

END OF LIFE PLANNING

Fill out this form, adapted from a similar form from the Funeral Consumer Alliance, and send a copy to the SEF. Write "funeral" on the lower left side of the envelope. We will not open the envelope, but will store it *sealed* in a file with your name on it. No one from the SEF will look at it, unless directed by you or your designated agent. This is particularly important if you want SEF members to perform your funeral, burial service, etc. We need to know. Please, tell us.



Do Not Put This Information In A Safety Deposit Box!



VITAL STATISTICS:

Full Legal Name _____

Date Of Birth _____

Place Of Birth _____

Citizenship _____

Marital Status:

- Married Life Partner Separated Divorced
- Widow/Er Remarried Never Married

Name Of Spouse Or Partner _____

Children _____

Name And Address Of 'Ex' _____

Father's Legal Name _____

Mother's Maiden Name _____

Date This Page Was Modified _____

Military Service Dates: from ____/____/____ To ____/____/____

Military Serial Number: _____

Social Security Number: _____

WHERE ARE THE:

Advance Directives: _____

Healthcare Proxy Or Medical Power Of Attorney: _____

Living Will: _____

Designated Agent For Body Disposition Authorization: _____

Body, Organ Or Tissue Donor Information: _____

Medical Device Recycling Information: _____

Obituary Information If Not In This Booklet: _____

Will: _____

Military Discharge Papers: _____

Pre-purchased Cemetery Or Funeral Plans: _____

Social Security Information: _____

Medicare Or Medicaid Information: _____

Health Insurance: _____

Address Book: _____

Date This Page Was Modified _____

WHO IS: *(Be Sure To Include Phone Numbers)*

Next-Of-Kin Or Authorized To Sign Releases: _____

Executor: _____

Lawyer: _____

Most Trusted Friend: _____

Doctors And Their Phone Numbers:

Dentist: _____

Blood-Type And Medical Conditions Of Concern To My Family:

I Have A Pace-Maker

Other Implanted Devices: _____



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Instructions About 911

- Yes, I Want Resuscitation-Call 911
- No, I Do Not Want Resuscitation-Do Not Call 911

Further Instructions For Medical Decisions - Take Into Account The Following:

- Comfort Care Only
- Yes, I Have A Living Will
- Aggressive Pain Control Even If Death Is Hastened
- If Death Occurs At Home And Has Been Anticipated Or Expected,
Call My Personal Physician, Not 911
- If My Death Was Not Expected,
The Doctor May Ask You To Call The Medical Examiner Or Police
- Other: _____

AFTER I'M GONE. . .

Donate My Organs Or Tissues:

- Eyes Only
- Any Of Use
- Donate My Whole Body For Medical Study
- This Medical School Only: _____
- Nearest Medical School If I Die While Traveling
- My Family Knows Of And Agrees With These Wishes

I Prefer:

- Whole Body Burial
- Cremation
- I Have Signed Advance Cremation Authorization
- Cemetery (Where I Own Interment Or Inurnment Space) and phone number:

Other Disposition For Cremated Remains

- Scattering (Where): _____

- Burial (Where): _____

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Disposition Should Be Handled By:

- My Family: _____
- Religious Funeral Committee: Phone: _____
- Funeral Home: Phone: _____
- Embalming
- No Embalming
- No Viewing
- Private Viewing
- Public Viewing
- Visitation Only
- Private Family Service
- Memorial Service
- Funeral With Casket Present
- Graveside Service Only
- Religious Objection To Autopsy
- My Family Knows Of And Agrees With These Wishes

Clergy/Person To Lead Service: _____

Church Affiliation: _____

If you have questions, my funeral planning organization may be of assistance:

(phone): _____

or call the national office: _____



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PLEASE DO at my funeral / memorial service:

Include any particular readings and/or songs you want done, and anything you would like to say to attendees.

PLEASE DON'T at my funeral/memorial service:

PLAIN PINE BOX?

- I have built a plain pine box. It is located
- please use a simple alternative container
- buy a coffin of
- wood
- metal
- fiberglass
- buy the best
- buy the cheapest
- use a rental casket
- shroud only

FOR CREMATED REMAINS:

- leave remains in container from the crematory
- I already have an urn. It is located
- buy an urn
- have one made
- wood
- ceramic
- metal
- ornate
- simple

MARKING THE SPOT:

- I am eligible for a veteran's marker
- I have already purchased a marker. It's at _____
- the cemetery
- monument dealer

Inscription should read: _____

Other memorials:

- bench
- sundial
- tree
- plant
- statue



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Insurance Policies And Policy Numbers:

Life: _____

Health: _____

Long-Term Care: _____

Property: _____

Employee/Business: _____

Union: _____

Trusts: _____

Titles/Deeds/Leases: _____

Auto: _____

RV/Boat: _____

Home: _____

Other Real Estate: _____

Date This Page Was Modified _____

Banks:

Savings: _____

Checking: _____

Who Has Access: _____

Where Are Statements: _____

Securities And Investments;

Location Of Certificates: _____

Other Records: _____

Broker (S): _____

FAMILY & FRIENDS TO CONTACT:

Name:

Phone:

Date This Page Was Modified _____

Individual Retirement Accounts: _____

Retirement Benefits From Employment: _____

Deferred Annuities: _____

Safe Deposit Box:

Bank _____

Branch location _____

Key location _____

Who Has Access _____

Contents _____

Debts I Owe/Mortgages:

Date This Page Was Modified _____

Debts Owed To Me;

Credit Cards:

800 Cancellation Number:

Tax Returns For Past Six Years Are Located:

Accountant/Tax Preparer:

Contact Info:

Date This Page Was Modified _____

MISCELLANEOUS CONTACTS:

PHONE #

Therapist: _____

Hairdresser/barber (Please Cancel Standing Appointment): _____

Plumber Who Knows Where The Septic Tank Is: _____

Heating Fuel Company: _____

Electric Company: _____

Yard And Garden Helper: _____

Household Helper: _____

Veterinarian: _____

Volunteer Commitments: _____

Social Clubs To Which I Belong: _____

Date This Page Was Modified _____

NOTES:

THE LAST WORD: *Besides the information contained in the VITAL STATISTICS section, I wish this to be used for my obituary:*

Children: _____

Close Relatives: _____

Education: _____

Work/Career: _____

Community Activities: _____

Honors/Prizes: _____

Hobbies/Avocation: _____

Volunteer Activities: _____

Memorial Gifts May Be Given To: _____

Date This Page Was Modified _____

IT AIN'T OVER 'TILL IT'S OVER:

A Checklist for Survivors

- decide on time/place of funeral/memorial service
- name a suitable charity for memorial gifts if I didn't
- submit obituary with time and place of service
- notify others
- keep record of calls, visits, food, offers of help (have a friend assist with this)
- arrange hospitality for visiting relatives
- arrange childcare if needed coordinate food needed
- coordinate household chores
- notify insurance companies and social security
- notify executor and/or lawyer
- send acknowledgment of remembrances
- check debts/payments due
- if deceased was living alone, protect valuables,
take precautions against intruders
- provide for pets and houseplants
- cancel subscriptions:
newspaper, e-mail or internet accounts, credit cards, cable TV
- deal with utilities, landlord, post office, yard or household help
- recycle medical devices
(pacemaker, glasses, hearing aid, walking aids, commode, etc.)

- other _____
- _____
- _____
- _____
- _____
- _____

MASSACHUSETTS HEALTH CARE PROXY

(1) I, *(print name)* _____,

hereby appoint *(name, home address and telephone number of agent):*

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise below.

This Health Care Proxy shall take effect in the event I become unable to make or communicate my own health care decisions.

(2) Name of alternate agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent (optional):

(3) I direct my agent to make health care decisions in accord with my wishes and limitations as may be stated below, or as he or she otherwise knows. If my wishes are unknown, I direct my agent to make health care decisions in accord with what he or she determines to be my best interests.

(4) Other directions (optional):

(5) Signature: _____

Address: _____

Date: _____ ***(Important: witnesses sign next page)***

Date This Page Was Modified _____

Statement by Witnesses:

I declare that the person who signed this document appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as agent or alternate agent by this document.

Witness 1: _____

Address: _____

Date: _____

Witness 2: _____

Address: _____

Date: _____

CHOICE IN DYING LIVING WILL

I, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally' required to be specific about future treatments, if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want tube feeding.
- I do not want antibiotics.
- However, I do want maximum pain relief, even if it may hasten my death.

Other directions (insert personal instructions): _____

These directions express my legal right to refuse treatment under federal and state law. I intend my instructions to be carried out, unless I have revoked them in a new writing or by clearly indicating that I have changed my mind.

Signed: _____

Print name: _____

Address: _____

Date: _____ *(Important: witnesses sign next page)*

Date This Page Was Modified _____

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 (print name): _____

Sign: _____

Address: _____

Date: _____

Witness 2 (print name): _____

Sign: _____

Address: _____

Date: _____

June 1996

Courtesy of Choice in Dying INC

1035 30th St NW

Washington, DC 20007

(202) 338-9790

< www.choices.org >