

Name(s): _____

FINANCIAL POWERS OF ATTORNEY

Financial POA for (client A): _____

Effective upon: [] signing [] written determination of incapacity by your physician

Agents (in order of priority):

1. Name: _____

Address: _____

Relation: _____

Phone: _____

2. Name: _____

Address: _____

Relation: _____

Phone: _____

3. Name: _____

Address: _____

Relation: _____

Phone: _____

4. Name: _____

Address: _____

Relation: _____

Phone: _____

Financial POA for (client B): _____

Effective upon: [] signing [] written determination of incapacity by your physician

Agents (in order of priority):

1. Name: _____

Address: _____

Relation: _____

Phone: _____

2. Name: _____

Address: _____

Relation: _____

Phone: _____

3. Name: _____

Address: _____

Relation: _____

Phone: _____

4. Name: _____

Address: _____

Relation: _____

Phone: _____

HEALTH CARE POWERS OF ATTORNEY

Health Care POA for (client A): _____

Agents (in order of priority):

1. Name: _____

Address: _____

Relation: _____

Phone: _____

2. Name: _____

Address: _____

Relation: _____

Phone: _____

3. Name: _____

Address: _____

Relation: _____

Phone: _____

4. Name: _____

Address: _____

Relation: _____

Phone: _____

Health Care POA for (client B): _____

Agents (in order of priority):

1. Name: _____

Address: _____

Relation: _____

Phone: _____

2. Name: _____

Address: _____

Relation: _____

Phone: _____

3. Name: _____

Address: _____

Relation: _____

Phone: _____

4. Name: _____

Address: _____

Relation: _____

Phone: _____