CONFIDENTIAL DATA

DATE: _____

	Husband	Wife
Full Name		
Other Names Used		
Home Address		
Employer or Firm		
Occupation		
Business Address		
Email Address		
Facsimile No.		
Phone: Home (1)	(1)	(1)
Business (2)	(2)	(2)
Cell (3)	(3)	(3)
Birth: Date (1)	(1)	(1)
Place (2)	(2)	(2)
Citizenship		
Social Security No.		
Date of Marriage		
Place of Marriage		
Domicile at Marriage		
Military Service		
(Dates, Rank		
Serial No.		
Prior Marriages:		
Former Spouse		
Terminated by:	Death ___Divorce___On_____	Death ___Divorce___On_____
Divorce Obligations to or from Former Spouse:		
Child Support		
Alimony		
Life Insurance		
Other		

A copy of your separation agreement and divorce decree, including amending decrees, should accompany this data sheet.

Children and Deceased Children (*Indicate if Adopted ("A") or if child only of husband ("H") or wife ("W")).

	1.	2.
Name		
Date of Birth		
Place of Birth		
Address (if other than yours)		
Home Telephone		
Business Telephone		
Cell Telephone		
Present or Past Occupation		
Social Security No.		
Spouse's Name		
Date of Marriage		
Spouse's Present or Past Occupation		
Children of This Child (Name/Birth Date)	( )	( )
	( )	( )
	( )	( )
	( )	( )

	3.	4.
Name		
Date of Birth		
Place of Birth		
Address (if other than yours)		
Home Telephone		
Business Telephone		
Cell Telephone		
Present or Past Occupation		
Social Security No.		
Spouse's Name		
Date of Marriage		
Spouse's Present or Past Occupation		
Children of This Child (Name/Birth Date)	( )	( )
	( )	( )
	( )	( )
	( )	( )

Husband's Parents	Address	Age (or date of death)

Husband's Brothers and Sisters	Address	Age (or date of death)

Wife's Parents	Address	Age (or date of death)

Wife's Brothers and Sisters	Address	Age (or date of death)

Are there any persons (other than minor children) partially or wholly dependent upon you for support now or possibly in the future?

Are there any inheritances likely to be received by you in the future?

Any especially important (or unusual) estate planning objectives (or problems)?

Location of Safe Deposit Box _____

Names and Telephone
Numbers of:

Physicians _____

_____

_____

Accountant _____

_____

_____

Insurance Advisor _____

_____

_____

Banker _____

_____

_____

Stock Broker _____

_____

_____

Other Advisors _____

_____

_____

Whom do you wish to appoint as your Attorney-in-Fact to make financial decisions for you if you are unable to make these decisions for yourself?

Husband's Attorney-in-Fact _____
Substitute(s) _____
Second Substitute (if any) _____

Wife's Attorney-in-Fact _____
Substitute(s) _____
Second Substitute (if any) _____

Whom do you wish to appoint as your health care agent to make medical decisions for you if you are unable to make these decisions for yourself?

Husband's Health Care Agent _____
Home Address _____
Home Telephone No. _____ Work Telephone No. _____
Cell Telephone No. _____

Husband's Substitute Health Care Agent _____
Home Address _____
Home Telephone No. _____ Work Telephone No. _____
Cell Telephone No. _____

Husband's Second Substitute Health Care Agent _____

Home Address _____

Home Telephone No. _____ Work Telephone No. _____

Cell Telephone No. _____

Wife's Health Care Agent _____

Home Address _____

Home Telephone No. _____ Work Telephone No. _____

Cell Telephone No. _____

Wife's Substitute Health Care Agent _____

Home Address _____

Home Telephone No. _____ Work Telephone No. _____

Cell Telephone No. _____

Wife's Second Substitute Health Care Agent _____

Home Address _____

Home Telephone No. _____ Work Telephone No. _____

Cell Telephone No. _____

For instructions to HUSBAND'S HEALTH CARE AGENT, check only ONE in each paragraph 1-8 and complete 9 and 10:

1. Burial or Cremation. _____ Burial OR Cremation _____

2. Disposition of Remains.

   Health Care Agent _____ MAY or _____ MAY NOT direct disposition of your remains.

   If Health Care Agent MAY NOT direct, YOUR direction is _____.

3. Autopsy.

   Health Care Agent _____ MAY or _____ MAY NOT authorize an autopsy.

4. Organ Donation.

   Health Care Agent _____ MAY or _____ MAY NOT consent to a donation of all or any of your tissue or organs for transplantation.

5. Anatomical Study.

   Health Care Agent _____ MAY or _____ MAY NOT donate your entire body for anatomical study.

6. Your Condition is Incurable or Irreversible.

   _____ Withhold and Withdraw Treatment OR _____ Maintain Maximum Treatment

   If you have an incurable or irreversible condition that will result in your death within a relatively short period of time.

7. You are Unconscious and are Unlikely to Regain Consciousness.

   _____ Withhold and Withdraw Treatment OR _____ Maintain Maximum Treatment

   If you are unconscious and to a high degree of medical certainty you will never regain your consciousness.

8. You Suffer from Advanced Dementia or Other Condition.

   _____ Withhold and Withdraw Treatment OR _____ Maintain Maximum Treatment

   If you suffer from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible.

9. Artificial Nutrition and Hydration.

If I am diagnosed to be in the medical conditions described in 6, 7, and 8 above, then I direct my physician to

____ Withhold Artificial Nutrition ____ Withhold Artificial Hydration

____ Give Artificial Nutrition ____ Give Me Artificial Hydration

10. Please indicate below any limitations or restrictions you want to place on the exercise of discretion by your Health Care Agent: _____
_____
_____

For instructions to WIFE'S HEALTH CARE AGENT, check only ONE in each paragraph 1-8 and complete 9 and 10:

1. Burial or Cremation. _____ Burial OR Cremation _____

2. Disposition of Remains.

   Health Care Agent _____ MAY or _____ MAY NOT direct disposition of your remains.

   If Health Care Agent MAY NOT direct, YOUR direction is _____.

3. Autopsy.

   Health Care Agent _____ MAY or _____ MAY NOT authorize an autopsy.

4. Organ Donation.

   Health Care Agent _____ MAY or _____ MAY NOT consent to a donation of all or any of your tissue or organs for transplantation.

5. Anatomical Study.

   Health Care Agent _____ MAY or _____ MAY NOT donate your entire body for anatomical study.

6. Your Condition is Incurable or Irreversible.

   _____ Withhold and Withdraw Treatment OR _____ Maintain Maximum Treatment

   If you have an incurable or irreversible condition that will result in your death within a relatively short period of time.

7. You are Unconscious and are Unlikely to Regain Consciousness.

   _____ Withhold and Withdraw Treatment OR _____ Maintain Maximum Treatment

   If you are unconscious and to a high degree of medical certainty you will never regain your consciousness.

8. You Suffer from Advanced Dementia or Other Condition.

   _____ Withhold and Withdraw Treatment OR _____ Maintain Maximum Treatment

   If you suffer from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible.

9. Artificial Nutrition and Hydration.

If I am diagnosed to be in the medical conditions described in 6, 7, and 8 above, then I direct my physician to

____ Withhold Artificial Nutrition ____ Withhold Artificial Hydration

____ Give Me Artificial Nutrition ____ Give Me Artificial Hydration

10. Please indicate below any limitations or restrictions you want to place on the exercise of discretion by your Health Care Agent: _____

_____

_____