

ESTATE PLANNING WORKSHEET

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY	Title 10, USC, Section 3013
PRINCIPAL PURPOSE	The purpose of this form is to assist the attorney in preparing legal documents for the client, and to prepare statistical reports on legal assistance services provided during the year. The information on this form is protected by the attorney/client privilege and may be released only in accordance with law or with approval of the client.
ROUTINE USES	Information on this form will be used to provide legal advice and to prepare legal correspondence and documents for the client, and to prepare statistical reports.
DISCLOSURE	Voluntary. However, nondisclosure may preclude the legal assistance desired by the client.

ESTATE PLANNING has a lasting effect on you and your family. What you do now affects what property they may take after you die. Your estate plan may include one or more of the following: Will; Advance Medical Directive (“living will”); Durable Power Of Attorney for Health Care; Durable Power Of Attorney in case of incompetence; Life Insurance (especially beneficiary designations); a trust (possibly in your will); and an anatomical gift designation (often on your driver’s license).

A properly executed will leaves instructions to a probate court about your intended property distribution. It may provide simple instructions, or may contain a trust. A will is especially important for parents with young children. In this situation, you should name a guardian (and preferably a backup) for your children in case the natural parent also dies while the children are minors. You should consider naming a trustee to manage your property and properly invest on their behalf. Consider carefully who you trust with these important duties. You should also discuss your wishes with all of those named to ensure that they know that you named them, and what your desires are.

You must plan carefully and that requires you think about your situation, family, and desires. Don’t wait until right before you deploy or find yourself in failing health to consider this important matter. Do so now while you have the time to reflect.

This worksheet will help you organize the information your legal assistance attorney needs to advise you and prepare your estate plan. Some individuals need very complex plans that may require you to obtain assistance beyond what is available through your local legal assistance office. Your legal assistance attorney will advise you if that is necessary in your case.

Getting Started. You and your spouse, if you are married, should read and complete the attached worksheet. Please email the completed worksheet(s) to the Client Services Division prior to your appointment or bring your completed worksheet with you when you consult with your attorney.

NOTE: If both you and your spouse will see the same attorney for estate planning advice, be sure to discuss a dual representation waiver. Dual representation is not required, but frequently is more efficient, especially when both spouses have similar estate planning goals.

Instructions for Completing Estate Planning Worksheet

Step One: Complete the Client Legal Assistance Record on the top of the next page.

Step Two: Complete the Will Worksheet (pages 4-8 of this document).

Step Three: Complete the Advance Medical Directive Planning Worksheet (page 9 of this document).

Step Four: Complete the Durable General Power of Attorney For Financial Matters Worksheet (page 10 of this document).

DO NOT alter pages 11-25 of this document.

The answers you provide in Steps One through Four will be automatically inserted into pages 11-25, creating a partially completed version of your Advance Medical Directive and your Durable General Power of Attorney. If you want to have these documents executed you can do so when you come to our office to have your will signed, witnessed, and notarized. These documents are NOT VALID until properly signed. We advise you not to attempt to have these documents executed without discussing them with a Client Services Attorney first.

Step Five: Save the completed document. Name the file as follows – “LastName, FirstName, Estate Planning Worksheet”.

Step Six: Call the Client Services Division (CSD) (765-1500) to make an appointment for a telephonic interview with an attorney who will prepare your will after you email your Estate Planning Worksheet to the CSD office.

PLEASE WRITE LEGIBLY

1. NAME (First MI Last)		4. CLIENT CATEGORY		5. MIL GRADE/RANK OF CLIENT OR SPONSOR	
		Active			
2. MARITAL STATUS (circle)		Reserve		6. CLIENT DOD ID NUMBER	
Single Married Divorced Widow/er		Army Navy Air Force Marines Coast Grd			
3. SPOUSE/FRMR SP (First MI Last)		Natl Grd		7. CLIENT SSN (last 4)	
		Family Member(FM) RETired RETFM CIV CIVFM OTH			
9. CLIENT'S LOCAL MAILING ADDRESS (or unit/barracks address)				8. ID Card Expiration Date	
				MM DD YYYY	
10. HOME PHONE		11. WORK PHONE		12. CELL PHONE	
13. CLIENT'S EMAIL ADDRESS (if authorizing email communication)					
SPECIAL STATUS					
<input type="checkbox"/> WW - Wounded Warrior <input type="checkbox"/> WWFM - Wounded Warrior Family Member <input type="checkbox"/> SVC - Special Victim <input type="checkbox"/> KIA - Killed In Action					
DATA REQUIRED BY THE PRIVACY ACT OF 1974					
AUTHORITY	Title 10, USC, Section 3013				
PRINCIPAL PURPOSE	The purpose of this form is to assist the attorney in preparing legal documents for the client, and to prepare statistical reports on legal assistance services provided during the year. The information on this form is protected by the attorney-client privilege and may be released only in accordance with law or with approval of the client.				
ROUTINE USES	Information on this form will be used to provide legal advice and to prepare legal correspondence and documents for the client, and to prepare statistical reports.				
DISCLOSURE	Voluntary. However, nondisclosure may preclude the legal assistance desired by the client.				

FORT LEE CLIENT LEGAL ASSISTANCE RECORD
For use of this form, see AR 27-3, the proponent agency is OTJAG

If you have adopted children or stepchildren, do you wish to treat them under your will the same as if they were your natural children? ____yes ____no ____ not applicable

D. VALUE OF ESTATE: The value of your estate will determine what type of will is most appropriate. Include the value of all of the property you own in your name, jointly with others, and if married, the value of your spouse's property. If any of your property secures a debt (for example, a mortgage on your home), include your equity in the property. Also include the face value of your life insurance policies (SGLI, VGLI, etc.). The value of your estate will determine whether estate taxes will apply in your case. If you have a high value estate, it may be more advantageous for you to obtain specialized estate planning assistance in order to avoid or minimize estate taxes.

Estimated value of your estate: _____

E. DISINHERITANCE: Is there anyone in your family you do not want to inherit from your estate? ____yes ____no

NAME	RELATIONSHIP	CITY / STATE

F. SPECIFIC BEQUESTS: You may make separate gifts of cash, specific investments, real estate or personal property to specific people or charities in your will. These bequests will be distributed first and reduce the amount of property left for your other beneficiaries. Specific bequests (and trusts) are appropriate methods of setting aside money and property for children of prior relationships. If you make no specific bequests, all of your property will pass to your primary beneficiaries listed below in Part H.

Some states, such as Florida and Virginia, allow the use of a Personal Property Memorandum (PPM), which allows you to give items of personal property by a listing you make outside your will and which you can update as needed. You may wish to ask your attorney about whether your state allows a PPM.

Do you wish to make any specific bequest in your will? ____yes ____no

If yes, please list your specific bequest(s) and who you want to receive it (them):

Do you wish to dispose of personal property by using a PPM (if allowed in your state) ? ____yes ____no

G. **SPECIAL PROVISIONS:** Do you wish to leave a gift to a disabled person? ____yes ____no

Is any beneficiary receiving Medicaid or other form of assistance? ____yes ____no

There are specific limitations concerning the level of assets allowable to a disabled person who is receiving or anticipates receiving government assistance. In some cases, receiving property under a will could disqualify the disabled person from receiving benefits. There are estate planning tools available to avoid this. It is, however, a very specialized area of estate planning and is beyond the capabilities of the Fort Lee Client Services Office.

H. **PRIMARY BENEFICIARIES:** Your beneficiaries are the people or entities (charities or organizations) that will receive the property remaining after the payment of your debts and probate expenses, and after any specific bequests have been made. Since most people do not make specific bequests, the "residuary estate" usually describes all the property left to your beneficiaries after all of the debts, taxes, and fees are paid.

_____My spouse, if he/she survives me, and if not, then my children.

_____My children.

_____My parents in equal shares, or if not, then my siblings in equal shares (provide names and relationships):

_____To the following named beneficiaries in the percentages noted below:

If any of the above beneficiaries die before you and leave descendants (children/issue), do you want the share of the deceased beneficiary to pass to their children, or to pass only to the beneficiaries you named above? (For example, if one of your children dies before you and leaves children, do you want the share of your deceased child to pass to his/her children (your grandchildren) or to go only to your surviving children?)

_____To the children of any deceased beneficiary. _____Only to the named beneficiaries listed above.

I. **SECONDARY BENEFICIARIES:** If your primary beneficiaries predecease you or die within 30 days of your death, to whom do you wish to leave your estate (provide name, relationship, and percentage of inheritance).

J. TRUSTS FOR CHILDREN AND OTHERS: If any of your beneficiaries are minors, or incapable of managing money, at what age do you want them to receive their portion of your estate? (Note: Distribution at age 18 or 21 is most common and avoids many of the complications associated with a formal trust.)

_____18 _____21 _____25 _____Some other age (please indicate the age): _____

Do you want one trust for the benefit of all minors, with proceeds to be paid when the last reaches the age of distribution _____ or separate trusts for each minor, with proceeds paid to each as they reach the age of distribution _____?

Whom do you want to serve as Trustee and be responsible to manage the money for and support your minor beneficiaries? (Please list name and relationship):

1st choice: _____

2nd choice (optional): _____

K. EXECUTOR: Your Executor (or in some States, “personal representative”) ensures your estate is settled according to your wishes upon your death. This ordinarily involves going through “probate”, a court-administered procedure for settling an estate as provided in your will or under State law. Probate involves petitioning a court for letters of appointment, settling creditor claims, finding and distributing assets, and filing any necessary tax returns. Any adult may serve as your executor, although many States prefer or require an executor who is a legal resident of the State where probate is conducted. Therefore, if possible, you should select family members or responsible friends who are residents of the same State as your legal residence or the state where you own real estate. Whom do you wish to have as your executor?

_____My spouse.

_____One executor other than my spouse.

_____My spouse and a co-executor.*

_____One executor and a successor executor, neither of whom are my spouse.**

_____My spouse and a successor executor.**

_____Two co-executors, neither of whom are my spouse.*

***This option is usually not recommended because conflicts can arise between the executors that could complicate the administration of your estate.**

****The successor will act only if your first choice is unable to serve as your executor.**

Names of Executor and Alternate Executor.

NAME	RELATIONSHIP	CITY / STATE	PHONE NUMBER
First			
Second			

L. GUARDIANS FOR CHILDREN: If your children are minors when you die, and if the other natural parent is not alive or for any reason cannot act as guardian, the court will normally appoint the person(s) you name to act as legal guardian(s) of your minor children person and property. The individual(s) named will have physical control and custody of the children until they reach the age of 18 and control over the property passing to them under your Will, unless you have established a Trust. If you are divorced, the court will usually appoint the child's natural parent, your former spouse, as guardian of the person, even if you provide otherwise in your will. You should still name a guardian, however, in case your former spouse dies before you, or for any reason cannot act as the guardian. Note: You can name a separate person as Guardian for the property only.

Do you wish to appoint:

_____ One guardian for any child when I die.

_____ Two co-guardians.

_____ One guardian and a successor guardian.

_____ No guardian.

NAME	RELATIONSHIP	CITY / STATE	PHONE NUMBER
First			
Second			

ADVANCE MEDICAL DIRECTIVE PLANNING WORKSHEET

A. APPOINTMENT OF HEALTH CARE AGENT: Appointing a health care agent allows you to designate someone to make medical care decisions for you if you cannot make your own medical decisions. Your agent will have the authority to make a wide range of medical decisions on your behalf, to access to your medical information, and to fully participate with your treating physicians in deciding the care you receive. Once you are able to make your own medical care decisions again, your health care agent's authority will end.

Do you want to appoint a health care agent? (Please initial) _____ Yes _____ No

Who do you want to name as your agent(s)? Naming alternate (back-up) agents is a good idea, but not required.

	NAME	RELATIONSHIP	ADDRESS (street, city, state, zip)	PHONE NUMBER
FIRST				
SECOND				

B. ADVANCE MEDICAL DIRECTIVE/"LIVING WILL": An advance medical directive or "living will" is separate from your will, but may be an important part of your estate plan. It tells your physicians and family what medical care you would like to receive in the event you are incapacitated with an incurable medical condition and your death is imminent. This document indicates whether you would like to be removed from life support and whether you would like to end the administration of nutrition and hydration under the conditions described above. Do you want a living will?

(Please initial) _____ Yes _____ No

C. DISPOSITION OF REMAINS: I want to provide the following instructions concerning the disposition of my remains upon my death?

(Please initial) _____ Yes _____ No

ORGAN DONATION

1. I authorize my agent to donate my organs and or tissue for transplant upon my death.

(Please initial) _____ Yes _____ No

2. My agent(s) may also direct donation of my organs and or tissue for **medical, educational, or scientific purposes.**

(Please initial) _____ Yes _____ No

FUNERAL ARRANGEMENTS

Upon my death, I desire to be (check all that apply):

1. Cremated _____ with _____ or without _____ full military honors

2. Buried _____ with _____ or without _____ full military honors

3. At a specific location, cemetery, or at sea _____ (specify location below)

4. At a location, cemetery, or at sea at my Executor's discretion _____

5. Other _____

6. I have _____ or have not _____ contracted for, or paid for, any funeral arrangements

DURABLE GENERAL POWER OF ATTORNEY
FOR FINANCIAL MATTERS

Your will enables you to dispose of your property as you wish **after** you die. While you are living, you have the right to decide what happens to that property as long as you are of sound mind. But if you become incapacitated, and cannot handle your own affairs, a court order may revoke your right to manage your own money/property and appoint a guardian or conservator. To protect you from this, you may appoint an agent through a power of attorney (POA). A POA is your written authorization for someone to act on your behalf, for whatever purpose you designate. Ordinarily, a POA expires if you become mentally disabled – the time when you need help the most. A **durable** POA will survive disability or incapacity and remains valid until the expiration date or until you revoke it. As long as you are mentally competent, you can revoke a durable power of attorney whenever you like simply by destroying the document. If you choose to have a durable general POA, remember to name someone you trust as your agent or attorney-in-fact. Your agent will have great authority over your affairs. Not only can they keep your affairs in order, but they have the potential to abuse this document at your expense.

Would you like a durable general POA? _____ yes _____ no

Your durable general POA will become effective immediately. We strongly recommend that you only appoint someone you are sure you can trust and that you limit the length of time the POA will be in effect.

You **MUST** enter a termination date for the POA.

On what date should the POA terminate? _____ (three year maximum)

Whom do you wish to name as your agent(s)? Naming an alternate (back-up) agent is a good idea, but is not required.

	NAME	RELATIONSHIP	CITY / STATE	PHONE NUMBER
FIRST				
SECOND				

PREAMBLE: This is a **MILITARY ADVANCE MEDICAL DIRECTIVE** prepared pursuant to Title 10 United States Code, Section 1044c. It was prepared by an attorney who is authorized to provide legal assistance for an individual who is eligible to receive legal assistance. Federal law exempts this document from any requirements of form, substance, formality, or recording that is prescribed for an advance medical directive by the laws of a state. Federal law specifies that this advance medical directive shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the state concerned.

TO: My family, physicians and all those concerned with my care:

I, _____ presently residing at _____, and being an adult of sound mind, willingly and voluntarily make known my wishes and health care decisions in the event that I am later determined to be incapable of making an informed decision, as follows:

I understand that my advance directive may include my selection of an agent(s), as well as set forth my health care choices. The term "**health care**" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability, including but not limited to: medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility, or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase "**incapable of making an informed decision**" means unable to understand the nature, extent, and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a proposed health care decision, as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. The determination that I am incapable of making an informed decision shall be made by my attending physician and a capacity reviewer, if certification by a capacity reviewer is required by law, after a personal examination of me, and shall be certified in writing.

I understand that prior to signing this document, I am permitted to make handwritten additions and deletions to reflect my decisions regarding my future health care.

I. APPOINTMENT OF HEALTH CARE AGENT(S)

Initial _____ ONLY if you **do not wish to appoint an agent(s)** for health care decisions. After you initial, skip to Section III.

I hereby appoint and authorize _____ (**my primary agent**), of

_____ (address, city, state, zip), _____ (telephone number), as my primary agent and attorney-in-fact to make health care decisions on my behalf as authorized in this document and to be my personal representative as defined pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule.

If my primary agent is not reasonably available or is unable or unwilling to act as my agent, I appoint and authorize _____ (**my successor agent**), of

_____ (address, city, state, zip), _____ (telephone number), to serve in that capacity.

I hereby grant my agent(s), named above, full power and authority to make healthcare decisions on my behalf, as described below, whenever I have been determined to be incapable of making an informed decision. My agent(s)'s authority hereunder is effective as long as I am incapable of making an informed decision.

In exercising the power to make health care decisions on my behalf, my agent(s) shall follow my desires and preferences stated in this document or otherwise known to them. My agent(s) shall be guided by my medical diagnosis and prognosis and any information my physicians provide as to the intrusiveness, pain, risks, and side effects associated with treatment or non-treatment. My agent(s) shall not make any decision regarding my health care they know, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent(s) cannot determine what health care choice I would have made on my own behalf, then my agent(s) shall make a choice for me, based upon what they believe to be in my best interests.

II. MY AGENT(S)'S POWERS

My agent(s)'s powers shall include the following:

A. Give, Withhold or Withdraw Consent to Medical Treatment. To consent to or refuse or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, without limitation: artificial respiration; artificially administered nutrition and hydration; and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of pain-relieving medication dosages in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death. My agent(s)'s authority under this Clause A shall be limited by any specific instructions I may have given in the later section furnishing the OPTIONAL ADVANCE MEDICAL DIRECTIVE regarding my health care if I have a terminal condition or have fallen into a permanently unconscious state;

B. Gain Access to Medical Records and Other Personal Information. To request, receive, and review any information, verbal or written, regarding my physical or mental health, including, but not limited to: medical and hospital records; and to consent to the disclosure of this information;

C. Employ/Discharge Health Care Personnel. To employ or discharge my health care providers;

D. Admission to and Discharge from Facilities. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility. If I have authorized admission to a health care facility for treatment of mental illness, such authority is stated in Clauses E and/or F below;

E. Voluntary Entry into Mental Health Treatment Facility. To authorize my admission to a health care facility for treatment of mental illness for no more than 10 calendar days, provided I do not protest the admission and that a physician on the staff of, or designated by, the proposed admitting facility examines me and states in writing that I have a mental illness and I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility;

F. Involuntary Entry into Mental Health Treatment Facility. To authorize my admission to a health care facility for the treatment of mental illness for no more than ten (10) calendar days, even over my protest, if a physician on the staff of, or designated by, the proposed admitting facility examines me and states in writing that I have a mental

illness and I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility. (If you give your agent the powers described in Clause F, your physician or licensed clinical psychologist must complete the following attestation.)

Physician Attestation: *I am the physician or licensed clinical psychologist of the declarant of this Advance Directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.*

Physician name/signature: _____ **Dated:** _____

G. Other Actions by Agent to Address Dementia. To authorize the specific types of health care identified in this Sections II A-E of this advance directive even over my protest, if a physician on the staff of, or designated by, the proposed admitting facility examines me and states in writing that I have a mental illness and I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility. (If you give your agent the powers described in Clause G, your physician or licensed clinical psychologist must complete the following attestation.)

Physician Attestation: *I am the physician or licensed clinical psychologist of the declarant of this Advance Directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.*

Physician name/signature: _____ **Dated:** _____

H. Continuous Service. To continue to serve as my agent(s), even in the event that I protest the agent(s)'s authority, after I have been determined to be incapable of making an informed decision;

I. Participation in Health Care Study for my Benefit. To authorize my participation in any health care study approved by an institutional review board or research review committee, according to applicable federal or state law, that offers the prospect of my direct therapeutic benefit;

J. Participation in Health Care Study Not Benefiting Me. To authorize my participation in any health care study approved by an institutional review board or research review committee, pursuant to applicable federal or state law that aims to increase scientific understanding of any condition I may have, or to otherwise promote human well-being, even though it may not directly benefit me.

K. Visitation. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions: *(Leaving this clause blank signifies that I do not have any instructions regarding visitation.)*

L. To Take Other Lawful Actions. To take any other lawful actions that may be necessary to carry out these decisions, including releasing medical providers of liability. Further, my agent(s) shall not be liable for health care costs pursuant to their authorization, based solely on that authorization.

III. OPTIONAL ADVANCE MEDICAL DIRECTIVE

Initial here _____ ONLY if **you do not want to give instructions** about your health care if you are in a terminal condition.
After you initial, skip to Section IV.

A. Terminal Condition. If, at any time, my attending physician determines I have a terminal condition and am facing imminent death, and applying life-prolonging procedures (including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially administered hydration) would only artificially prolong the dying process, I provide the following instructions. **Choose and initial ONE (1) of the following:**

1. I direct such **procedures be withheld or withdrawn**, and I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. I understand I will still receive treatment to relieve pain and make me comfortable. Additionally, I do not want lifesaving treatment removed until such time as my family has seen me.
2. I want **all treatments to prolong my life as long as possible** within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.
3. I want **treatments for a period of time** in hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent(s) and attorney(s)-in-fact, in consultation with my physician. I understand that I will still receive treatment to relieve pain and make me comfortable.
4. I **authorize my agent(s)'s to make all decisions** regarding whether to withdraw life prolonging procedures when they would serve only to artificially prolong the dying process or to continue treatments to prolong my life as long as possible within the limits of generally accepted health care standards. My agent(s) and attorney(s)-in-fact are authorized to make this decision consulting with my physician. I understand that I will still receive treatment to relieve pain and make me comfortable.

B. Unaware of Myself or my Surroundings. If my condition makes me unaware of myself or my surroundings, or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment, I provide the following instructions. **Choose and initial ONE (1) of the following:**

1. I **do not want any treatments to prolong my life** when they would serve only to artificially prolong the dying process. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing I machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. Additionally, I do not want lifesaving treatment removed until such time as my family has seen me.
2. I want **all treatments to prolong my life as long as possible** within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.
3. I want **treatments for a period of time** in hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent and attorney-in-fact in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.



4. I **authorize my agent(s) to make all decisions** regarding whether to withdraw life prolonging procedures when they would serve only to artificially prolong the dying process or to continue treatments to prolong my life as long as possible within the limits of generally accepted health care standards. My agent(s) and attorney(s)-in-fact are authorized to make this decision after consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

C. Other Optional Directions about Life Prolonging Procedures. If you wish to provide your own directions, or if you wish to add to the directions you have given above, you may do so here. If you wish to give specific instructions regarding certain life prolonging procedures, such as artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially administered hydration, this is where you should write them. *Leaving this clause blank signifies you do not have any such instructions.* I direct that:

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to authorize or refuse health care and acceptance of the consequences of such authorization or refusal.

IV. DISPOSITION OF REMAINS

Initial here _____ ONLY if **you do not want to give instructions** concerning the disposition of your remains.

The agent(s) named in Section I shall control the disposition of my remains upon my death, consistent with my instructions below.

A. Funeral Arrangements. Upon my death, I desire to be *(check all that apply)*:

- 1. Cremated _____ with _____ or without _____ full military honors
- 2. Buried _____ with _____ or without _____ full military honors
- 3. At a specific location, cemetery, or at sea _____ *(specify location below)*

- 4. At a location, cemetery, or at sea at my Executor's discretion _____
- 5. Other _____
- 6. I have _____ or have not _____ contracted for, or paid for, any funeral arrangements

B. Organ Donation.

1. I authorize my agent to donate my organs and or tissue for **transplant** upon my death. *(Initial ONE (1))*: Yes _____ No _____

2. My agent(s) may also direct donation of my organs and or tissue for **medical, educational, or scientific purposes**. *(Initial ONE (1))*: Yes _____ No _____

V. MISCELLANEOUS TERMS

A. Ability to Contract in my Name. I further delegate to my agent(s) and attorney(s)-in-fact the power and authority to contract in my name and on my behalf for all health care services, including, without limitation: medical, nursing, and hospital care, as my agent(s) and attorney(s)-in-fact shall deem appropriate. I confirm that I shall be, and remain, personally liable for the payment of all care and services to the same extent as if I had personally entered into the contract. Further, my agent(s) and attorney(s)-in-fact shall not be liable for the costs of health care pursuant to their authorization, based solely on that authorization.

B. Authorization to Disclose Protected Health Information. I grant to my agent(s) the authority and power to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and the regulations in 45 C.F.R. Sec. 160 et seq., and any other applicable federal, state or local laws or regulations (collectively "HIPAA"), including the authority to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under HIPAA. I understand that health and medical records can include information relating to subjects such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my agent to execute any and all releases or other documents that may be necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

C. Execute Documents on My Behalf. I authorize my agent(s) and attorney(s)-in-fact to execute on my behalf any documents necessary or desirable to implement the health care decisions that my agent(s) and attorney(s)-in-fact are authorized to make pursuant to this document, including, without limitation: all documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider. **My agent(s) are instructed to sign documents on my behalf as follows: "(My Name) by (Name of Agent), as Attorney in Fact."**

REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK.

EXECUTION PAGE FOLLOWS.

VI. EXECUTION

I understand the full importance and meaning of this document, and I am aware it may authorize a physician to withhold and withdraw life prolonging procedures. This document is a durable power of attorney and the authority of my agent(s) and attorney(s)-in-fact shall not terminate if I become disabled, incompetent or incapacitated.

Further, this Advance Directive shall not terminate in the event of my disability. By signing below, I indicate that I am emotionally and mentally capable of making this Advance Directive and that I understand the purpose and effect of it. Further, I understand I may revoke all or any part of this document at any time (i) with a signed and dated writing; (ii) by physical cancellation or destruction of this Advance Directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

Declarant Sign: _____ Date: _____

Declarant Print: _____

IN WITNESS WHEREOF, the Declarant signed the foregoing Advance Directive in my presence. I am not the Declarant's spouse or blood relative. I have no interest in or claim against the Declarant's estate. I believe the Declarant to be of sound mind and under no constraint, duress, fraud or undue influence.

Executed this the _____ (day) of _____ (month) 20____ (year), at the Office of the Staff Judge Advocate, Client Services Division, 701 27th Street, Fort Lee, VA 23801.

Witness 1 Sign: _____

Witness 1 Print: _____

Witness 2 Sign: _____

Witness 2 Print: _____

COMMONWEALTH OF VIRGINIA, COUNTY OF PRINCE GEORGE

I, _____, a notary public (under the law of the Commonwealth of Virginia or under Title 10 U.S.C. 1044a), certify that the above named Declarant and Witnesses signed the foregoing instrument, dated the _____ (day) of _____ (month) 20____ (year), acknowledged the same before me.

Notary Public

My commission expires on:

PREAMBLE: This is a MILITARY POWER OF ATTORNEY prepared pursuant to Title 10 United States Code, Section 1044b, and executed by a person authorized to receive legal assistance from the military services. Federal law exempts this power of attorney from any requirement of form, substance, formality, or recording that is prescribed for powers of attorney by the laws of a state, the District of Columbia, or a territory, commonwealth or possession of the United States. Federal law specifies that this power of attorney shall be given the same legal effect as a power of attorney prepared and executed in accordance with the laws of the jurisdiction where it is presented.

DURABLE POWER OF ATTORNEY

KNOW EVERYONE BY THESE PRESENTS, which are intended to constitute a Durable General Power of Attorney, **THAT I**, _____, currently residing at _____, hereby make, constitute and appoint _____, telephone number: _____, or if _____ is unable, unwilling or unavailable to act, then _____, telephone number: _____, as my agent TO ACT in my name, place and stead in any way which I could do, if I were personally present, to the extent that I am permitted by law to act through an agent:

(a) to ask, demand, sue for, recover and receive all manner of goods, chattels, debts, rents, interest, sums of money and demands whatsoever, due or to become due, that are thought to be owing, belonging or payable to me in my own right or otherwise, and to execute, acknowledge and deliver acquittances, receipts, releases, satisfactions or other discharges for the same;

(b) to sell, transfer, exchange, convert, abandon, or otherwise dispose of, or grant options with respect to, real and personal property, at public or private sale, with or without security, in such manner, at such times, for such prices, and upon such terms and conditions as my agent may deem necessary or appropriate;

(c) to buy, sell, exchange, invest and reinvest in common or preferred stocks, bonds, commodities, options, limited liability companies, investment trusts, mutual funds, regulated investment companies and other types of securities and financial instruments, foreign or domestic, including any undivided interest in any one or more common trust funds, whether or not such investments be of the character permissible for investments by fiduciaries under any applicable law, and without regard to the effect any such investment may have upon the diversity of investments; to demand, receive and obtain any money or other things of

value to which I am or may become or may claim to be entitled in connection with any stocks, bonds or other financial instruments; to cause securities or other property to be held or registered in the name of a nominee or nominees or unregistered or in any other form; to vote in person at meetings of stock or security holders and adjournments thereof, to enter into voting trusts, and to vote by general or limited proxy with respect to any stock or securities;

(d) to make, execute, endorse, accept and deliver in my name or in the name of my agent all checks, notes, drafts, warrants, securities, stock certificates, certificates of deposit, bonds, acknowledgments, and any other agreements, certificates or instruments of any nature, as my agent may deem necessary or appropriate;

(e) to deposit and withdraw any sums to or from any bank, savings or similar account maintained by me alone or jointly; to open, continue, modify or terminate any account or banking arrangement in my name or jointly with others; to borrow money at such interest rates and upon such terms and conditions as my agent may deem necessary or appropriate, and to provide security therefor from my assets; to pay, renew or extend the time of payment of any note given by me or on my behalf; to prepare financial statements concerning my assets and liabilities or income and expenses, and deliver them to financial institutions; to receive statements, notices and other documents from financial institutions; to open or cause to be opened any safe deposit box in my name and to examine and remove any or all of the contents of such box; and to conduct such other banking transactions as my agent may deem necessary or appropriate;

(f) to take possession of, recover, obtain and hold any tangible personal property belonging to me or to which I may be entitled, and to receive and take for me and in my name any rents, issues and profits of any such property; to purchase, invest in, reinvest in, accept as a gift, sell, exchange, lease, grant options upon, assign, transfer, abandon, pledge, encumber or otherwise dispose of any personal property of any nature and wherever situate; to store property for hire or on a gratuitous bailment; to make repairs and alterations; and to execute, acknowledge and deliver all contracts, leases, notes, security agreements, guarantees, bills of sale, assignments, extensions, releases, waivers, consents, and any other agreements, writings and instruments of any nature affecting any personal property, as my agent may deem necessary or appropriate;

(g) to possess, recover, manage, hold, control, develop, subdivide, partition, mortgage, lease or otherwise deal with any real property belonging to me or to which I may be entitled; to purchase, invest in, reinvest in, accept as a gift, sell, exchange, lease, sublease, grant options upon, convey with or without covenants, quitclaim, assign, transfer,

abandon, encumber or otherwise dispose of any real property of any nature and wherever situate; to borrow money at such interest rates and upon such terms and conditions as my agent may deem necessary or appropriate, and to provide security therefor by mortgage, deed of trust or similar instrument or pledge of any property; to satisfy, discharge, release or extend the term of any mortgage, deed of trust or similar instrument; to apply for zoning, rezoning or other governmental permits; to make repairs, replacements and improvements, structural or otherwise; to pay, compromise or contest real estate taxes, assessments, water charges and sewer rents; to abstain from the payment of real estate taxes, assessments, water charges and sewer rents, repairs, maintenance and upkeep of the same; to abandon property if deemed to be worthless or not of sufficient value to warrant keeping or protecting; to permit property to be lost by tax sale, foreclosure or other proceeding or to convey property for a nominal consideration or without consideration; and to execute, acknowledge and deliver all contracts, deeds, leases, mortgages, notes, security agreements, guarantees, transfers to trusts, bills of sale, assignments, extensions, satisfactions, releases, waivers, consents, and any other agreements, writings and instruments of any nature affecting any real property, as my agent may deem necessary or appropriate;

(h) to commence any actions or proceedings for the recovery of any real or personal property or for any other purpose; to appear in, answer and defend any actions or proceedings commenced against me; and to prosecute, maintain, appeal, discontinue, compromise, arbitrate, mediate, settle and adjust all actions, proceedings, accounts, dues and demands that now or hereafter may exist, as my agent may deem necessary or appropriate;

(i) to create, amend or terminate one or more trusts, partnerships, corporations, limited liability companies, co-tenancies or any other form of ownership or entity for the purpose of dealing with any property or property interest of any nature that I may have or hereafter acquire, under such terms and with such provisions as my agent may deem necessary or appropriate; to transfer any or all property in which I have an interest into any trusts, partnerships, corporations, limited liability companies, co-tenancies or other entities, whether created by me or my agent or otherwise (and, in this regard, that my agent may be a remainderman, partner, shareholder, member, co-tenant or beneficiary of any such entity shall not affect the validity of any action hereunder, and shall not, by itself, constitute a breach of fiduciary duty); to remove property from any such entity; and to give to any such entity, or to any person acting as agent or trustee under any instrument executed by me or on my behalf, such instructions or authorizations as I may have the right to give;

(j) to join or become a party to, or to oppose, any reorganization, readjustment, recapitalization, foreclosure, merger, voting trust, dissolution, consolidation or exchange, and to deposit any securities with any committee, depository or trustee, and to pay any fees, expenses and assessments incurred in connection therewith, and to charge the same to principal, and to exercise conversion, subscription or other rights, and to make any necessary payments in connection therewith, or to sell any such privileges;

(k) to deal with all matters relating to all forms of insurance and annuities, including the procurement, maintenance and termination thereof; however, notwithstanding the powers given my agent in this and other provisions of this power of attorney, my agent shall have no incidents of ownership in any life insurance policy in which I own an interest and which insures the life of my agent;

(l) to do all acts necessary to maintain my customary standard of living and that of my family and other persons customarily supported by me, including without limitation the power to pay for medical, dental and surgical care, living quarters, usual vacation and travel expenses, shelter, clothing, food, education, organizational fees and contributions, and other living costs;

(m) to act for me in all matters which affect my right to government benefits and assistance, including without limitation Social Security, Medicare, Medicaid, qualified state tuition programs, and other governmental benefits and benefits relating to civil or military service; to file, prosecute, submit to arbitration or settle any claim for benefits or assistance; to establish new residency and domicile; and to receive the proceeds of claims and conserve, invest, disburse and use them on my behalf;

(n) to take all steps and remedies necessary or appropriate for the conduct and management of any business in which I may have an interest; to exercise in person or by proxy any right, privilege or option which I may have with respect to any business; to continue, modify, negotiate, renegotiate, extend and terminate any and all contracts or agreements heretofore or hereafter made with respect to the business; to pay, compromise or contest business taxes or other claims or obligations; to determine the policies of the business as to the location, methods and manner of its operations including its financing, accounting, and insurance; and to add or remove capital from the business;

(o) to employ such agents, attorneys, accountants, investment counsel, trustees, caretakers and other persons and entities providing services or advice, irrespective of whether my agent may be associated therewith,

and to rely upon information or advice furnished thereby or to ignore the same, and to delegate duties hereunder and pay such compensation, as my agent may deem necessary or appropriate; and

(p) to do, execute, perform and finish for me and in my name all things which my agent shall deem necessary or appropriate in and about or concerning my property or any part thereof.

This power of attorney is a durable power of attorney, and it shall not be affected by my becoming disabled, incompetent or incapacitated. It is my intent that the authority conferred herein shall be exercisable notwithstanding my physical disability or mental incompetence.

This power of attorney, however, shall terminate on _____, unless sooner revoked by me.

Notwithstanding my inclusion of a specific expiration date herein, if on that specified expiration date I should be or have been properly certified, in writing, by a physician to be disabled from or incapable of exercising control over my person, property, personal affairs, or financial affairs, then this Power of Attorney shall remain valid and in full effect until sixty (60) days after I have recovered from such disability.

It may be necessary for my agent to have access to my medical records to establish whether medical bills are valid and appropriate or for other purposes. I grant to my agent the authority and power to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, the regulations in 45 C.F.R. Sec. 160 et seq., and any other applicable federal, state or local laws or regulations (collectively "HIPAA"), including the authority to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under HIPAA. I understand that health and medical records can include information relating to subjects such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from

any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my agent to execute any and all releases or other documents that may be necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

It is my desire and request that no guardian or conservator of my person or property be appointed in the event of my disability or incapacity. If, however, a guardian or conservator of my person or property is to be appointed for me, I hereby nominate and appoint my agent hereunder to serve as guardian and conservator without bond.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this power of attorney may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party. I, for myself and my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied upon the provisions of this power of attorney.

I reserve the power to revoke this power of attorney at any time by communicating my intent to revoke in any manner in which I am able to communicate.

This power of attorney shall be governed by Virginia law, although I request that it be honored in any state or other location in which I or my property may be found. If any provisions hereof shall be unenforceable or invalid, such unenforceability or invalidity shall not affect the remaining provisions of this power of attorney.

***REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK.
EXECUTION PAGE FOLLOWS.***

IN WITNESS WHEREOF, I have executed this power of attorney this ____ day of _____, 20__.

We, the undersigned, each being over 18 years of age, hereby witness the signing of the above power of attorney by _____, known to us to be the person who signed the above power of attorney as principal, at the request of and in the presence of the principal and in the presence of each other on the day and year set forth above. We believe that the principal is of sound mind, that he had the opportunity to read the power of attorney and that he signed the above power of attorney as his free and voluntary act and deed, free of duress, fraud or undue influence, for the purposes therein expressed. None of us is related to the principal by blood, marriage or adoption, and to the best of our knowledge none of us is entitled to any portion of the estate of the principal upon the death of the principal under any will or codicil or by operation of law.

Witness 1 Sign: _____

Residing at: _____

Witness 1 Print: _____

Witness 2 Sign: _____

Residing at: _____

Witness 2 Print: _____

COMMONWEALTH OF VIRGINIA, COUNTY OF PRINCE GEORGE

I, _____, a notary public (or person authorized to administer oaths under Title 10 U.S.C. 1044a), certify that _____, whose name is signed to the foregoing power of attorney, dated _____, 20__, acknowledged the same before me.

Given under my hand and official seal this ____ day of _____, 20__.

Notary Public
My commission expires on

[NOTE: The following affidavit may be executed by the attorney-in-fact at a later date if some third party requests evidence that the power of attorney is in effect.]

**AFFIDAVIT THAT POWER OF ATTORNEY
IS IN FULL FORCE AND EFFECT**

COMMONWEALTH OF VIRGINIA, COUNTY OF _____

I, _____, being duly sworn, depose and say:

THAT _____, as principal, did, in a writing dated _____, 20____, appoint me his/her true and lawful attorney-in-fact, and that attached hereto is a true copy of said power of attorney.

THAT I have no actual knowledge or actual notice of the revocation or termination of the aforesaid power of attorney by death or otherwise, or knowledge of any facts indicating the power of attorney has been revoked or terminated. I have no actual knowledge or actual notice that the power of attorney has been modified in any way that would affect the ability of the agent to authorize or engage in any transaction with a third party, or knowledge of any facts indicating the power of attorney has been so modified. I further represent, to the best of my knowledge after diligent search and inquiry, that: said principal is now alive; has not, at any time, revoked, terminated, suspended or repudiated the power of attorney; and the power of attorney still is in full force and effect.

THAT I make this affidavit for the purpose of inducing to accept delivery of the following instrument(s), as executed by me in my capacity of attorney-in-fact of said principal, with full knowledge that this affidavit will be relied upon in accepting the execution and delivery of said instrument(s) and in paying good and valuable consideration therefor:

Dated:

Subscribed and sworn to before me, a notary public (or person authorized to administer oaths under Title 10 U.S.C. 1044a), in said County and State, as witness my hand and official seal, on

Notary Public
My commission expires on