MLCP® Health Care Document Set / Data Entry

Entry fields with a red asterisk (*) are minimally required for submission.

*Access Code: _____

CLIENT / SPOUSE PERSONAL INFORMATION

Client:

_____	___	_____	_____	____	_____
*First Name	MI	*Last Name	DOB	M/F	Y/N - U.S. Citizen

Spouse:

_____	___	_____	_____	____	_____
First Name	MI	Last Name	DOB	M/F	Y/N - U.S. Citizen

Address:

_____ _____
*Street Address (or P.O. Box # Unit

_____ _____ _____
*County/Parish *State *Zip Code

Contact:

_____ _____
*Daytime Phone Other Phone

_____
*E-mail Address

PERSONAL HEALTH CARE AGENT APPOINTEE(S)

If you are married, it is assumed that your spouse will serve as your Primary Health Care Agent, if able, before the appointees listed below.

Client's Appointments:

1) _____ ___ _____ _____
First Name Initial Last Name Relationship

2) _____ ___ _____ _____
First Name Initial Last Name Relationship

Spouse's Appointments:

1) _____ ___ _____ _____
First Name Initial Last Name Relationship

2) _____ ___ _____ _____
First Name Initial Last Name Relationship

NOTES / COMMENTS / QUESTIONS

NOTICE TO PURCHASER: Entries in the "Notes/Comments/Questions" textbox below will be auto-posted and permanently recorded in your (forthcoming) Client Console's NotePad Message Center. Archived NotePad message entries can be made available, by your choosing, for viewing and additional text entry applications by your legal counsel and/or other select persons.

My LifeCard Plan®
Health Care Document Set w/Storage Account

- Contract & Purchase Agreement -

I, _____, identified as the Purchaser(s) entering into this Contract hereby acknowledge and agree to the following representations and terms:

- Overview & Disclosure of Terms-

1) Service Platform. The My LifeCard Plan® (MLCP) **Health Care Document Set w/Storage Account** "placement" is offered to "Purchasers" through the **MLCP Silver Membership** subscription program and serviced exclusively through the MLCP-affiliated Inter-Networking Service Protocol (INSP) platform.
2) Originating Placement Fee. The MLCP Silver Membership placement fee represents payment for the **(i)** data base origination/processing, **(ii)** auto-generation and placement of a data-merged, personalized Health Care Document Set "template", and **(iii)** first 30-day MLCP Provisional Membership subscription fee deemed part of the Purchaser as Account Holder's MLCP subscription contract defined hereunder.
3) Printing/Shipping Policy. Unless otherwise requested through a line item purchase order, the Purchaser's MLCP Health Care Document Set will not be printed or shipped in material form by MLCP processing. The Health Care Document Set must be printed by the Purchaser/Account Holder from his/her personal MLCP Client Console (if printed pages are wanted in addition to the electronic pages).
4) Free/Unlimited Change Access. Through the Client Console portal, a current MLCP Silver Membership "Account Holder" shall have unlimited (24/7) access to personally edit database entries for (re)merging new data field entry names of the Health Care Document Set from time to time and as many times as desired. The effect is to help facilitate the Account Holder's ability to implement future changes, if needed, as to the personal applications and intents of the originally-placed documents. Additionally, the Account Holder shall be able to (re)merge the revised data into an updated Health Care Document Set with contemporary "auto-populated" dates, which can then be placed over portions of the previously placed document set affected by the change(s).
5) Length of Contract. If so elected, **the Purchaser/Account Holder must maintain active, paid account status of the MLCP Silver Membership subscription for a minimum of twelve (12) consecutive months commencing thirty (30) days after the original purchase date**. After the 12-month account subscription term has been completed, the Account Holder may cancel the subscription with no further obligations. If the Membership has not been cancelled after the required 12-month term has been fulfilled, it shall continue as an automatic renewal each month (or year) thereafter until the Account Holder cancels his/her Membership through his/her Client Console portal.
6) Pre-Term Cancellation Fee. A pre-fulfillment cancellation of the MLCP Silver Membership may incur a penalty fee. Such pre-fulfillment cancellation fee will be assessed directly to the Account Holder's INSP-registered credit card if the Account Holder opts to cancel his/her MLCP Silver Membership before the completion and contractual fulfillment of the 12-month recurring billing subscription term.
7) Membership Renewal Policy. Re/Activation Fees to renew a previously cancelled or lapsed MLCP Silver Membership will be prorated to the length of time that the account expired before the date of renewal.

- Acknowledgement of Terms –

I acknowledge that I have read and understand the above "Overview & Disclosure of Terms" of the My LifeCard Plan® (MLCP) Silver Membership Account Holder plan. I now choose to secure the products, services and benefits provided for a purchaser of the MLCP Health Care Document Set Placement w/Silver Membership Account; I therefore agree to abide by the terms defined therein and which are further described below:

8) Efficacy of Template Forms. I acknowledge that neither MLCP nor any affiliated service entities associated with the INSP® platform concerning the offering and production of the MLCP Health Care Document Set templates are providing me with independent legal counsel as to the application, suitability, or effectiveness of said Health Care Document Set templates and all forms included therewith, and no representation has been made to me otherwise.
9) LEGAL APPLICATIONS. I ACKNOWLEDGE AND AGREE TO ACCEPT FULL RESPONSIBILITY OF PERFORMING MY OWN DUE DILIGENCE (WITH MY LEGAL COUNSEL) IN REGARDS TO THE EFFICACY AND PERSONAL SUITABILITY OF ANY DOCUMENT PLACEMENT(S) HEREOF FOR USE IN MY CURRENT STATE OF DOMICILE AND ANY OTHER DOMESTIC AND/OR FOREIGN JURISDICTION(S) WHERE I MAY EMPLOY A PORTION OR ALL OF MY PLACED DOCUMENT SET FROM TIME TO TIME.

10) Inculpable Placement Offering. I acknowledge and agree that (absent fraud) MLCP, and any affiliated parties that may provide implementation or other services in conjunction with this offering, shall be removed from any liability concerning the legal and/or statutory meanings, applications, and/or the administrations of this MLCP Health Care Document Set w/Storage Account placement.
11) Free/Unlimited Change Access. I understand that one of the benefits provided to me as a current MLCP Platinum Membership Account Holder is having the ability to edit the name entry fields of my personal MLCP database to be able to replace any previous agent appointments and to replace and reprint changed documents, which can be done ONLY through my INSP® membership-assigned Client Console (as prescribed on the MLCP Account Holder Benefits Overview page).
12) Addendums to Documents. I understand that it is my personal responsibility to seek independent legal advice relative to not only the application of any documents provided by the MLCP/INSP platform but also for any addendums to the documents that I may request.
13) Document Delivery. I acknowledge that, unless otherwise ordered, all revised documents generated by the INSP platform for MLCP Account Holders will be completed and presented only in electronic form on the MLCP server through my Client Console.
14) Pre-Term Cancellation Fee. I acknowledge that if I cancel my MLCP Silver Membership prior to the completion of the contractual 12-month recurring-billing subscription term then I shall incur a penalty fee. I understand that such pre-term cancellation fee will be auto-assessed to my INSP-registered credit card or must otherwise be paid by me from another source if said card is no longer available.
15) Re/Activation Fees. **I acknowledge that if I opt out of my personal MLCP Account Holder membership subscription, or it lapses due to nonpayment, I will be charged a prorated, re/Activation Fee if I renew at anytime later than the 10-day grace period or the renewal deadline**. Additionally, I understand that if I renew my MLCP membership anytime after the subscription expiration date, I am required to pay the monthly fees that would have otherwise been assessed up to twelve (12) consecutive months after the renewal date *in addition to any re/Activation Fees*.
16) Recurring Billing. I acknowledge that if I opt into the billable MLCP Membership my account will be debited each month (or annually) for the prescribed MLCP Account Holder Platinum Membership Fee until formally cancelled or terminated or until the mandatory 12-month subscription period has been completed (if applicable). I understand that the MLCP Membership Fee cannot be (a) increased prior to the fulfillment of twelve (12) consecutive months of subscription activity and (b) not more frequently than annually.
17) INSP® Service Cancellation Policy. I acknowledge that the business model of the My LifeCard Plan Account Holder Silver Membership program includes long term service and accountability to the end-user Purchaser/Account Holder through the multidisciplinary MLCP/INSP service platform. Notwithstanding, I agree that the INSP service parties are autonomous and thus reserve independent rights to refuse service, whether contractual or implied, without cause to any MLCP Account Holder at any time upon submitting an electronic, 30-day notice of the same to the MLCP/INSP platform.

TOTAL PLACEMENT/CONTRACT FEE > FREE

I, _____, the above identified Purchaser, acknowledge the terms of the "My LifeCard Plan" Silver Membership Account Holder Placement Contract & Purchase Agreement and hereby confirm the same by clicking on the "I AGREE" button below thus signifying that I have read, do understand, and hereby agree to the representations, stipulations, disclosures, requirements, and terms prescribed therein.

I AGREE _____ *(please initial)*

ADVANCE MEDICAL DIRECTIVE WORKSHEET

- Data Entry Ledger -

PART A – This Advance Medical Directive shall be Created By:

Name _____

Address _____

City, State, Zip _____

Close to Death / End of Life –

If I am (a) close to death where tube feeding and/or life support would only postpone the moment of my death, and/or (b) unconscious and it is highly unlikely that I will ever regain consciousness again, and/or (c) I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize loved ones, and it is very unlikely that my condition will substantially improve, then I request that the following actions be taken, or not taken, as indicated by a marked box:

Check as applicable about TUBE FEEDING:

- ☐ I want tube feeding/hydration
- ☐ As my Agent recommends
- ☐ As my Physician recommends
- ☐ I want no tube feeding/hydration
- ☐ See my personal directives herein

Check as applicable about LIFE SUPPORT:

- ☐ I want life support
- ☐ As my Agent recommends
- ☐ As my Physician recommends
- ☐ I want no life support
- ☐ See my personal directives herein

Check for NO tube feeding or life support:

- ☐ **I Choose Not To Prolong My Life** if (a) I have an incurable and irreversible condition that will likely result in my death within a short time, and/or (b) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, and/or (c) the apparent risks and burdens if treatment would outweigh the expected benefits.

PART B – SPECIFIC DIRECTIVES

Requested Cardiopulmonary Resuscitation (CPR) Treatment –

If I stop breathing or my heart stops beating:

- ☐ Resuscitate me
- ☐ Do not resuscitate (DNR)

– UNLESS the following condition(s) exists:

Treatment for Pain –
I hereby direct that treatment to alleviate pain or discomfort be provided at all times, even if it hastens my death – EXCEPT AS FOLLOWS:

Surgery and Blood Dialysis/Transfusions –
If I am in an end-of-life condition as generally described in this Advance Directive, I direct that there be NO surgeries, blood dialysis or transfusions (of blood or other fluids) conducted to prolong my life, even if it hastens my death – EXCEPT AS FOLLOWS:

Potential Allergens –
Listed below are medicines, and/or certain foods, that cause or have caused an allergic reaction in my body (and my comments concerning such allergies):

Additional Health (and/or Mental) Care Instructions –

My Agent May Decide –
Unless otherwise indicated in this Advance Directive, and/or to the extent my wishes recorded herein are unknown, unclear, or logically deemed apparent by my agent as medically contrary to my current condition, my health care agent shall have the authority to make ALL health care decisions for me in accordance with what my agent determines to be in my best interest including: (a) consenting, refusing consent, and/or withdrawing consent for medical treatment including life-sustaining treatments; (b) requesting specific medical treatments on my behalf; (c) employing or discharging any public or private health care providers and/or public or private treatment venues; and (d) allowed access to my medical records NOTWITHSTANDING any information that may be regulated by the Health Insurance Portability and Accounting Act of 1996 (HIPAA) – EXCEPT AS FOLLOWS:

PART C – APPOINTMENT OF HEALTH CARE AGENT(S)

(*NOTE: You should not appoint your doctor, an employee of your doctor, or any owner, operator or employee of your health care facility as your Health Care Agent*.) THE FOLLOWING IDENTIFIED PERSON(S) ARE APPOINTED TO SERVE AS MY HEALTH CARE AGENTS SUCCESSIVELY IN THE ORDER SHOWN BELOW:

Primary H/C Agent Appointee:

Name / Relationship

Phone / Email

Current Address

Alternate H/C Agent Appointee:

Name / Relationship

Phone / Email

Current Address

PART D – AGENT'S AUTHORITY & ORGAN DONATION

(NOTE: You have a right to determine when your agent's authority becomes effective, which is either when your primary physician determines that you are unable to make decisions on your own or immediately.)

Agent's Effective Date –

My agent's appointment and authority becomes effective only when my attending physician determines that I am unable to make my own health care decisions – UNLESS OTHERWISE DETERMINED AS FOLLOWS:

Agent's Post-Decease Authority –

My agent is authorized to elect to order an autopsy and direct disposition of my remains – EXCEPT AS FOLLOWS:

Organ Donation Directive(s) –

- ☐ I do not authorize that any organs/tissue/parts be donated from my body.
- ☐ I authorize my agent to donate needed organs/tissue/parts from my body.
- ☐ I authorize specific-purpose donations for the following:
  - ☐ Transplant
  - ☐ Therapy
  - ☐ Research
  - ☐ Education
- ☐ I authorize certain limited donations as follows:

PART E – OTHER HEALTH CARE DOCUMENTS

(NOTE: A "Health Care Power of Attorney" appoints an agent to make certain health care decisions on one's behalf if unable himself/herself. A "Living Will" states wishes as to the extension or termination of one's life when in a terminal condition of such that he/she is unable to make such a decision.)

Health Care Power of Attorney –

Select as applicable:

- ☐ I have previously executed a Health Care Power of Attorney and IT IS TO REMAIN IN EFFECT. Notwithstanding, if any provision selected in this Advance Directive is not consistent with the provisions in my Health Care Power of Attorney then any such conflicting provision(s) selected in this Advance Directive shall instead apply.

- ☐ I have previously executed a Health Care Power of Attorney and I NOW REVOKE IT. Notwithstanding this revocation, if my medical treatment is being administered in a jurisdiction that otherwise requires the application of a portion or all of the terms of my Health Care Power of Attorney then any such required stipulations therein shall apply.

- ☐ I have NOT previously executed a Health Care Power of Attorney.

Living Will Declaration –
Select as applicable:

- ☐ I have previously executed a Living Will and IT IS TO REMAIN IN EFFECT. Notwithstanding, if any provision that I have selected in this Advance Directive is determined to be in conflict with any provision in my Living Will then any such conflicting provision(s) selected in my Advance Directive herein shall apply.

- ☐ I have previously executed a Living Will and I NOW REVOKE IT. Notwithstanding this revocation, if my medical treatment is being administered in a jurisdiction that necessitates the application of a part or all of the terms of my Living Will then any such required stipulations of my Living Will shall apply.

- ☐ I have NOT previously executed a Living Will.

– List Additional/Applicable Health Care Documents Below –

PART F – Appointment of Primary & Alternate Physician

NOTE: You have a right to designate a primary physician as applied herein. However, if you appoint a primary physician (and an alternate physician) who is not then available to act in that capacity on your behalf then the physician who would be attending to you at that time shall be allowed to act instead as your physician:

Select as applicable:

- ☐ I am not designating a primary physician with this document.

- ☐ I hereby designate the **following named physician(s) as my:**

Primary Physician:

Name / Relationship

Phone / Email

Current Address

Alternate Physician:

Name / Relationship

Phone / Email

Current Address

NOTICE: When you have completed your personal entries on this Data Entry Ledger to your satisfaction, you are ready to submit for processing. Submitting this Ledger – by clicking on the "Declaration" button (below) – will serve to auto-generate your personal Advance Health Care Directive Declaration according to the data you have entered. You will be able to electronically sign – ESIGN – your Advance H/C Directive that will INSTANTLY authenticate and simultaneously record the document. You may return to this Data Entry Ledger at any time 24/7 to make changes without limit as long as you have MLCP Membership access to your Client Console**. If circumstances permit, it is recommended that you also print out and sign your Advance Directive before witnesses and a Notary Public, and upload the same to the "Signed Health Care Documents" portal in your Client Console's E-Vault Center.**