An Advance Directive Packet

Peace of Mind in an emergency. Because it's your life.

This is an Advance Directive Packet That Protects Life-Choice Decisions.

Any Advance Directive is a Personal Choice.
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What is My LifePlan Holdings, Inc.™ (MLPH™)?

MLPH™ is a healthcare technology company that stores and transmits advance directives, living wills, medical history and other medical information for members.

NOTE: All information provided in this packet is confidential. You are responsible for what information you provide.

- MLPH™ Advance Directive Packet/Advance Directive Declaration gives each person authority to choose how to live out their life.
- MLPH™ will provide this educational packet when an individual is cognitive and under no duress.
- MLPH™ will store all information pertaining to the individual's choices and will transfer information almost instantly, by use of our bio-metric/computer technology, to:
  - First Responders
  - Hospitals
  - Donor Registries
  - Other Health-Care Facilities as needed

Although most people prefer not to discuss illness or death, everyone eventually faces both. At My LifePlan Holdings, Inc.™ (MLPH™) we want to inform people about their options regarding these phases of life.

MLPH™ understands that every individual has his/her own ideals, morals, religious beliefs, and lifestyles. We believe that each person should be able to express those opinions even if they become unable to speak and/or incapacitated.

MLPH™ can empower people to do just that.

How it works:

- Prospective MLPH™ members attend a free educational seminar or visit the MLPH™ website.
- Seminar attendees will complete an MLPH™ Advance Directive Packet with help from an MLPH™ representative. This can also be done online.
- The time, date, and location of each MLPH™ seminar will be noted in local newspapers, company website and other media.
- An attorney will be present to explain legal rights and issues.
- An MLPH™ Representative will explain how our program works.
- The person is then assigned an MLPH™ User ID and password.
- Each new MLPH™ member will receive an ID card containing MLPH™ member ID number and important contact phone numbers.
- MLPH™ will keep the original advance directives packet and members will keep a copy, and will be available online in a PDF format.
- MLPH™ enters member data into its database, secured through HIPAA encryption/SSL.
- The individual pays an annual processing fee.
- MLPH™ will send each member a brochure with information for ordering optional ID necklaces, bracelets, and tags. In an emergency, these items will alert first responders to the fact that the person in their care is an MLPH™ member.

How does one make Ethical Health Care Choices?

Each of us has to use our own common sense when deciding how to handle medical questions and be able to make proper choices, choices based on sound medical judgment by physicians as well as formed ethical considerations. Only you have to live with the outcome of the choices you make. MLPH™ allows each member to maintain and express their own individual values.
**What Ethical Roles do Hospitals have to follow?**

When an MLPH™ member arrives at the ER, hospital personnel will scan their finger or enter their ID card number. They will follow the patient’s directives and fulfill their most important role of treating the patient and helping them make a full recovery. If, however, a patient arrives at the ER in a condition from which doctors agree they will not recover, the patient’s advance directives may come into play regarding the patient’s feelings about being kept alive by artificial means.

The rules would be different; however, if a patient is kept alive through a feeding tube and/or other means of feeding/hydration before the hospital receives the patient’s advance directives. In that case, the hospital may need to keep the patient alive regardless of instructions in his/her advance directives.

**FAQ (Frequently Asked Questions)**

- **What is a Declarant?**
  A declarant is the person who is signing this document and whose wishes are indicated in the document.

- **What is an Advance Directive?**
  It is a legal document to be used if you become unable to speak on your own behalf. It will tell your doctor and your family exactly what medical choices you have made for yourself. It is also referred to as your Living Will.

- **What is a Do Not Resuscitate or DNR/DNI order?**
  It is the medical order in which the declarant states that they do not wish to be administered heart resuscitation (CPR) or wish a tube placed into the trachea (airway to the lung) for breathing purposes.

- **What is Cardiopulmonary Resuscitation or CPR?**
  Cardiopulmonary resuscitation (CPR) is an emergency procedure involving chest compressions (pressing down on the chest) and artificial respiration (rescue breathing) through a tube in the trachea (airway to the lungs). It can also involve inserting a tube through the nose or mouth into the stomach, receiving intravenous medication to help restart the heart or revive a low heart rate, or applying electric shock to the chest.

- **What is Healthcare?**
  Any medical procedure, treatment, or intervention used to maintain or diagnose any physical or mental condition. This is to include dental, nursing, psychological, and surgical.

- **What is a Healthcare Power of Attorney?**
  A form in which a person names an adult to be their agent and make or follow through with their healthcare choices if the declarant is unable to do so.

- **What is Life-Sustaining Treatment?**
  Any healthcare which will serve to prolong life.

- **What is an Agent or Attorney-In-Fact?**
  The adult the declarant names as his/her Healthcare Power of Attorney.

- **What is a Terminal State?**
  Someone at the end of the disease process and death is imminent within one week.

- **What is Comfort Care?**
  Any measure taken to diminish pain or discomfort, but not necessarily to prolong life, to include hydration and food, orally, intravenously, or by other means.

- **What is a Donor Registry Form?**
  This is a form filled out by the declarant that describes their wishes regarding making an Anatomical Gift or, stating that they do not wish to make one.

- **What is an Anatomical gift?**
  This is a donation of all or part of a human body that takes effect upon or after death. The declarant may wish to give some organs or tissue as a gift, or make no gift at all.

Please sign that you have read and understand all terms and conditions listed above.

Signature

Date

Witness Signature

Date
My LifePlan Holdings, Inc. ™ Advance Directive Declaration:

• When would the Advance Directive Packet not be used?
  If you are able to speak and tell your doctor your wishes about your medical treatment.

This is a legal document to be used if you become unable to speak on your own behalf. This Advance Directive Packet will tell your doctor and your family exactly what medical choices you have made for yourself. This packet will discuss what form of life sustaining measures you would like. Being of sound mind and cognitive state, you may determine options such as organ donations, medical treatments, comfort care treatment, and any other medical choice important to you.

The Advance Directive will only go into effect if you are unable to speak on your own behalf pertaining to your medical care wishes.

When the Advance Directive Packet is issued to the hospital, your physician will attempt to speak with any or all persons on your list of contacts.

The law does allow for the immediate family to challenge a physician's determination that there is no medical bridge to recovery, i.e., that you are terminal and incompetent. However, if you specify in your Advance Directive Packet what you want, the law will not allow for any family to change, alter, or create conflict to these binding and legal documents.

Your Advance Directive (Living Will) in the Advance Directive Packet of My LifePlan Holdings, Inc.™ takes precedent over the Healthcare Power of Attorney. You can disregard or change your Advance Directive Packet by calling My LifePlan Holdings, Inc.™ and setting up an appointment to review the packet. You may also revoke, in an emergency setting, your Advance Directive by informing your physician and family that you have changed your mind and would like to terminate your Advance Directive (Living Will) in the My LifePlan Holdings, Inc.™ Advance Directive Packet.

We will - Date and sign all Advance Directive forms in the presence of two witnesses to include signatures, addresses, and dates in front of a notary public and will then apply the My LifePlan Holdings, Inc. ™ seal.

The following people may not serve as a witness to your Advance Directive Packet:

Anyone related to you by blood, marriage, adoption, or any medical administrator or clinician in whose care you belong. This is to mean your husband or wife, your children, your family doctor, administrator of a nursing home, or any other administrator at a care facility.

Advance Directive General Contact Information Declaration

My Full Name: ____________________________ Date of Birth: __________ Social Security Number: ______
Street Address: ____________________________ Apt # ______
City: ____________________________ State: ______ Zip: ______ Home Phone: __________
Work Phone: __________ Cell Phone: __________ E-mail: ____________________________

Emergency Contact Information

1.) Name: ____________________________
   Street Address: ____________________________ Apt # ______
   City: ____________________________ State: ______ Zip: ______
   Home Phone: __________ Work Phone: __________ Cell Phone: __________

2.) Name: ____________________________
   Street Address: ____________________________ Apt # ______
   City: ____________________________ State: ______ Zip: ______
   Home Phone: __________ Work Phone: __________ Cell Phone: __________

3.) Name: ____________________________
   Street Address: ____________________________ Apt # ______
   City: ____________________________ State: ______ Zip: ______
   Home Phone: __________ Work Phone: __________ Cell Phone: __________
Emergency Health Care Information:

Physician Name: ___________________________ Phone Number: ___________________________
Physician Facility: ___________________________ Physician Facility Phone: __________________

Primary Health Insurance
Health Insurance Provider: ___________________________ Health Insurance Provider Phone: __________
Policy Holder: ___________________________ Policy Number: ___________________________

Secondary Health Insurance
Health Insurance Provider: ___________________________ Health Insurance Provider Phone: __________
Policy Holder: ___________________________ Policy Number: ___________________________

Please list all major medical conditions, even if you are not currently being treated:

Cardio Vascular Disorder/Disease: ____
If yes, Please specify:

Respiratory Disorder/Disease: ____
If yes, Please specify:

Cancer: ____
If yes, Please specify:

Diabetes: ____
If yes, Please specify:

Seizure Disorder: ____
If yes, Please specify:

Other Disorder: ____
If yes, Please specify:

PIC lines/Permanent Venous/ Arterial Devices: ____
If yes, Please specify:

Vision Impairment: ____
If yes, Please specify:

Hearing Impairment: ____
If yes, Please specify:

Speech Impairment: ____
If yes, Please specify:

________________________________________________________________________

List Current Medications (If Any)

List Any Known Allergies
My Advance Directive Declaration

Please initial any and/or all lines below:

*Put a line through any you do not want (if doing this manually).

___ I state that this is my Advance Directive Packet housed and distributed by My LifePlan Holdings, Inc.™ and that I am of sound mind and not under or subject to duress, fraud, or undue influence.

___ I am a competent adult who understands and accepts the consequences of this action.

If I am unable to speak for myself, I want the following:

___ DNR (do not resuscitate)
___ DNI (do not intubate)
___ DNRCC (do not resuscitate comfort care only)
___ Full Code
___ Cardiac resuscitation
___ Medication for pain only to the extent that it would not seriously threaten to shorten my life.
___ Intubation/ventilators
___ Hydration/IV Tube
___ Feeding tube
___ Medication/treatment/hospitalization as needed

If death is imminent and I cannot speak for myself, I want:

___ DNR (do not resuscitate)
___ DNI (do not intubate)
___ DNRCC (do not resuscitate comfort care only)
___ Full Code
___ Cardiac resuscitation
___ Medication for pain only to the extent that it would not seriously threaten to shorten my life.
___ Intubation/ventilators
___ Hydration/IV Tube
___ Feeding tube
___ Medication/treatment/hospitalization as needed

Special consideration: Pregnancy initial your choice/s:

___ If I am pregnant and cannot speak for myself, I want all lifesaving procedures for myself, even if I am declared legally brain dead, if there is a chance that prolonging my life could allow my child to be born alive. My attorney-in-fact must honor this declaration.

___ If I am pregnant and cannot speak for myself, I want any medical procedures that could prevent my death even if they could result in the death of my unborn child, provided all possible efforts are made to save the life of my unborn baby.

Other wishes:

Signature: ___________________________ Date: ______________

1.) Witness Signature: ___________________________ Date: ______________

Street Address: __________________________________________________________________________ Aapt # _____
City: ___________________________ State: ___________ Zip: ___________ Phone: ___________________________

2.) Witness Signature: ___________________________ Date: ______________

Street Address: __________________________________________________________________________ Aapt # _____
City: ___________________________ State: ___________ Zip: ___________ Phone: ___________________________

___ These choices given above are to be implemented in the event that I am unable to give directives pertaining to my health care.

___ I wish this Advance Directive Packet Declaration honored by my family and physicians as the final expression of my legal right to request or refuse healthcare.
Healthcare Power of Attorney

A Healthcare Power of Attorney is different from a financial power of attorney that you use to give someone authority over your financial matters.

Choose carefully, as your attorney-in-fact or agent will have the power to authorize and refuse medical treatment for you in the event you do not fill out the Advance Directive (Living Will) Packet in its entirety and only fill out the Health Care Power of Attorney section.

There are limitations on the authority of your attorney-in-fact or agent:

1. Your attorney-in-fact may order that life-sustaining treatment be refused or withdrawn only if death is imminent.
2. Your attorney-in-fact does not have the authority to order the withdrawal of comfort care.
3. If you are pregnant, your attorney-in-fact cannot order the withdrawal of life-sustaining treatment if doing so would terminate the pregnancy, unless indicated in your Advance Directive.
4. Your attorney-in-fact may order that nutrition and hydration be withdrawn only if death is imminent and two physicians agree that nutrition and hydration will no longer provide comfort or alleviate pain. If you want to give your attorney-in-fact the authority to withhold nutrition and hydration you must indicate this in the appropriate section of the following Health Care Power of Attorney form. If you also have an Advance Directive (Living Will), it should be consistent with your Health Care Power of Attorney regarding the withholding of nutrition and hydration.
5. If you previously have given consent for treatment (before becoming unable to communicate), your attorney-in-fact cannot withdraw your consent.

CHECK LIST:

☐ I have an Advance Directive Declaration from My LifePlan Holdings, Inc.™ (MLPH™).
☐ I have a Healthcare Power of Attorney Form
☐ I am an Anatomical Gifts Donor

My Full Name: ___________________________ Date of Birth: __________ Social Security Number: _________
Street Address: __________________________ Apt # _______
City: __________________________ State: _____ Zip: _____ Home Phone: __________________________
Work Phone: __________________________ Cell Phone: __________________________ E-mail: __________________________

Three addresses and phone numbers of closest family or friends

1.) Name: __________________________
Street Address: __________________________ Apt # _______
City: __________________________ State: _____ Zip: _____
Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________

2.) Name: __________________________
Street Address: __________________________ Apt # _______
City: __________________________ State: _____ Zip: _____
Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________

3.) Name: __________________________
Street Address: __________________________ Apt # _______
City: __________________________ State: _____ Zip: _____
Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________
Healthcare Power of Attorney (Cont.)

I state that this is my Healthcare Power of Attorney and I abolish any prior Healthcare Power of Attorney signed by me before this prior date ____/____/____. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document. The Healthcare Power of Attorney is in effect only when I cannot make healthcare decisions for myself. This does not require or imply that a court must declare me incompetent.

**Naming of my Agent:** The person named below is my agent who will make healthcare decisions for me as authorized in this document.

Agent's Name: ______________________________

Street Address: _____________________________ Apt # ______

City: __________________ State: _____ Zip: _____ Phone: __________________

**Naming of Alternate Agents:** [**Note:** You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, please cross out the unused lines.]

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

**First Alternate Agent:**

Name: ________________________________

Street Address: _____________________________ Apt # ______

City: __________________ State: _____ Zip: _____ Phone: __________________

**Second Alternate Agent:**

Name: ________________________________

Street Address: _____________________________ Apt # ______

City: __________________ State: _____ Zip: _____ Phone: __________________

Any persons can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

**Guidance to Agent:** My agent will make healthcare decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make healthcare decisions in my best interests. If no agent is available, this document will guide decisions about my healthcare.

**Authority of Agent:** My agent has full and complete authority to make all healthcare decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following:
Healthcare Power of Attorney (Cont.)

**[Note: Cross out any authority that you do not want your agent to have.]**

1. To consent to the administration of pain relieving drugs, treatment, or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment, or procedures may possibly hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.

2. If death is imminent, my agent can consent to give informed consent to life sustaining treatment including nutrition or hydration.

3. If death is imminent, my agent can consent to withdraw informed consent to life sustaining treatment including nutrition or hydration.

4. If death is imminent, my agent can refuse to give informed consent to life sustaining treatment including nutrition or hydration.

5. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and healthcare records.

6. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

7. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

8. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent’s instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Healthcare Power of Attorney. I will be bound by such indemnity entered into by my agent.

9. To select, employ, and discharge healthcare personnel and services providing home healthcare and the like.

10. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or healthcare facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes, and the like.

11. To transport or arrange for my transportation to a place where this Healthcare Power of Attorney is honored should I become unable to make healthcare decisions for myself in a place where this document is not enforced.

12. To complete and sign for me the following:
   a. Consents to healthcare treatment or the issuance of Do Not Resuscitate/Intubate (DNR/DNI) Orders or other similar orders; and
   b. Requests for my transfer to another facility, to be discharged against healthcare advice, or other similar requests; and
   c. Any other document desirable to implement healthcare decisions that my agent is authorized to make pursuant to this document

**Additional Instructions or Limitations.** I may give additional instructions or impose additional limitations on the authority of my agent

**[Note: On the lines below, you may write in additional instructions or limitations. Here you may include any specific instructions or limitations you consider appropriate, such as instructions to refuse specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. If the space below is not sufficient, you may attach additional pages. If you include additional instructions or limitations here and your wishes change, you should complete a new Healthcare Power of Attorney and tell your agent about the changes. If you do not have any additional instructions or limitations, you may wish to write None below or cross out the unused lines.]**

Agent should first contact:

Name: ____________________________

Street Address: ____________________________ Apt # ______

City: ____________________________ State: _____ Zip: ______ Phone: ______________________

Second Contact:

Name: ____________________________

Street Address: ____________________________ Apt # ______

City: ____________________________ State: _____ Zip: ______ Phone: ______________________
*If you wish to donate any of your organs after death, fill out the following form:

**DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)**

**Important Donation Facts**
- An gifts donation information provided through the state Donor Registry can be accessed and used only by authorized organ, tissue, and eye recovery agencies in your state.
- Your status as an anatomical gift donor is considered only after every effort has been made to save your life and you have been declared legally dead.
- The recovery of organs and tissues is a surgical procedure that ensures the donor's body is treated with dignity and respect. An open casket is still possible.
- All costs associated with organ and tissue donation are paid for by the organ procurement organization. You should know this may be a for profit organization as well.
- You can change your mind or refine your intent at any time, but only by completing a new Donor Registry Enrollment Form and sending it to the Bureau of Motor Vehicles.
- If you are under 18 years of age and wish to be a registered donor, one of the witnesses on your donor Registry Enrollment Form must be your parent or legal guardian.
- Organ donation is an anonymous process that ensures your gift will go to the person who needs it most.

**INSTRUCTIONS:**

In addition to completing the references to Anatomical Gifts in your Advance Directive Declaration and Healthcare Power of Attorney, you should also complete and file the Donor Registry Form in this Advance Directive Packet with your Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organ and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Donor Registry of your state and will be accessible only to appropriate organ, tissue, or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions.

*Two witness signatures below are required:*

Please choose one:

_____ Please include me in the Donor Registry
_____ Please remove me from the Donor Registry

**Advance Directive Anatomical Gift Giving:**

If you elect to make an anatomical gift (organ donation), please fill out list below. My LifePlan Holdings, Inc. ™ will house and store your information in our data bank and, upon your death; the hospital will immediately notify the Donor Registry Bank and let your wishes be known.

_____ I wish to make an anatomical gift.
_____ I do not wish to make an anatomical gift.
If you checked that you wish to make a gift, please fill out the **Donor Registry Enrollment Form**.

**DONOR REGISTRY FORM**

Name of Living Donor: ___________________________________________ SSN: _________________

Street Address: ___________________________________________ Apt #: ________

City: ___________________________ State: _____ Zip: ______ Home Phone: ______________________

Work Phone: ___________ Donor date of Birth _________ Drivers License or ID card Number: ____________

In the event of my death, I would like to donate the following: **(Please circle which organ/s you would like to donate if done manually)**.

Liver:
Bone/Ligament:
Heart Valves:
Heart:
Kidneys:
Veins:
Skin/Tissue:
Lung:
Pancreas:
Eyes:

Any other organ please name here (write manually).

In the hope that I, __________________ may help others upon my death or on my death; I make an anatomical gift of the specified organ/s, for any purposes indicated below: **(Please circle your choice/s manually)**.

- Transplantation
- Therapy
- Research
- Education
- Advancement of medical science
- Advancement of dental science

Signature of Donor ___________________________ Date _________________

Witness: ___________________________________________ Date _________________

Witness: ___________________________________________ Date _________________

**Notary Acknowledgment**

State of: ___________________________ County of: ___________________________

On ____________________________ , 20 ______, before me, the undersigned Notary Public, personally appeared (Client Name) ________________________________________, known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

Notary Public Name: ___________________________________________

Notary Public Signature: _______________________________________

My Commission Expires: _______________________________________

Notary Seal