The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Health Care Proxy

State of Massachusetts

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

MASSACHUSETTS HEALTH CARE PROXY FORM

I, EXAMPLE _____(the principal), residing at_____, _____ County, Massachusetts, pursuant to Massachusetts General Laws Chapter 201D, appoint the following person to be my Health Care Agent:

Name: _____ Phone #: _____

Address:_____ City/State/Zip: _____

If my Health Care Agent named above is not available, I name as an alternate Health Care Agent:

Name: _____ Phone #: _____

Address:_____ City/State/Zip: _____

I give my Health Care Agent authority to make all health care decisions on my behalf if I become incapable of making such decisions for myself, including but not limited to decisions concerning initiation, continuing, withdrawing or refusing any life-prolonging care, treatment, service or procedure, EXCEPT (here list the limitations, IF ANY, you wish to place on your Agent's authority):

_____

_____

_____

_____

_____

My Health Care Agent shall make health care decisions for me in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs. If my wishes are unknown, my Health Care Agent shall make such decisions for me only in accordance with my Health Care Agent's assessment of my best interests.

My Agent may obtain any and all medical information, including confidential medical information, as I would be entitled to receive. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

My Health Care Agent's authority to act on my behalf shall exist only for the period during which my attending physician determines that I lack capacity to make or communicate health care decisions for myself.

I sign this Health Care Proxy on _____, 20_____ in the presence of two witnesses.

Signed:_____

(If the Principal cannot sign) The principal is unable to sign and at the direction of the principal I have signed his/her name in his/her presence and in the presence of two witnesses.

Name:_____

Street: _____ City/Town: _____

MASSACHUSETTS HEALTH CARE PROXY FORM

We, the undersigned witnesses, each declare in the presence of the principal that neither of us has been named as Health Care Agent or alternate Health Care Agent in this Health Care Proxy, and we further declare that the principal signed this instrument as his/her Health Care Proxy, or directed its execution, in the presence of each of us, that each of us signs this Health Care Proxy as witness in the presence of the principal, and that to the best of our knowledge he/she is eighteen (18) years of age or over, of sound mind, and under no constraint or undue influence.

Witness: _____ Printed Name: _____

Address: _____

Witness: _____ Printed Name: _____

Address: _____

Statement of Health Care Agent (optional)

Health Care Agent: I have been named by _____ (the "principal") as the principal's **Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Health Care Agent:**_____ Date: _____

Statement of Alternate Health Care Agent (optional)

Alternate: I have been named by _____ (the "principal") as the principal's **Alternate Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Alternate Health Care Agent:**_____ Date: _____