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: ____

Do Not Put This Information In A Safety Deposit Box!

Date This Page Was Modified ____________________

Do Not Put This Information In A Safety Deposit Box!

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): ____

____

Do Not Put This Information In A Safety Deposit Box!

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: ____

Do Not Put This Information In A Safety Deposit Box!

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.

Date This Page Was Modified ____________________

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

Do Not Put This Information In A Safety Deposit Box!

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: ____

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:**

____

____

____

____

____

____

____

____

____

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)***

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)***

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** >