

HEALTH DIRECTIVES, LLC TERMS AND CONDITIONS

HEALTH DIRECTIVES, LLC, a Pennsylvania limited liability company ("Health Directives"), makes your advanced directive accessible via the Internet to health care providers, health care proxies (agents, surrogates), family and friends.

First, the central purpose of the Health Directives service is to make your advance directive available to your health care providers, health care proxies (agents, surrogates), family and friends in times of need. Therefore, any person may access your advance directive from Health Directive's database using either your Health Directives Identification Number or your Social Security Number.

Second, Health Directives charges an annual subscription fee. Your annual fee will not increase as long as you continue your subscription. If your method of payment is by credit card, Health Directives may automatically charge your credit card at the yearly anniversary of your subscription unless or until you have canceled your Health Directive's subscription. You may cancel your Health Directive's service at any time by contacting Health Directives. Health Directives may terminate your subscription for failure to pay any part of the annual fee.

Third, the Health Directives service is provided to you by Health Directives "AS-IS" and "AS AVAILABLE." Health Directives does not assume any responsibility and/or liability for the timeliness, deletion, error, misdelivery or failure to store or communicate any information that you provide. Health Directives may, at any time, make modifications to its service (or any part thereof) with or without notice to you. In addition, Health Directives may, at any time, discontinue (temporarily or permanently) its service (or any part thereof), and Health Directives shall make reasonable efforts to notify you of such discontinuance. Health Directives shall not be liable to you or to any third party for any such modification or discontinuance of the service.

Fourth, Health Directives and The Benefit Network is not responsible for and/or liable to you for any direct, indirect, incidental, special, consequential or exemplary damages whatsoever in connection with your or any third party's use of its service, including without limitation, damages resulting from (a) a health care provider's reliance on, or failure to rely on, your advance directive, and (b) a health care provider's inability to access your advance directive from the Health Directives service for any reason.



*Communicate your health care wishes in time of need
with*

Health Directives™



www.healthdirectives.org
Voice: 866-MED-WISH

info@healthdirectives.org
Fax: 215-493-1062

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Patent Pending

An **Advance Directive (AD)** is (1) a **Living Will** expressing your medical wishes if you are unable to speak for yourself **and/or** (2) a **Health Care Proxy** designating another person or persons to speak on your behalf if you are unable to speak for yourself.

Instructions

1. Complete the information on the opposite page. Make sure that the information is correct and that you have understood and agree to the Health Directives, LLC Terms and Conditions.
2. By using The Benefit Network ID the Amount payable is \$15.
3. Complete an Advance Directive or attach an already completed Advance Directives. Make sure your Advance Directive is properly signed and witnessed or notarized.
4. Mail or fax the completed information and Advance Directive to:

Health Directives, LLC
 38 Timber Knoll Dr.
 Suite 200
 Washington Crossing, PA 18977
 Fax: (215) 493-1062

5. Upon receipt Health Directives will:
 - a. Activate your subscription.
 - b. Mail:
 - i. Copy of your personal information,
 - ii. Payment information,
 - iii. Username and password for accessing your Subscriber record at www.healthdirectives.org,
 - iv. Ten (10) wallet-size ID cards for distribution by you to those who may “need to know” including your doctor and family members.
 - c. If there are any inaccuracies, contact Health Directives immediately at info@healthdirectives.org or 1-866-MEDWISH.

Registration The Benefit Network 0201

First Name	
Middle Initial	
Last Name	
Address Line 1	
Address Line 2	
City	
State	
Zip Code	
Home Phone	
Alternate Phone	
Email	
Gender	
Date of Birth (mm/dd/yyyy)	
Social Security Number	
Driver’s License Number	
Health Insurance Number	
Credit Card (VISA, MasterCard)	
Name (as appears on card)	
Street Address	
City	
State	
Zip	
Amount	\$15.00
Card Type	<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard
Card Number	
Expiration	Month (mm) ____ Year (yyyy) ____

OR

Check or Money Order Enclosed
Made payable to Health Directives, LLC

1. I AGREE TO THE **TERMS AND CONDITIONS** ON THE NEXT PAGE; AND
2. I REPRESENT AND WARRANT THAT THE INFORMATION ABOVE IS TRUE, CURRENT, COMPLETE, AND ACCURATE; AND
3. I CONSENT TO THE SPONSOR NAMED AND IDENTIFIED ABOVE TO CONVEYING THE INFORMATION ABOVE AND MY ACCOMPANYING ADVANCE DIRECTIVE TO HEALTH DIRECTIVES, LLC.

(Signature)

(Date)

DECLARATION

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become unable to speak for myself. This declaration reflects my firm and settled commitment regarding life-sustaining treatment under the circumstances indicated below.

I do **or** I do not want my attending physician to **withhold or withdraw** life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I do **or** I do not want my treatment to include measures to keep me comfortable and to relieve pain.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment. I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed below, I may receive that form of treatment.

I do **or** I do not want cardiac resuscitation.

I do **or** I do not want mechanical respiration.

I do **or** I do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I do **or** I do not want blood or blood products.

I do **or** I do not want any form of surgery or invasive diagnostic tests.

I do **or** I do not want kidney dialysis.

I do **or** I do not want antibiotics.

Other instructions:

I do **or** I do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name, address, and phone of surrogate (if applicable):

(Name)

(Address)

(Phone)

Name, address, and phone of substitute surrogate (if surrogate above is unable to serve):

(Name)

(Address)

(Phone)

I do () **or** I do not () want to donate an anatomical gift of all or part of my body, subject to the following limitations, if any:

(Place signatures on the following page)

