Name: _____

FINANCIAL POWER OF ATTORNEY

Effective upon: ☐ signing ☐ written determination of incapacity by your physician

Agents (in order of priority):

1. Name: _____ Relation: _____
   Address: _____ Phone: _____
2. Name: _____ Relation: _____
   Address: _____ Phone: _____
3. Name: _____ Relation: _____
   Address: _____ Phone: _____
4. Name: _____ Relation: _____
   Address: _____ Phone: _____

HEALTH CARE POWER OF ATTORNEY

Agents (in order of priority):

1. Name: _____ Relation: _____
   Address: _____ Phone: _____
2. Name: _____ Relation: _____
   Address: _____ Phone: _____
3. Name: _____ Relation: _____
   Address: _____ Phone: _____
4. Name: _____ Relation: _____
   Address: _____ Phone: _____