

Advance Health Care Directive

# Health Care Power of Attorney *and* Living Will

INSIDE: LEGAL DOCUMENTS AND INSTRUCTIONS TO ASSIST YOU WITH IMPORTANT HEALTH CARE DECISIONS

APPROVED BY:



ALLEGHENY COUNTY  
MEDICAL SOCIETY

Allegheny County  
Bar Association

*Raising the Bar  
on Legal and Community Service*

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# Health Care Decision Making

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Modern health care can help you live a long and full life. In certain situations, modern health care can also prolong the process of your dying or may maintain you in a state of permanent unconsciousness. You may see this as undesirable and such medical care unduly burdensome.

In Pennsylvania, you have the legal and ethical right to make your own decisions about the type of health care you want. As long as you are well enough, your physicians will involve you directly in making decisions about your medical treatment. However, if you are unable to make decisions about your care, others will have to make these decisions for you. You have the right to decide

- **who** will make these decisions for you
- **when** someone can speak for you
- **how** those decisions would be made, and
- **what** instructions you may wish to give your doctor and your agent about these health care decisions

Your wishes are most likely to be followed if you express those wishes in advance by:

1. naming a health care agent to decide treatment for you; and
2. giving health care treatment instructions and guidance to your health care agent and your doctor

You should consider planning ahead for a time when you cannot make decisions about your medical treatment. You can give directions in advance in case you become unable to understand, make or communicate decisions about your medical care, and:

- you are in an end-stage medical condition (for example, you are dying from an incurable cancer or you are in an advanced state of a chronic obstructive lung disease or congestive heart failure); or
- you have no possibility of recovery from an unconscious state (for example, due to a severe stroke or a traumatic brain injury); or
- you have an irreversible medical condition such as advanced Alzheimer's disease that leaves you unable to care for yourself or even unable to recognize loved ones

You can tell others who you want to make those decisions for you and how you want to be treated by preparing an advance health care directive, commonly called a Living Will.

# Questions and Answers About Advance Health Care Directives

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## **Q. What is an Advance Health Care Directive?**

An Advance Health Care Directive is a written set of instructions expressing your wishes for medical treatment. It may contain a Health Care Power of Attorney, where you name a person called a “Health Care Agent” to decide treatment for you. It may contain health care treatment instructions, or a “Living Will”, where you tell your health care agent and health care providers your choices about starting, continuing, refusing or stopping life-preserving treatment and other specific directions. Often, as with the form attached, it contains both a Living Will and a Health Care Power of Attorney.

## **Q. What is a Health Care Agent?**

A Health Care Agent is a person you choose to make health care decisions for you. You can name a family member or a friend who is familiar with your beliefs and values to interpret your instructions and to make these decisions. This Health Care Agent can authorize, withhold or withdraw treatment.

## **Q. When does my Health Care Agent speak for me?**

This form gives your Health Care Agent the power to speak for you whenever you cannot speak for yourself. If you get better and are again able to make your own decisions, you can again speak for yourself. The law allows you to have your Health Care Agent to speak for you immediately, if you wish. If you want your Health Care Agent to speak for you right away, or at any time, all you need to do is personally inform your attending physician, who should record your decision in your medical records. If you have any questions about this, you may wish to consult with your attorney and physician to be sure that your wishes are clearly expressed.

## **Q. Should I talk to my Health Care Agent about this?**

Absolutely. It is very important that you discuss your wishes with your Health Care Agent, so that you know that the person you appoint is willing to act as your Health Care Agent, and that your Health Care Agent understands your wishes and priorities as well as possible.

## **Q. Will my agent be responsible for my medical bills?**

No. Your agent makes decisions about your care. The cost of your medical care is your responsibility or the responsibility of your insurance company.

## **Q. If I am unable to make decisions, what happens if I don't have an Advance Health Care Directive?**

If you don't have an Advance Health Care Directive, a Health Care Representative may be selected in the order prescribed by the Pennsylvania statute from your relatives or another adult person who may know your preferences and values for purposes of health care decision making. However, the person selected by the statute may not be the one you wish to make decisions for you. Without any written guidance, your family members may be confused or disagree about what care to give you. Your wishes may not be followed.

**Q. What if my physician or health care provider does not want to follow my advance directive?**

Your physician or health care provider must tell you if they cannot in good conscience follow your wishes or if the policies of the institution prevent them from honoring your wishes. By law the physician or health care provider must help transfer you to another physician or health care provider willing to carry out your directives.

**Q. What should I do with my completed Advance Health Care Directive?**

You should give a copy of your Advance Health Care Directive to your Health Care Agent, to your alternative Health Care Agents and to your physician and discuss it with them. Tell your family that you have written this document and discuss it with them and with others, such as your attorney or clergy, if you desire. Keep a copy in an accessible but secure place. Note that a copy kept in a safe deposit box may not be accessible when needed.

**Q. Can I change my Advance Health Care Directive?**

Yes! You can change your mind by telling your physician at any time. You can write a new Advance Health Care Directive and replace all old copies with the new one. You should discuss any changes with your Health Care Agent and physician as well as family members and loved ones.

**Q. What if I fill out an Advance Health Care Directive in one state and am hospitalized in a different state?**

Legal requirements vary from state to state. Your Advance Health Care Directive helps your doctors understand your wishes no matter where you are. If you spend a lot of time in another state you might consider consulting an attorney in that state to make sure that your wishes will be honored in that state.

**Q. Whom can I contact for additional information:**

You can contact: Allegheny County Bar Association, (412) 261-6161 Allegheny County Medical Society, (412) 321-5030

**Conclusion**

A discussion of Advance Health Care Directives touches on sensitive matters. Most of us would rather not think about being sick or dying. But, by considering these issues now, you can save your family and those close to you the burden of having to make choices for you without adequate guidance. Talking with your family, your physician, clergy, or with others whose views you respect may help you decide on the path best suited for you.

## INSTRUCTIONS FOR PAGE 1

A Durable Health Care Power of Attorney and Living Will form is attached for your use. This form allows you to do two things. The Durable Health Care Power of Attorney appoints a *specific person* (a Health Care Agent) who will have the power to make health care decisions for you. The Guidance for Agent and the Health Care Treatment Instructions (Living Will) tell your Health Care Agent and your health care providers what *specific health care treatments you do want and do not want* to receive to prolong life in certain situations. Because you cannot anticipate every circumstance, the appointment of a Health Care Agent is critical. If you appoint an agent who knows you and your values, and who is willing to be involved in your care, it is more likely that your wishes will be honored.

If you disagree with any of the statements in this form, you may cross out that portion. If you do so, you should *consult with your physician or attorney to make sure that your wishes are clearly understood*.

### **Specific Instructions: Part I – Durable Health Care Power of Attorney/Appointing an Agent**

***Name and County.*** Fill in your full name and the county where you live.

***Health Care Agent Speaks for You Only When Needed Or Whenever You Want Them to Speak for You.*** This form allows your Health Care Agent to speak for you when you are unable to understand, make or communicate a choice regarding a health care decision. This is based upon the point of view that you should keep control of your health care decisions as long as you can. If you wish your Health Care Agent to make health care decisions for you right away, or at any time, you may do so by personally informing your doctor, who will record your decision in your medical records. If you have any questions about this, you may wish to discuss it with your physician or your attorney.

***Appointment of Health Care Agent and Alternates.*** Fill in the full name, address, telephone numbers and email address of your Health Care Agent and any alternative agents. Note that you may not appoint your doctor or other health care provider as your health care agent unless they are family members. If, for any reason, your agent is not reasonably available under the circumstances, your alternative agents will be contacted in the order you list them.

***Only One Health Care Agent at a Time.*** This form gives only one Health Care Agent the power to act at any time, provided that he or she is reasonably available, so that the line of authority is very clear. The Health Care Agent is strongly urged to discuss decisions with the Alternate Health Care Agents, other family members, clergy and other trusted advisors, where possible, to insure that your wishes are followed. If you wish for two or more of your Health Care Agents to act together, you should consult with your attorney and physician to prepare a form that deals with unavailability or disagreement among the Health Care Agents.

***Separate HIPAA Authorization.*** Your Health Care Agent has full access to your medical records when they are acting on your behalf, but before that time, those records are private. However, it is desirable that your doctor may be able to discuss your care with your Health Care Agent while you are still able to make your own decisions for yourself, or in communications between your doctor, your Health Care Agent and you. This language is intended to encourage that communication.

**ADVANCE HEALTH CARE DIRECTIVE PAGE 1**

**I. HEALTH CARE POWER OF ATTORNEY  
AND**

**II. HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE  
MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS  
("LIVING WILL")**

**PART I - DURABLE HEALTH CARE POWER OF ATTORNEY**

I, \_\_\_\_\_, of \_\_\_\_\_ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me whenever I cannot understand, make or communicate a choice regarding a health care decision as determined by my doctor or whenever I personally inform my doctor. My agent may not delegate the authority to make decisions.

**APPOINTMENT OF HEALTH CARE AGENT:**

I appoint the following health care agent: *You may not appoint your doctor or other health care provider as your health care agent unless related to you by blood, marriage or adoption.*

Health Care Agent: \_\_\_\_\_  
(Name and Relationship)

Address:

Telephone Numbers

\_\_\_\_\_ Home

\_\_\_\_\_ Work

E-Mail: \_\_\_\_\_ Cell

If my health care agent is not reasonably available, or is unable or unwilling to act in a timely manner, or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents).

<b>1<sup>ST</sup> ALTERNATE</b>	
	Name and Relationship
	Address
	City State Zip
	Home Phone Cell Phone
	Work Phone E-Mail

<b>2<sup>ND</sup> ALTERNATE</b>	
	Name and Relationship
	Address
	City State Zip
	Home Phone Cell Phone
	Work Phone E-Mail

**SEPARATE HIPAA AUTHORIZATION EFFECTIVE IMMEDIATELY**

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the regulations issued under HIPAA and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to these privacy rules.

**HEALTH CARE AGENT POWERS**

My health care agent has all of the following powers subject to the health care treatment instructions that follow in PART II (cross out any powers you do not want to give your health care agent):

1. To **authorize, withhold or withdraw** medical care and surgical procedures.
2. To **authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.**
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and obtain health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, a Physician Order for Life-Sustaining Treatment (POLST) or other order effectuating my wishes and to sign any required documents and consents.
6. To carry out my wishes regarding funeral, burial, and the disposition of my body.
7. To take any legal action necessary to do what I have directed.

The foregoing powers shall apply with respect to both physical and mental health care as defined under Section 5422 of the Probate, Estates and Fiduciaries Code. I do not have a mental health care power of attorney or declaration under Chapter 58 of the Probate, Estates and Fiduciaries Code. (Modify or use a different form as needed if you have a mental health care power of attorney or declaration)

I nominate my health care agent as the guardian of my person, should such a guardian be necessary.

**GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL) Goals (Leave Blank if Goals Adequately Expressed in the Rest of this Document):**

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities, such as comfort care, preservation of life for as long as possible, preservation of mental function, care at home, etc.):

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**Severe Brain Damage or Brain Disease:**

If I should suffer from severe and irreversible brain damage or brain disease which has made me unable to recognize or interact with other people and from which my doctors believe there is no realistic hope of significant recovery, I would consider such a condition unacceptable and the application of aggressive medical care to extend my life in this condition to be burdensome. I therefore request that my health care agent respond to any life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials \_\_\_\_\_ I agree. Keep me comfortable and allow natural death to occur.

Initials \_\_\_\_\_ I disagree. Use all medical treatment that is needed to keep me alive.

## INSTRUCTIONS FOR PAGE 2

***List of Health Care Agent's Powers.*** The form lists seven broad powers for your agent. Pay particular attention to number 2, which gives your agent the power to withhold or withdraw food or water supplied by tube. You may cross out any power you do not wish to give to your agent, but if you do, be sure to discuss it with your doctor and your lawyer to make sure that your wishes are clearly expressed.

***Mental Health Care.*** This form grants powers to your Health Care Agent which generally include both physical and mental health care. It does not, however, express your specific wishes concerning mental health conditions apart from severe brain damage or brain disease which might make you unable to recognize or interact with other people. *It assumes that you do not have a separate mental health care power of attorney or mental health care declaration which deals directly with specific mental health issues and is governed by Chapter 58 of the Probate, Estates and Fiduciaries Code.* If you do have such a separate document, or you wish to express specific wishes concerning mental health care, you should consult with your lawyer and your doctor and use a different form or forms to do so.

***Appointment of Health Care Agent as Guardian of the Person.*** By signing a Health Care Power of Attorney appointing a Health Care Agent to make decisions for you when you are unable to do so yourself, you minimize the chance that a court proceeding will be necessary under Pennsylvania's Guardianship laws to appoint a guardian of your person to make decisions about your care. However, should such a guardian of your person be required for any reason, you nominate your Health Care Agent as such Guardian.

***Guidance for Health Care Agent.*** This section gives you the opportunity to separately state your health care goals should you suffer from an end-stage medical condition or other extreme and irreversible medical condition. If your wishes and priorities are adequately expressed in the remainder of the document, you may leave this section blank. But this is an opportunity to express the values that *are most important to you*, whether it is the preservation of your life for as long as possible, or to be cared for at home as long as possible, even if this might result in a shortened life, then this is the place provided to you to say it.

***Severe Brain Damage or Brain Disease.*** This section refers to conditions currently believed to be irreversible, such as advanced Alzheimer's disease or other severe brain damage. In such situations, you might not be in an end-stage medical condition or permanently unconscious, but you might be unable to care for yourself, or even unable to recognize loved ones. You should tell your Health Care Agent and your doctor whether you wish medical care to be applied aggressively or not in that situation.

For example, if you were to develop a life-threatening condition (pneumonia for example) and life-preserving measures must be considered, you may wish for your doctor and your Health Care Agent to follow your instructions just as if you were in an end-stage medical condition or are permanently unconscious. Alternatively, you may wish for your doctor and your Health Care Agent to use all medical treatment that is needed to keep you alive.

**Specific Instructions: Part II – Health Care Treatment Instructions (Living Will)**

**How to Complete Your Living Will**

**End-Stage Medical Condition or Permanent Unconsciousness**

A Living Will in Pennsylvania states what medical care you do and do not want to keep you alive if you are in an end-stage medical condition or in a state of permanent unconsciousness. It does not apply to any other situations. This is different from your Health Care Power of Attorney, which applies whenever you are unable to understand, make or communicate a health care decision.

By initialing your choice that you do or do not want aggressive medical care in those situations, you agree to the instructions set out below those statements. Read these instructions carefully to make sure they state your wishes accurately. If they do not, you may modify them, but you should review any modifications to these instructions with your physician and your attorney to make sure that your wishes are expressed clearly.

**Special Rules For Pregnancy.**

If you are a woman and are diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, special rules apply. Pennsylvania law directs that life-sustaining treatment, including nutrition and hydration, be given unless your attending physician and an obstetrician who have examined you certify in your medical record that such treatment will not permit the continuing development and birth of the unborn child, will be harmful to you, or will cause pain that cannot be alleviated by medication. If you wish to express your wishes in this regard, and it is different from the Pennsylvania law, you may wish to discuss this matter with your attorney.

**Tube Feedings.** Initial one of the two choices.

**Agent's Use of Instructions.** Initial the first choice if you want your Health Care Agent to be bound by your instructions. Initial the second choice if you want your Health Care Agent to be able to override your instructions and do what he or she thinks is best for you.

**Follow your Instructions.** If you direct that your Health Care Agent is to follow your instructions, you are taking full responsibility for the choices that you have directed. Your doctor and your Health Care Agent will still have considerable authority to make judgments about your health care choices since they must determine under the circumstances whether there is realistic hope of a significant recovery. But otherwise, your instructions must be followed.

**Full Power to Health Care Agent.** If you give your Health Care Agent full power and final authority, even to override your instructions, you will have given your Health Care Agent all of the power which you yourself possess over your health care. If you choose to give your Health Care Agent this full power and authority, you may list any limitations on that authority in the lines below. If you list such limitations, it is extremely important that you express your wishes clearly, so it is advisable to review the wording with your doctor and your lawyer.

**PART II - HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS (LIVING WILL)**

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I cannot understand, make or communicate my treatment decisions:

**END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS**

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, then I choose the following (indicate your choice by initialing your preference):

Initials \_\_\_\_\_ **I do not want aggressive medical care**, and give the following instructions (cross out any treatment instructions with which you do not agree):

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming. Medical or surgical treatment to relieve pain or provide comfort may be given even though I do not want it as a life prolonging procedure.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I specifically do not want any of the following as life prolonging procedures: heart-lung resuscitation (CPR), mechanical ventilation (breathing machine), dialysis (kidney machine), surgery, chemotherapy, radiation treatment or antibiotics.

Initials \_\_\_\_\_ **I do want aggressive medical care**, and give the following instructions.

I wish to receive all medical and surgical treatment needed to keep me alive as long as possible, even though my doctor believes that it will only delay the time of my death or maintain me in a state of permanent unconsciousness. In addition, I direct that I be given health care treatment to relieve pain or provide comfort provided that it does not hasten my death.

**Tube Feeding**

I have indicated below, by my initials, whether I want nutrition (food) or hydration (water) medically supplied by a tube into my nose, stomach, intestine, arteries, or veins if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery.

Initials \_\_\_\_\_ **I do** want tube feedings to be given.

OR

Initials \_\_\_\_\_ **I do not** want tube feedings to be given.

**Health Care Agent's Use of Instructions (Initial one option only).**

Initials \_\_\_\_\_ My health care agent **must follow** these instructions.

OR

Initials \_\_\_\_\_ These instructions are **only guidance**. My health care agent shall have final say and may override any of my instructions. (Indicate below any desired limitation of agent's authority.)

**ADVANCE HEALTH CARE DIRECTIVE PAGE 4**

**Legal Protection**

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

**Organ Donation (Initial one option only.)**

\_\_\_\_\_ I **do consent** to donate my organs and tissues at the time of my death for the purpose of **transplant, medical study or education**. If life prolonging measures are required for a short period in order to carry out my transplant wishes, I want my health care agent to decide how to best carry out my wishes. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

\_\_\_\_\_

\_\_\_\_\_

OR

\_\_\_\_\_ I **do not consent** to donate my organs or tissues at the time of my death.

**SIGNATURE:**

Having carefully read this document, I have signed it this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, revoking all previous health care powers of attorney and health care treatment instructions.

Witnesses

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

\_\_\_\_\_

Date of Birth

*Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)*

**NOTARIZATION (OPTIONAL)**

*(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)*

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me personally appeared the aforesaid principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of \_\_\_\_\_, State of \_\_\_\_\_ the day and year first above written.

\_\_\_\_\_

My commission expires

\_\_\_\_\_

Notary Public

## INSTRUCTIONS FOR PAGE 4

**Legal Protection.** This provision is added so that you and your financial estate stand behind your agent and health care providers to protect them from lawsuits against them simply because they followed your wishes. *It does not excuse negligence or malpractice in the way your instructions are carried out.* If you have any questions about this release, consult an attorney for guidance.

**Organ Donation.** This section allows you to express your preference concerning organ donation, whether you wish to do so, or you do not wish to do so. Note that if you do wish to allow organ donation for transplant, but not for medical study or other purposes, you may indicate that preference here. An indication on your driver's license that you are an "Organ Donor" would allow your body to be used for transplant, medical study or medical research. In order for an organ transplant to be successful, it is often necessary to keep the donor on life support until transplant surgery is performed. This form gives your Health Care Agent the power to make a decision on how best to carry out your wishes if there is a conflict between your wishes to be an Organ Donor and your wishes concerning life prolonging care.

**Signature and Witnessing.** Date and sign the document with your full name in the presence of two witnesses who are at least 18 years old. Address and birth date are added to insure that your Advance Health Care Directive is not confused with another person of the same or similar name.

**Signature by Mark or by Another.** If you are physically unable to sign your name, you may sign by making your mark in place of your signature, and then have another person subscribe your name either before or after you make your mark. Or you may have someone sign for you at your direction. *Note that neither a health care provider nor an employee of a health care employer who provides health care services to you can sign your name for you.*

**Witnesses.** Two witnesses' signatures are required for your Advance Health Care Directive to be valid in Pennsylvania. If you sign by mark or if you direct someone to sign your name for you, that person who signs your name may not be a witness. It is best where possible to avoid the use of witnesses who may be financially interested persons such as your heirs, your creditors, or your health care providers.

**Notarization.** Notarization is not required in Pennsylvania, but it is required in some other states, such as West Virginia. The form is more likely to be followed in other states if it is notarized.

**What to do now?** Carefully remove the two sheets which are your Advance Health Care Directive from this brochure, make copies to give to your doctor and agents and keep the original in a safe and accessible place. Make sure to tell your agents where you keep your original.

# Allegheny County Bar Association

*Raising the Bar  
on Legal and Community Service*



**ALLEGHENY COUNTY  
MEDICAL SOCIETY**

**ADVANCE HEALTH CARE DIRECTIVE NOTIFICATION**

Name: \_\_\_\_\_

I have a Health Care Power of Attorney and a Living Will, and I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

\_\_\_\_\_  
Agent Best Telephone No. \_\_\_\_\_

\_\_\_\_\_  
1st Alternate Best Telephone No. \_\_\_\_\_

\_\_\_\_\_  
2nd Alternate Best Telephone No. \_\_\_\_\_

Fill out this card and keep it in your wallet with your medical insurance card and driver's license.

_____	_____
My Physician	Telephone
_____	_____
My Attorney	Telephone

Fill out this card and keep it in your wallet with your medical insurance card and driver's license.