Mentally Capable? **	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was an Adult Interdependent Partner Agreement in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the Adult Interdependent Partner related to the Deceased by blood or adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No			

* If the Spouse, Former Spouse, and/or the Adult Interdependent Partner are known by any other name(s), please list all name(s) of the Spouse, Former Spouse, and/or the Adult Interdependent Partner, as the case may be, in the space provided.

** Adult Interdependent Partner is a person that had:

- (a) been in a relationship of interdependence with the Deceased for a continuous period of not less than three (3) years; *** or
- (b) been in a relationship of interdependence of some permanence with the Deceased of which there is a child born; *** or
- (c) executed an Adult Interdependent Partnership Agreement with the Deceased.

*** A relationship of interdependence means a relationship outside marriage in which any two (2) persons:

- (a) share one another’s lives,
- (b) are emotionally committed to one another, and

(c) function as an economic and domestic unit.

CHILDREN OF THE DECEASED				
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age	Date of Death	
Check all that apply	<input type="checkbox"/> Child of Spouse	<input type="checkbox"/> Child of Former Spouse	<input type="checkbox"/> Child of AIP ***	
	<input type="checkbox"/> Full-Time Post-Secondary Student	<input type="checkbox"/> Dependent Adult **	<input type="checkbox"/> Died leaving Children	
Full Name(s) *				
Address				
Email Address			Phone .No.	
Date of Birth		Age	Date of Death	
Check all that apply	<input type="checkbox"/> Child of Spouse	<input type="checkbox"/> Child of Former Spouse	<input type="checkbox"/> Child of AIP ***	
	<input type="checkbox"/> Full-Time Post-Secondary Student	<input type="checkbox"/> Dependent Adult **	<input type="checkbox"/> Died leaving Children	
Full Name(s) *				
Address				
Email Address			Phone. No.	
Date of Birth		Age	Date of Death	
Check all that apply	<input type="checkbox"/> Child of Spouse	<input type="checkbox"/> Child of Former Spouse	<input type="checkbox"/> Child of AIP ***	
	<input type="checkbox"/> Full-Time Post-Secondary Student	<input type="checkbox"/> Dependent Adult **	<input type="checkbox"/> Died leaving Children	
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age	Date of Death	
Check all that apply	<input type="checkbox"/> Child of Spouse	<input type="checkbox"/> Child of Former Spouse	<input type="checkbox"/> Child of AIP ***	
	<input type="checkbox"/> Full-Time Post-Secondary Student	<input type="checkbox"/> Dependent Adult **	<input type="checkbox"/> Died leaving Children	

* If the Children of the Deceased are known by any other name(s), please list all name(s) of the Children of the Deceased, in the space provided.

** Please check this box if the adult Child is unable to earn a livelihood by reason of mental or physical disability. If a certificate of incapacity has been issued for the adult Child, please provide the details in the notes at the end of the Questionnaire. If there is a Guardianship Order and/or a Trusteeship Order in place for the adult Child, please provide the details, including who the appointed Guardian and/or Trustee is, in the notes at the end of the Questionnaire. If an Enduring Power of Attorney and/or a Personal Directive has been enacted for the adult Child, please provide the details, including who the appointed Attorney(s) and/or Agent(s) are, in the notes at the end of the Questionnaire.

If there is a concern that any minor Child of the deceased will be unable to earn a livelihood when they become an adult by reason of a current mental or physical disability, please provide the details of said disability in the notes at the end of the Questionnaire.

*** Adult Interdependent Partner is a person that had:

- (a) been in a relationship of interdependence with the Deceased for a continuous period of not less than three (3) years; **** or
- (b) been in a relationship of interdependence of some permanence with the Deceased of which there is a child born; **** or
- (c) executed an Adult Interdependent Partnership Agreement with the Deceased.

**** A relationship of interdependence means a relationship outside marriage in which any two (2) persons:

- (a) share one another’s lives,
- (b) are emotionally committed to one another, and
- (c) function as an economic and domestic unit.

THE DECEASED’S GRANDCHILDREN OR GREAT GRANDCHILDREN				
Full Name(s) *				
Address				
Email			Phone No.:	
Date of Birth		Age	<input type="checkbox"/> Dependent on Deceased**	
Check all that apply		<input type="checkbox"/> Grandchild <input type="checkbox"/> Great Grandchild	Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Name(s) *				
Address				
Email			Phone No.:	
Date of Birth		Age	<input type="checkbox"/> Dependent on Deceased**	
Check all that apply		<input type="checkbox"/> Grandchild <input type="checkbox"/> Great Grandchild	Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Name(s) *				
Address				
Email			Phone No.:	
Date of Birth		Age	<input type="checkbox"/> Dependent on Deceased**	
Check all that apply		<input type="checkbox"/> Grandchild <input type="checkbox"/> Great Grandchild	Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Name(s) *				
Address				
Email			Phone No.:	
Date of Birth		Age	<input type="checkbox"/> Dependent on Deceased**	
Check all that apply		<input type="checkbox"/> Grandchild <input type="checkbox"/> Great Grandchild	Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No	
Full Name(s) *				
Address				
Email			Phone No.:	
Date of Birth		Age	<input type="checkbox"/> Dependent on Deceased**	
Check all that apply		<input type="checkbox"/> Grandchild <input type="checkbox"/> Great Grandchild	Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No	

Date of Birth		Age		<input type="checkbox"/> Dependent on Deceased**
Check all that apply	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Great Grandchild		Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name(s) *				
Address				
Email				Phone No.:
Date of Birth		Age		<input type="checkbox"/> Dependent on Deceased**
Check all that apply	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Great Grandchild		Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name(s) *				
Address				
Email				Phone No.:
Date of Birth		Age		<input type="checkbox"/> Dependent on Deceased**
Check all that apply	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Great Grandchild		Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name(s) *				
Address				
Email				Phone No.:
Date of Birth		Age		<input type="checkbox"/> Dependent on Deceased**
Check all that apply	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Great Grandchild		Mentally Capable? *** <input type="checkbox"/> Yes <input type="checkbox"/> No

*** Grandchildren or Great Grandchildren that are dependent on the Deceased are Grandchildren or Great Grandchildren of the Deceased that are:**

- (a) under the age of eighteen (18) years of age at the time of the Deceased’s death;
- (b) treated by the Deceased with a settled intention to treat the Grandchild or the Great Grandchild as his or her own child;
- (c) whose primary home, since birth or for at least two (2) years immediately before the Deceased’s death was living with the Deceased; and
- (d) whose primary financial support, since birth or for at least two (2) years immediately before the Deceased’s death, was provided by the Deceased.

If there is a concern that any minor Grandchild or Great Grandchild that is dependent on the deceased will be unable to earn a livelihood when they become an adult by reason of a current mental or physical disability, please provide the details of said disability in the notes at the end of the Questionnaire.

** If any of the Grandchildren or Great Grandchildren that are dependent on the Deceased are known by any other name(s), please list all the name(s) of said Grandchildren or Great Grandchildren, as the case may be, in the space provided.

ALL BENEFICIARIES NAMED IN THE WILL (AS WELL AS IN ANY CODICILS TO THE WILL)				
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		
Full Name(s) *				
Address				
Email Address			Phone No.	
Date of Birth		Age		Date of Death
Relationship		Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No		

Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				
Full Name(s) *					
Address					
Email Address				Phone No.	
Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				
Full Name(s) *					
Address					
Email Address				Phone No.	
Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				
Full Name(s) *					
Address					
Email Address				Phone No.	
Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				
Full Name(s) *					
Address					
Email Address				Phone No.	
Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				
Full Name(s) *					
Address					
Email Address				Phone No.	
Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				
Full Name(s) *					
Address					
Email Address				Phone No.	
Date of Birth		Age		Date of Death	
Relationship	Mentally Capable? ** <input type="checkbox"/> Yes <input type="checkbox"/> No				

*** If any of the Beneficiaries are known by any other name(s), please list all name(s) of the said Beneficiaries in the space provided.**

**** Please check “No” if the Beneficiary is a represented adult or is an incapacitated person. A represented adult is an adult for whom a Guardianship Order and/or a Trusteeship Order has been granted. An incapacitated person is a person who is the subject of a certificate of incapacity that is in effect. If there is a Guardianship Order and/or a Trusteeship Order in place for the adult Beneficiary, please indicate this in the notes at the end of the Questionnaire. If an Enduring Power of Attorney and/or a Personal Directive has been enacted for the adult Beneficiary please provide the details in the notes at the end of the Questionnaire.**

DECEASED’S ASSETS AND LIABILITIES LOCATED IN ALBERTA		
LAND AND BUILDINGS		
Address		
Description		Owned With?
Current Fair Market Value		<input type="checkbox"/> Joint Tenants <input type="checkbox"/> Tenants in Common
Balance of Mortgage		
Address		
Description		Owned With?
Current Fair Market Value		<input type="checkbox"/> Joint Tenants <input type="checkbox"/> Tenants in Common
Balance of Mortgage		
MINE AND MINERAL RIGHTS		
Address		
Description		Owned With?
Current Fair Market Value		<input type="checkbox"/> Joint Tenants <input type="checkbox"/> Tenants in Common
Balance of Mortgage		
HOME CONTENTS AND FURNISHINGS		
Description		
Current Fair Market Value		
VEHICLES		
Description (year, make, model, VIN #)		
Current Fair Market Value		
Balance of Loan		<input type="checkbox"/> Leased <input type="checkbox"/> Owned
MISCELLANEOUS EQUIPMENT/MACHINERY		
Description (year, make, model)		
Current Fair Market Value		

TRAILER/RECREATIONAL VEHICLE/MOTORHOME			
Description (year, make, model, serial #)			
Current Fair Market Value			
Balance of Loan		<input type="checkbox"/> Leased	<input type="checkbox"/> Owned
BOAT/AIRCRAFT			
Description (year, make, model, serial #)			
Current Fair Market Value		<input type="checkbox"/> Leased	<input type="checkbox"/> Owned
Balance of Loan			
PRIVATE CORPORATION			
Name of Corporation			
Was the deceased a director of the Corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of Shares Held		Current Fair Market Value of Shares	
OTHER ASSETS (ART, JEWELRY, ANTIQUES, STAMPS, COINS, TOOLS, ETC.)			
Description			
Current Fair Market Value			
Description			
Current Fair Market Value			
Description			
Current Fair Market Value			
Description			
Current Fair Market Value			
Description			
Current Fair Market Value			
LIVESTOCK			
Description			
Current Fair Market Value			
LIFE INSURANCE			
Description and special details of the policy			
Amount		Designated Beneficiary	
RRSPs/RRIFs			
Description			

Current Fair Market Value		Designated Beneficiary	
TFSAs			
Description			
Current Fair Market Value		Designated Beneficiary	
PENSIONS			
Description			
Current Fair Market Value		Designated Beneficiary	
OTHER INVESTMENTS (SAVINGS, TERM DEPOSITS, BANK ACCOUNTS, STOCKS, BONDS, ETC.)			
Location/Name of Bank			
Description		Joint with:	
Account Number			
Amount			
Location/Name of Bank			
Description		Joint with:	
Account Number			
Amount			
Location/Name of Bank			
Description		Joint with:	
Account Number			
Amount			
Location/Name of Bank			
Description		Joint with:	
Account Number			
Amount			
Location/Name of Bank			
Description		Joint with:	
Account Number			
Amount			
ASSETS HELD IN TRUST FOR CHILDREN			
Location			
Description		Name of Beneficiary	
Amount			
DEBTS (CREDIT CARDS, LINES OF CREDIT, BANK LOANS, INCOME TAXES, LOANS FROM THIRD PARTIES, PERSONAL GUARANTEES, ETC.)			
Description			

Amount	
Description	
Amount	
Description	
Amount	
Description	
Amount	
Description	
Amount	
Description	
Amount	
Description	
Amount	
Description	
Amount	

Any assets and/or liabilities located outside of Alberta? If yes, please describe.

Additional Notes: