Your Complete

Information for Life™

Kit

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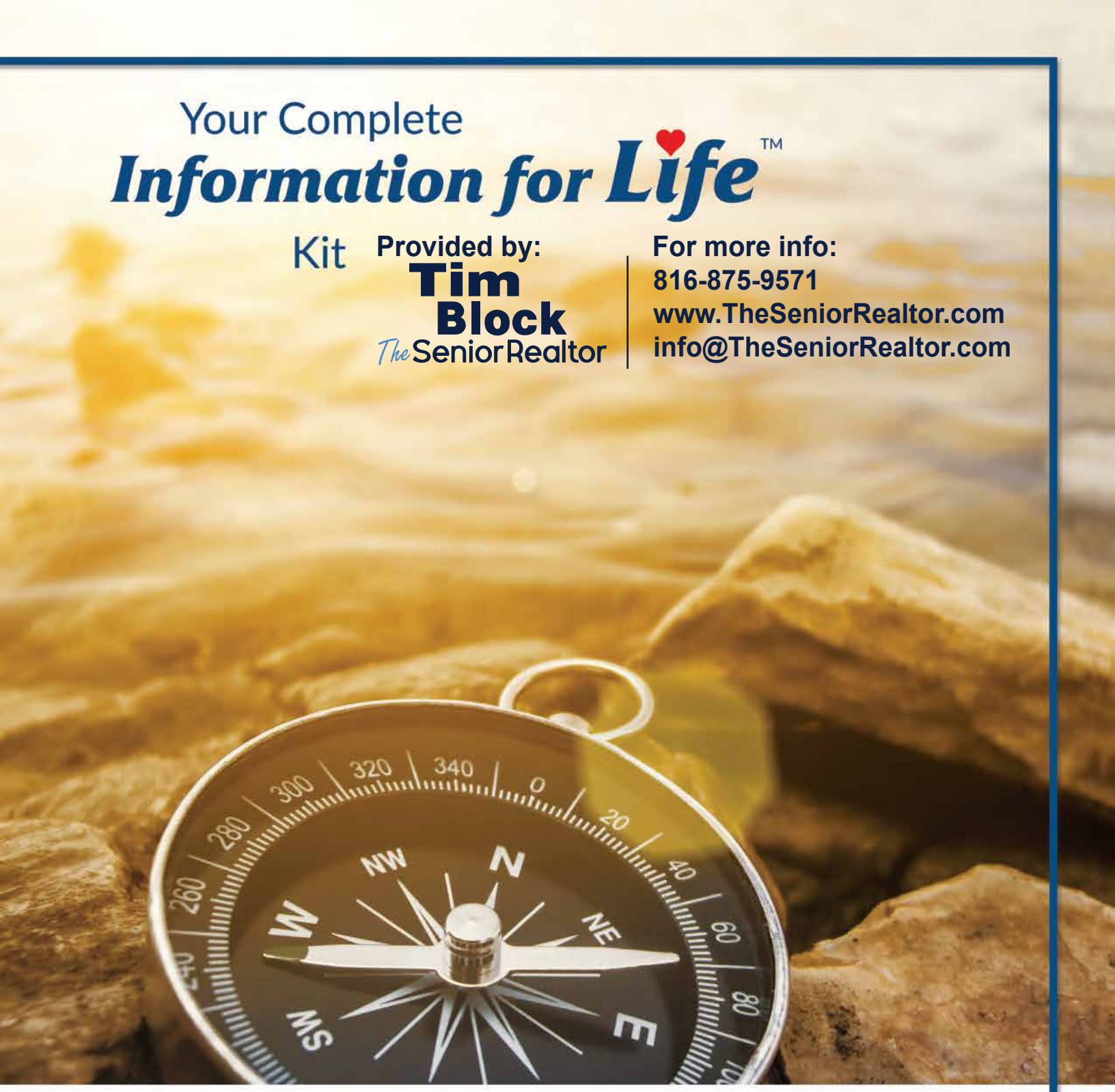

CSA

Society of Certified Senior Advisors®

The Information for Life Kit gives your family and trusted agents vital information they need to act on your behalf when you are unable to do so for yourself.

Most of us spend a lifetime developing a bond with family and friends. We love and care for each other, but one critical life-changing crisis can expose how unaware and uninformed our loved ones are concerning our vital records, information, and important wishes in the event of our incapacity or end of life.

Thinking proactively and using the Information for Life Kit™ provides a roadmap for your family and/or trusted agent(s) to have the vital information they need to act, as you have specifically directed, when you are unable to do so for yourself.

This comprehensive kit provides the guidance, forms and checklists you need to make your personal, health, legal, and financial information in order and up-to-date. Once you have completed your Information for Life Kit, it is critical that you inform your trusted agent(s) of its existence and location. Take the time to explain the purpose, use, and when an agent is to access this information.

Security and storage of the Information for Life Kit is very important. It should be stored in a safe place and it is recommended that a copy be made, which also needs to be stored in a safe place, possibly with your trusted agent.

The Information for Life Kit may not appear to be a typical gift, but it truly is one of the best gifts you can give yourself and those who care about you. The last thing we want to leave for those we love is an overwhelming burden. Once you have completed the Information for Life Kit for yourself, encourage your family members to be proactive and complete their Information for Life Kit.

This Information for Life Kit is brought to you by the Society for Certified Senior Advisors®.

CSA
Society of Certified Senior Advisors®

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About the Society of Certified Senior Advisors (SCSA)®

SCSA is the premier membership organization offering education and certification for professionals who serve older adults. The Certified Senior Advisor (CSA)® certification program was developed through a rigorous practice analysis involving hundreds of professionals in health, social, financial, legal and other areas who work with older adults. Dually accredited by the American National Standards Institute (ANSI) and the National Commission for Certifying Agencies (NCCA), the CSA credential applies to professionals in all areas of the aging industry. It signifies a person who has invested time and effort in learning about the things that are important to older adults, how to serve them more effectively, helping them navigate the complexities of aging, and supporting them in enjoying the unique opportunities of their later years.

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Information for Life™ Checklist

Use this page to monitor completion progress and for noting additional information.

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Basic Information

Use this section to provide basic and important information in the event you become ill or injured.

Personal Information

Full Name:

Nickname:

Date of Birth: Gender:

Address:

City: State: Zip:

Phone: Alternate Phone:

Email: Alternate Email:

Work Information

Employer:

Main Contact:

Address:

City: State: Zip:

Phone: Email:

Religious/Spiritual Information

Affiliation:

Pastor, Rabbi, Spiritual Leader: Phone:

Church, Synagogue, Spiritual Organization:

Address:

City: State: Zip:

Phone: Email:

Community Affiliations

Club, Group, Volunteer Organization:

Address:

Phone: Email:

Medical Conditions & History

Use this section to provide basic and important medical condition information.

Medical Conditions

Neurologic:

- ☐ Cerebral Palsy
- ☐ Epilepsy / Seizure Disorder
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Other:_____

Cardiovascular:

- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Other:_____

Kidney / Urinary:

- ☐ Renal Insufficiency / Failure
- ☐ Urinary Retention
- ☐ Recurrent Infection
- ☐ Other:_____

Gastrointestinal:

- ☐ GERD
- ☐ Dysphagia
- ☐ Constipation
- ☐ Other:_____

Metabolic / Endocrine:

- ☐ Diabetes
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Other:_____

Cancer / Neoplasm:

- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Stomach Cancer
- ☐ Brain Cancer
- ☐ Skin Cancer
- ☐ Other:_____

Respiratory:

- ☐ Pneumonia
- ☐ Asthma
- ☐ COPD
- ☐ Recurrent Infection
- ☐ Aspiration

Musculoskeletal:

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other:_____

Other Conditions

This section is not intended to replace full medical records.

Medical Conditions & History

Use this section to provide information about past hospitalization, surgery, and trauma.

Surgery, Trauma, Hospitalizations

Date / Year of Event	Type of Event	Outcome

Additional Information

This section is not intended to replace full medical records.

Medical Conditions & History

Use this section to provide information about your family health history.

Family History

Condition	Relationship
☐ Diabetes	
☐ High Cholesterol	
☐ High Blood Pressure	
☐ Heart Disease	
☐ Colon Polyps	
☐ Osteoporosis	
☐ Osteoarthritis	
☐ Stroke	
☐ Cancer	
☐ Other:_____	

Additional Information

This section is not intended to replace full medical records.

Medical Conditions & History

Use this section to provide information about medication or supplements you take.

Medications

Medication/Supplement Name and Description of Pill	Reason for Taking	Frequency and Dosage

Additional Information

This section is not intended to replace full medical records.

Medical Conditions & History

Use this section to provide additional medical information.

Allergies

1. Allergic to:
Reaction:
2. Allergic to:
Reaction:
3. Allergic to:
Reaction:

Immunizations

1.	**Date:**
2.	**Date:**
3.	**Date:**

Physical Aids

General Aids:

☐ Glasses ☐ Dentures ☐ Hearing Aid ☐ Other: _____

Mobility Aids:

☐ Walker ☐ Cane ☐ Wheelchair ☐ Scooter ☐ Other: _____

☐ Prostheses	Details:
☐ Transfer Aids (sling, belt, etc.)	Details:
☐ Bed Accessories (rails, etc.)	Details:
☐ Bathroom Accessories	Details:
☐ Other Aids	Details:

Additional Information

_____

_____

_____

_____

_____

This section is not intended to replace full medical records.

Please review the information in this section.

Introductory Guide to Advance Directives

What is an Advance Directive?

If you become unable to make decisions for yourself, an advance directive tells healthcare providers what kind of treatments you want and what kind of treatment you don't want. The directives also provide guidance and peace of mind for family members and friends, because your wishes are clearly indicated.

Individuals 18 years of age or older can prepare advance directives so their wishes are known in case of an accident or the sudden onset of an illness. Advance directives are typically prepared by people who are terminally or seriously ill.

Advance directives are different in each state and can take various forms. Be sure to check with your state when preparing your advance directives.

Preparing Advance Directives

- Get thorough information about the various life-sustaining treatments.
- Make a decision about what treatment(s) you prefer.
- Talk to your family and/or healthcare providers about your preferences.
- Use a form provided by your doctor, write down your directives yourself, or talk with an attorney.
- Follow your state-specific guidelines, which can be found at the state health department or state department on aging.
- Have the document(s) signed by appropriate witnesses or a notary.
- You do not need a lawyer to prepare advance directives, but be sure to follow your state's guidelines.

Storing Advance Directives

- They must be easily accessible and protected from theft, fire, flood, etc.
- Make several copies and distribute to your doctors, a trusted family member or loved one, your Health Care Agent, your attorney, and for your personal files.

Types of Advance Directives:

1. **Living Will** – A written legal document that expresses your decisions for medical treatment or life-sustaining treatments in the event you are incapacitated. This document does not let you designate someone to make decisions for you like a Durable Power of Attorney for Health Care does.
2. **Durable Power of Attorney for Health Care** – This document asserts whom you have chosen to make health care decisions for you. It is activated when you become unconscious or not able to make decisions for yourself. Because this person will be making significant decisions for you, select a person whom you trust and who knows you well, such as a family member or close friend.
3. **Do Not Resuscitate Order (DNR)**

   In-Hospital DNR - This specifies to doctors and hospital staff that you do not want to be given CPR (cardiopulmonary resuscitation) if your heart stops or if you stop breathing. If you tell your doctor prior to being admitted to the hospital that you do not want to be resuscitated, the doctor will put a DNR order into your chart. DNR orders are recognized in all states.

   Out-of-Hospital DNR – This document allows individuals to specify that if they should stop breathing and their hearts stop beating while in their own home, out in their community, or in a medical care facility or hospice setting, they do not want to be resuscitated by emergency medical services personnel. The document allows people to declare that certain resuscitative measures will not be used on them.
4. **Organ Donor Card or Form** – A driver's license has organ donor preferences on the back side. You can also fill out an organ donor card or form, downloadable at organdonor.gov.
5. **Funeral Plan** – A plan for funeral and final arrangements can take many forms. The purpose of gathering final arrangement information is to guide loved ones in planning your funeral and writing your obituary at the time of your death. (See the "Funeral Planning" section.)

Please review the information in this section.

Understanding Power of Attorney

What is a Power of Attorney?

A power of attorney is an authorization to act on someone else's behalf in a legal or business matter. The individual who authorizes another person to act is the principal or grantor. The individual who is authorized to act is the agent. The term 'durable power of attorney' means that the power of attorney remains in effect when the principal becomes incapacitated or dies.

What is a Medical Power of Attorney?

Also known as Durable Power of Attorney for Health Care, this authorization is made by an individual to allow the health care agent to make decisions about healthcare on his or her behalf should the authorizing party become incapacitated or otherwise unable to make decisions regarding medical treatment.

Benefits of Having a Medical Power of Attorney

- The agent knows you well and understands your desired medical treatments.
- As your condition changes, the agent can discuss options for treatment with physicians and has the power to either authorize or withdraw them.
- The agent can actively advocate on your behalf throughout your period of incompetence.
- If you have prepared a living will, your agent has that as a guide for your preferred treatment and can encourage healthcare providers to follow those guidelines.

Choosing the Right Person to Be Your Health Care Agent

The person chosen to have Medical Power of Attorney should be a trusted family member or friend who knows you well and is willing to take on the responsibility should the need arise.

Acting as a health care agent is a significant responsibility. When selecting someone for this position, consider the following:

- Select someone whom you trust completely and who understands your decisions for medical care. Suggestions for discussion are below.
- Be sure that the person you ask is willing to be an effective agent for you, will ask questions of healthcare professionals, and will gather information needed to make decisions.
- Ultimately, the person you select will be making decisions based on your living will and your discussions with him or her. Be sure your agent has full understanding of your wishes.

Talking with Your Health Care Agent About End-of-Life Wishes

Your health care agent should be aware of your values, quality-of-life beliefs, and how you feel about identified medical treatments and situations.

Discussion questions to help you clarify your wishes with yourself and your health care agent:

- What medical treatments would you refuse or accept at the point you become incapacitated, and why?
- What are you afraid might occur if you can't make decisions for yourself?
- What are your family members beliefs in relation to your own beliefs about what should happen?
- What are your views about artificial nutrition (food) and hydration (fluid)?
- Under what conditions is it acceptable and not acceptable for hospital staff to perform CPR
- (cardiopulmonary resuscitation) to restart your heart?
- What are your feelings about receiving treatments such as mechanical ventilation, antibiotics or a feeding tube?
- In what situations does it make sense for you to receive these treatments?
- If your condition doesn't improve, would you want treatments discontinued after a time? What does that mean specifically?

Medical Advance Directives

Use this section to provide information about your medical advance directives.

Powers of Attorney

Speak to a legal professional for clarification of various powers of attorney.

Power of Attorney

Name: Phone:

Location of original document:

Durable Power of Attorney for Health Care

Name: Phone:

Location of original document:

Health Care Directives

Do Not Resuscitate Order (DNR) – In-Hospital

Location of original document:

Do Not Resuscitate Order (DNR) – Out-of-Hospital

Location of original documentation:

Organ Donor Card

Location of original document:

Living Will/Five Wishes (www.agingwithdignity.org)

Location of original document:

Psychiatric Advance Directive

Location of original document:

Other: _____

Location of original document:

Helpful Advance Directive Contacts

Attorney (medical): Phone:

Physician: Phone:

Emergency Contact: Phone:

Other: _____ Phone:

Other: _____ Phone:

Health Care Providers

Use this section to provide information about your medical and health care providers.

Primary Care Doctor

Name:

Address:

City: State: Zip:

Phone: Email:

Specialists and Other Medical Providers

1. Name:	Phone:
Specialty:	
2. Name:	Phone:
Specialty:	
3. Name:	Phone:
Specialty:	
4. Name:	Phone:
Specialty:	

Home Health Aide or Caregiver

Name:	
Phone:	Cell Phone:
Name:	
Phone:	Cell Phone:

Geriatric Care Manager or Social Worker

Name:	
Phone:	Cell Phone:
Name:	
Phone:	Cell Phone:

Pharmacy

1. Name:	2. Name:
Phone:	Phone:

Use this section to provide information about your health insurance.

Health Insurance Information

☐ **Medicare**	Policy Number:
☐ **Medicaid**	Policy Number:
☐ **Social Security Disability**	Policy Number:
	Sponsor Name:
☐ **Other Disability**	Name of Entity:
	Sponsor Name:
	Policy Number:
☐ **Veterans Coverage**	Name of Entity:
	Sponsor Name:
	Policy Number:
☐ **Other Coverage**	Name of Entity:
	Sponsor Name:
	Policy Number:
☐ **Other Coverage**	Name of Entity:
	Sponsor Name:
	Policy Number:

Private Insurance Coverage

☐ **Company:**	
Group/Policy Number:	
Sponsor Name:	Phone:
☐ **Company:**	
Group/Policy Number:	
Sponsor Name:	Phone:
☐ **Company:**	
Group/Policy Number:	
Sponsor Name:	Phone:

Personal Insurance

Use this section to provide information about your personal insurance policies.

Home and Property Policies

Homeowner's Policy

Company: Policy Number:

Company: Policy Number:

Property and Casualty Policy

Company: Policy Number:

Company: Policy Number:

Umbrella Liability Policy

Company: Policy Number:

Company: Policy Number:

Auto Policy

Company: Policy Number:

Company: Policy Number:

Boat, Motorcycle, RV, Other Policy

Company: Policy Number:

Company: Policy Number:

Pet Medical Policy

Company: Policy Number:

Company: Policy Number:

Other Policies

Company:

Coverage for:

Group/Policy Number: Phone:

Company:

Coverage for:

Group/Policy Number: Phone:

Company:

Coverage for:

Group/Policy Number: Phone:

Home Information

Use this section to provide information about your home if you become ill or injured.

Contacts

Landlord (if applicable):	
Phone:	Email:
Security System Company:	
Phone:	Email:
Home Cleaning Company:	
Phone:	Email:
Garbage Collection Company/County:	
Phone:	Email:
Lawn Services Company:	
Phone:	Email:
Other: _____	
Phone:	Email:
Other: _____	
Phone:	Email:

Key & Password Locations

Car Keys:	Mailbox Keys:
House Keys:	Other Keys:
Safe Deposit Box Keys:	Other Keys:
Password List Location:	

Mail and Delivery Locations

☐ Primary Residence	Address:	
☐ Secondary Residence	Address:	
☐ PO Box #: _____	Address:	
☐ Mailbox Kiosk	Box #: _____	Address:
Subscriptions: (magazine, newspaper, etc.)		

Pet Information

Use this section to provide information about your pet(s) if you become ill or injured.

Pet Care Contacts

Name:	Phone:
Name:	Phone:

My Pets

1. Name:	Type of Animal:	
Daily Routine:		
Where food and medicine can be found:		
Where food and water bowls can be found:		
Food:	Amount:	Times per Day:
Medicine:	Amount:	Times per Day:
2. Name:	Type of Animal:	
Daily Routine:		
Where food and medicine can be found:		
Where food and water bowls can be found:		
Food:	Amount:	Times per Day:
Medicine:	Amount:	Times per Day:

Medical Information

Veterinarian:		Phone:
Address:		
City:	State:	Zip:
Emergency Clinic/Hospital:		Phone:
Address:		
City:	State:	Zip:
Financial arrangements to pay for the care of my pet(s):		
☐ Self-pay		
☐ Pet Insurance	Company:	Policy #:
☐ Other:		

Important Contacts

Use this section to provide contacts, such as family and friends, if you become ill or injured.

Contacts

☐ Notify this person if I am ill or injured.		
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Mobile Phone:	Email:	
Relationship:		
☐ Notify this person if I am ill or injured.		
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Mobile Phone:	Email:	
Relationship:		
☐ Notify this person if I am ill or injured.		
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Mobile Phone:	Email:	
Relationship:		

Additional Information

Use this section to provide contacts, such as family and friends, if you become ill or injured.

Contacts - Continued

☐ Notify this person if I am ill or injured.		
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Mobile Phone:	Email:	
Relationship:		
☐ Notify this person if I am ill or injured.		
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Mobile Phone:	Email:	
Relationship:		
☐ Notify this person if I am ill or injured.		
Name:		
Street Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Mobile Phone:	Email:	
Relationship:		

Additional Information

Use this section to give details about daily and lifestyle routines.

Routines

Daily Routines

Descriptions, preferences, and schedules for personal care items such as bathing, skincare, dental care, dressing, sleeping, exercising, etc.

Care Item	Description/Preferences	Schedules

Lifestyle Routines

Descriptions, preferences, and schedules for activities and favorite items such as leisure time, foods, television, radio, people and places to visit, etc.

Care Item	Description/Preferences	Schedules

Use this list to create a safer home environment for individuals receiving care.

Home Safety Checklist

Medication Safety

- ☐ Ask pharmacists for child-resistant containers.
- ☐ Organize medicine in daily dosage packs to prevent medication distribution errors.
- ☐ Know what each pill is for and what it looks like. Write the description on the outside of the bottle or take a picture of each pill and put it on the outside of the bottle, or with medication information.
- ☐ Throw away expired prescriptions and unmarked bottles.
- ☐ Keep all medications in original containers.
- ☐ Store all medicine in a secure location.

General Home Safety

- ☐ Post all emergency phone numbers near the phone or on the refrigerator, i.e. emergency contacts, doctors, poison control, etc.
- ☐ Lock up all cleaning products in the kitchen, bathroom, laundry room, etc.
- ☐ Place frequently used items within reach and off of high shelves.
- ☐ Remove potential tripping hazards: electrical cords, area rugs, etc.
- ☐ Inspect walkways and driveways, have problem areas repaired.
- ☐ Install night lights or motion lights throughout the home to light the way.
- ☐ Check light levels for daytime and nighttime vision to be sure they are adequate in work areas, hallways, and frequently used rooms.
- ☐ Check that footwear worn in the home has non-skid soles and is in good condition.
- ☐ Install or inspect smoke alarms to assure proper functioning.
- ☐ Check that small appliances are working properly and are in good condition, i.e. toasters, spaceheaters, blenders, coffee makers, microwaves, etc.
- ☐ Dispose of flammable liquids, i.e. paint, gasoline, etc.
- ☐ Remove clutter from main traffic areas.
- ☐ Inspect handrails for proper, secure, installation and that they can support appropriate weight.
- ☐ Position furniture to allow plenty of space for walking. Remove furniture, if necessary.
- ☐ Replace handles on doors, cabinets, and/or furniture for better grip, if necessary.
- ☐ Lock any cabinets that contain sharp or dangerous items or remove the items from the home.

Use this list to create a safer home environment for individuals receiving care.

Home Safety Checklist - Continued

Kitchen Safety

- ☐ Remove knobs from stove or unplug it from the wall to avoid accidents.
- ☐ Keep knives out of reach or locked up, if necessary.
- ☐ Regularly inspect foods for freshness and expiration dates.

Bedroom Safety

- ☐ Remove all sources of flame and do not allow smoking in the bedroom.
- ☐ Move furniture with sharp corners away from the bed in case of a fall.
- ☐ Move breakable items away from the bed.
- ☐ Encourage the wearing of nonskid socks to bed to avoid falls if getting up in the middle of the night.
- ☐ Install adjustable bed rails to prevent falling out of bed and for assistance getting in and out of bed.

Bathroom Safety

- ☐ Install non-skid surfaces on the, floor, shower, and bathtub.
- ☐ Install grab bars near the toilet and bathtub.
- ☐ Have shower/tub chairs accessible.
- ☐ Install a raised toilet seat for easier transferring.
- ☐ Replace faucet fixtures with an easy-to-use style, if necessary.
- ☐ Set water heater at 120 degrees or less to avoid scalding.
- ☐ Remove all sharp objects such as razors, scissors, etc.

Extra Safety Steps

- ☐ Use a cordless phone or cell phone in the home that can be carried by the individual being cared for.
- ☐ Install a call button system that will immediately alert authorities in case of emergency.
- ☐ Use web cams that can be accessed from a remote location to check on individuals under care.
- ☐ Install a GPS in the home or car to allow for easy tracking.
- ☐ Reduce phone calls to the home by adding numbers to the Do Not Call Registry, www.donotcall.gov.

Use this page to offer caregivers resources and support.

Caregiver Resources

AARP
800-424-3410
www.aarp.org

Aging with Dignity
888-594-7437
www.agingwithdignity.org

Alzheimer's Association
800-272-3900
www.alz.org

American Red Cross
202-303-4498
www.redcross.org

Caregiver Action Network
301-942-6430
www.caregiveraction.org

Elder Care Locator
800-677-1116
www.eldercare.gov

National Institute on Aging
800-222-2225
www.nia.nih.org

Meals on Wheels Association
703-548-5558
www.mowaa.org

Hospice Foundation of America
800-854-3402
www.hospicefoundation.org

Aging Life Care Association
520-881-8008
www.aginglifecare.org

National Council on Aging (NCOA)
800-424-9046
www.ncoa.org

Family Caregive Alliance
800-445-8106
www.caregiver.org

The Society of Certified Senior Advisors
800-653-1785
www.csa.us

US Administration on Aging
202-619-0724
www.aoa.gov

National Hospice and Palliative Care Organization
800-658-8898
www.nhpco.org

National Association of Area Agencies on Aging
202-872-0888
www.n4a.org

National Association for Home Care & Hospice
202-547-7424
www.nahc.org

Caregiver's Bill of Rights

by *Jo Horne*

I have the right:

To take care of myself. This is not an act of selfishness. It will give me the capability of taking better care of my loved one.

To seek help from others, even though my loved ones may object. I recognize the limits of my own endurance and strength.

To maintain facets of my own life that do not include the person I care for, just as I would if he or she were healthy. I know that I do everything that I reasonably can for this person, and I have the right to do some things just for myself.

To get angry, be depressed, and express other difficult feelings occasionally.

To reject any attempts by my loved one (either conscious or unconscious) to manipulate me through guilt and/or depression.

To receive consideration, affection, forgiveness and acceptance for what I do from my loved ones, for as long as I offer these qualities in return.

To take pride in what I am accomplishing and to applaud the courage it has sometimes taken to meet the needs of my loved one.

To protect my individuality and my right to make a life for myself that will sustain me in the time when my loved one no longer needs my full-time help.

To expect and demand that as new strides are made in finding resources to aid physically and mentally impaired persons in our country, similar strides will be made towards aiding and supporting caregivers.

Important Legal Documents

Use this section to provide information about, and the location of, legal documents.

Identification Documents

Birth Certificate Location:
Driver's License Location:
Social Security Card Location:
Marriage Certificate Location:
Passport Location:
Military ID Location:

Will

Attorney	
Name:	Email:
Address:	Phone:
Executor	
Name:	Email:
Address:	Phone:
General or Durable Power of Attorney Appointee	
Name:	Email:
Address:	Phone:

Trust Information

1. Name of Trust:	
☐ *Copy of this trust included with this kit.*	
Location of original document:	
Trustee of this trust:	Phone:
2. Name of Trust:	
☐ *Copy of this trust included with this kit.*	
Location of original document:	
Trustee of this trust:	Phone:

Important Legal Documents

Use this section to provide information about, and the location of, legal documents.

Contracts & Agreements

Divorce, Annulment, Pre- or Post-Nuptial Agreements

1. Document Type:

Location:

2. Document Type:

Location:

3. Document Type:

Location:

Child Support, Alimony, Adoption Papers

1. Document Type:

Location:

2. Document Type:

Location:

3. Document Type:

Location:

Rental Lease, Senior Housing Contract, Home Care Agreements

1. Document Type:

Location:

2. Document Type:

Location:

3. Document Type:

Location:

Other Legal Documents (cell phone contacts, car title, etc.)

1. Document Type:

Location:

2. Document Type:

Location:

3. Document Type:

Location:

Financial Accounts

Use this section to provide information about financial accounts.

Accountant & Financial Advisor Contact Information

Accountant:		Email:	
Address:		Phone:	
Financial Advisor:		Email:	
Address:		Phone:	

Safe Deposit Box

Institution where the safe deposit box is located:	
Address:	Phone:
Key Location:	
Person(s) with official access to the safe deposit box.	
Name:	Phone:
Name:	Phone:

Financial Accounts and Cash

Include checking, savings, FSA/HSA, and money market accounts.

Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:

Credit Cards

Include department store cards, general credit cards, lines of credit, etc.

Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:
Institution:	Type:	Acct #:

Use this section to provide information about owned properties.

Owned Properties

Make sure to include 1st, 2nd, and reverse mortages.

1. Property address:

☐ I live at this property. ☐ Property is empty. ☐ Property is being rented.

Renter's Name:

Location of lease:

Ownership status: ☐ Bank-owned ☐ Self-owned ☐ Other: _____

If bank-owned
Institution: Phone:

Account number:

If self-owned
Location of property title:

Make sure to include 1st, 2nd, and reverse mortages.

2. Property address:

☐ I live at this property. ☐ Property is empty. ☐ Property is being rented.

Renter's Name:

Location of lease:

Ownership status: ☐ Bank-owned ☐ Self-owned ☐ Other: _____

If bank-owned
Institution: Phone:

Account number:

If self-owned
Location of property title:

Make sure to include 1st, 2nd, and reverse mortages.

3. Property address:

☐ I live at this property. ☐ Property is empty. ☐ Property is being rented.

Renter's Name:

Location of lease:

Ownership status: ☐ Bank-owned ☐ Self-owned ☐ Other: _____

If bank-owned
Institution: Phone:

Account number:

If self-owned
Location of property title:

Financial Assets & Liabilities

Use this section to provide information about additional assets.

Rental Properties

1. Property address:

Name of leasing company:

Location of lease:

2. Property address:

Name of leasing company:

Location of lease:

Automobile Information

1. Make: Model: Year:

Ownership status: ☐ Loan ☐ Lease ☐ Self-owned ☐ Other: _____

If under loan or lease
Institution: Phone:

Account number:

If self-owned
Location of property title:

2. Make: Model: Year:

Ownership status: ☐ Loan ☐ Lease ☐ Self-owned ☐ Other: _____

If under loan or lease
Institution: Phone:

Account number:

If self-owned
Location of property title:

Other Assets or Liabilities

1. Description:

Location of loan papers or title:

2. Description:

Location of loan papers or title:

Student loan, tuition agreements
Description: Phone:

Location of documents:

Coins, stamps, other collections:

Season tickets for sports or theater venue:

Financial Investments

Use this section to provide information about various investments.

Investments

Mutual Funds	
Institution:	Account number:
Institution:	Account number:
Stocks and Bonds	
Institution:	Account number:
Institution:	Account number:
Annuities	
Institution:	Account number:
Institution:	Account number:
Certificates of Deposit (CDs)	
Institution:	Account number:
Institution:	Account number:
Real Estate Investment Trust (REITs)	
Institution:	Account number:
Institution:	Account number:
Treasury Securities, Notes, Bills	
Institution:	Account number:
Savings Bonds	
Institution:	Account number:
Other investments:	
Other investments:	

Loans made to others - business and personal

1. Loanee:	Phone:
Address:	
Location of contract:	
2. Loanee:	Phone:
Address:	
Location of contract:	

Business Assets

Use this section to provide information about business assets and intellectual property.

Key Business Information

1. Business Name:	
Admin Contact:	Phone:
Accounting Contact:	Phone:
Location of ownership documents:	
Location of bank account documents:	
2. Business Name:	
Admin Contact:	Phone:
Accounting Contact:	Phone:
Location of ownership documents:	
Location of bank account documents:	

Domain Names, Blogs, Websites

Name	Registrar	Account Manager

Trade Names, Trademarks, Copyrights, Patents

Name:	Registrar:
Name:	Registrar:
Name:	Registrar:

Business Licenses (sales tax, county, etc.)

1.
2.
3.

Other Business Assets

Business Insurance

Use this section to provide information about business insurance policies.

Business Policies

Life Insurance Policy (key man, etc.)	
Company:	Account number:
Company:	Account number:
Disability Policy (long-term, short-term)	
Company:	Account number:
Company:	Account number:
Business Overhead Expense (BOE) Policy	
Company:	Account number:
Company:	Account number:
Property and Casualty Policy (commercial, general, fleet auto, etc.)	
Company:	Account number:
Company:	Account number:
Liability Policy (general, product, professional, etc.)	
Company:	Account number:
Company:	Account number:
Business Interruption	
Company:	Account number:

Other Policies

Company:	
Coverage for:	
Account Number:	Phone:
Company:	
Coverage for:	
Account Number:	Phone:
Company:	
Coverage for:	
Account Number:	Phone:

Financial Retirement Benefits

Use this section to provide information about retirement benefits.

Retirement Information

Social Security:

Are you collecting Social Security? ☐ Yes ☐ No ☐ Other _____

401(k), IRAs, Etc.

1. Institution Name:

Type of plan: Account number:

Location of documents:

2. Institution Name:

Type of plan: Account number:

Location of documents:

3. Institution Name:

Type of plan: Account number:

Location of documents:

Stock Options (employee stock, profit sharing, ownership plans, etc.)

1. Company Name: Account number:

Location of documents: Type:

2. Company Name: Account number:

Location of documents: Type:

3. Company Name: Account number:

Location of documents: Type:

Pension(s)

1. Institution Name: Account number:

Location of documents:

2. Institution Name: Account number:

Location of documents:

Veterans Benefits (www.va.gov)

I have a: ☐ Veterans Retirement Plan ☐ Survivors Benefit Plan ☐ Death Gratuity/Pension Plan

Location of DD 214:

Last branch of service: Dates of service:

Use this section as a guide for managing details of deceased and estate after death.

Documents to obtain in order to complete after-death responsibilities.

- ☐ Death Certificates (10-15 certified copies)
- ☐ Will
- ☐ Social Security Card
- ☐ Marriage Certificate
- ☐ Birth Certificate
- ☐ Deed and Titles to Property
- ☐ Insurance Policies
- ☐ Stock Certificates
- ☐ Bank Records
- ☐ Military Discharge Papers or DD214
- ☐ Recent Income Tax Return and W-2 Forms
- ☐ Vehicle Title and Registration Form
- ☐ Loan Documents

First 5 Days After-Death Checklist

- ☐ Contact a funeral home and make arrangements for services. (Ask friends, family, or clergy, if unsure)
- ☐ If appropriate, ask a church or clergy member to assist in the organization of the services.
- ☐ Contact people involved in the service. (Pallbearers, person giving the eulogy, readers, etc.)
- ☐ If the deceased is a veteran, contact the local veterans agency to obtain discharge papers. (Other assistance may also be provided.)
- ☐ Obtain 10 – 15 copies of the death certificate. (The funeral director should be able to provide them or additional information.)

First 30 Days After-Death Checklist

- ☐ If the deceased was receiving Social Security benefits, notify the Social Security office. Survivor's benefits for spouses may be available and applied for through the Social Security office, as well.
- ☐ Contact insurance companies (life insurance, health insurance, etc.). Some account balances, such as loans, mortgages, credit card accounts, etc., may be covered by a credit life insurance policy.
- ☐ If the deceased was employed, contact his or her employer to inquire about pension plans, credit unions, and death benefits related to employment.
- ☐ Contact banks and credit card companies where the deceased had accounts to notify them.
- ☐ Contact banks, stockbrokers, credit card companies, etc., where the deceased had joint accounts and arrange to have the deceased's name removed.
- ☐ Make sure that important bills continue to get paid or that services are discontinued.
- ☐ Seek advice from an accountant, tax advisor, and/or attorney.

**Mortuaries and cemeteries offer to file the death certificate and submit obituaries, as well as take care of Social Security, life insurance, and VA benefits, as part of their services.*

Each state has its own laws regarding after death issues. Professional advice may be required.

Use this section to provide basic historical information needed to plan end-of-life services.

Basic Information

Full Name:

Place of Birth: Date of Birth:

Marital Status: Maiden Name:

Marriage Date: Marriage Location:

Family Members

Children:

Grandchildren:

Siblings:

Work History Date of Retirement: _____

Occupation:

Company: Position:

Duration of Employment:

Occupation:

Company: Position:

Duration of Employment:

Education

Elementary School:

High School:

College:

Other:

Military Service Veteran: ☐ Yes ☐ No

Branch: Dates Served:

War(s):

Medals / Honors:

Use this section to provide information regarding your obituary and wishes for your remains.

Obituary

I have written my own: ☐ Yes ☐ No

Fill in any information you would like included in your obituary.

Basic Information (see previous page): ☐ Yes ☐ No

Donations requested: ☐ Yes ☐ No If yes, where to:

Manner of passing: ☐ Yes ☐ No

Preceded in death by: ☐ Yes ☐ No If yes, who:

Picture with obituary: ☐ Yes ☐ No If yes, which:

Other:

Publish obituary in (list publications):

Wishes for Remains

Organ Donation: ☐ Yes ☐ No

Specify which organs:

Specify where (medical school, science institution, etc.):

If already planned, please list contacts or location of documents:

Dispersement of Remains:

☐ Casket Burial ☐ Cremation & Burial ☐ Cremation (no burial) ☐ Other

If Other, explain:

Burial Options: Wishes for Physical Remains

1. Funeral Home / Mortuary of Choice:

Do you have a pre-arranged policy with this company? ☐ Yes ☐ No

Location of policy:

2. Embalmed: ☐ Yes ☐ No

3. Clothes to be worn:

4. Jewlery to be worn:

Jewlery to be removed before internment: ☐ Yes ☐ No

5. Glasses to be worn: ☐ Yes ☐ No

6. Preferences for casket or urn (metal, wood, kosher, etc.):

Use this section to provide helpful information regarding your burial wishes.

Burial Information

Burial Site Location

1. Type of site:
☐ Cemetery ☐ Lawn Crypt ☐ Mausoleum ☐ Columbarium ☐ Other

If Other, explain:

2. Location Name:

Section: Lot #: Grave:

Location of deed:

3. Other Details:

Burial Site Location

1. Marker: ☐ Yes ☐ No

Type of marker (flat, upright, marble, stone, etc.):

Inscription details (image, picture, wording, etc.):

2. Monument: ☐ Yes ☐ No

Details:

3. If a veteran, do you want a flag on your casket? ☐ Yes ☐ No

If yes, should the flag be draped over the casket or folded? ☐ Draped ☐ Folded

4. Other requests:

Use this section to provide information about your wishes for any final services.

Service Information

I want the following services: ☐ Funeral ☐ Memorial ☐ Burial ☐ Other

1. Type of Service:

Clergy to officiate:

Location:

Remains present at service: ☐ Yes ☐ No

Casket viewing: ☐ Yes ☐ No If yes: ☐ Open ☐ Closed

Attendees (family and friends only, immediate family only, etc.):

Pallbearers:

Eulogy Presenter: I wrote my own: ☐ Yes ☐ No

Description of service (readings, music, flowers, etc.):

2. Type of Service:

Clergy to officiate:

Location:

Remains present at service: ☐ Yes ☐ No

Casket viewing: ☐ Yes ☐ No If yes: ☐ ☐ Closed

Attendees (family and friends only, immediate family only, etc.):

Pallbearers:

Eulogy Presenter: I wrote my own: ☐ Yes ☐ No

Description of service (readings, music, flowers, etc.):

Use this section to provide information about your wishes for any final services.

Service Information - Continued

3. Type of Service:

Clergy to officiate:

Location:

Remains present at service: ☐ Yes ☐ No

Casket viewing: ☐ Yes ☐ No If yes: ☐ Open ☐ Closed

Attendees (family and friends only, immediate family only, etc.):

Pallbearers:

Eulogy Presenter: I wrote my own: ☐ Yes ☐ No

Description of service (readings, music, flowers, etc.):

4. Type of Service:

Clergy to officiate:

Location:

Remains present at service: ☐ Yes ☐ No

Casket viewing: ☐ Yes ☐ No If yes: ☐ ☐ Closed

Attendees (family and friends only, immediate family only, etc.):

Pallbearers:

Eulogy Presenter: I wrote my own: ☐ Yes ☐ No

Description of service (readings, music, flowers, etc.):

Additional Forms

Please review this page for information about the following forms.

Instructions

It is important to complete as much information on the forms as possible to better help your emergency contact(s) should you become seriously ill or injured.

The information on these forms should only be given to person(s) that you trust such as your emergency contact, executor, health care agent, etc.

Please review the checklist below to ensure you have completed the forms and use the provided spaces to make note of whom they have been distributed to.

Additional forms may be obtained through the Society of Certified Senior Advisors ® website (www.csa.us).

Form Checklist and Distribution

☐	**Emergency Contact Form**
	This form was given to:
☐	**Health Care Providers & Insurance**
	This form was given to:
☐	**Medical Advance Directives Form**
	This form was given to:
☐	**Medical Conditions & History Form (2 pages)**
	This form was given to:
☐	**Home & Pet Information Form**
	This form was given to:

Only provide your personal information to persons you can trust.

Information for Life™

Emergency Contact

This form is to be given to an individual you trust to handle your private information.

Instructions

The person that has given you this form trusts you with his or her private and personal information.

If the individual becomes seriously ill or injured, you may be called upon to use this information and assist him or her as they have instructed here.

Please keep this form in a safe place that is easily accessible should you need it suddenly.

Basic Information

Name of person filling out this form:
Name of the person this form was given to:

Health Related Information

I am allergic to:	
I have these health conditions:	
My doctor:	Phone:
My preferred hospital:	
Health Insurance Company:	Policy/Group #:
Medicare/Medicaid ID #:	
Other Insurance:	
Contact this person immediately:	Phone:

Home Access

Instructions to access my home:
Spare key location:
I have provided a key to my home along with this form : ☐ Yes ☐ No

Additional information can be obtained from my Information for Life ™ Kit. See the reverse side of this form.

Information for Life™ Emergency Contact - continued

This form is to be given to an individual you trust to handle your private information.

Information for Life™ Kit

My Information for Life Kit is located:
Other documents with my kit:
What to do with the kit:

Information included in the kit :

- Advance Directives
- Health Needs and Medical History
- Important Legal Documents
- Financial Information
- Insurance Policies
- Home, Family, Friends, and Community
- End of Life and Funeral Planning

Additional Information

Information for Life™

Health Care Providers

This form is intended to provide information about health care providers and insurance.

Primary Care Doctor

Name:

Address:

City: State: Zip:

Phone: Email:

Specialists and Other Medical Providers

1. Name:	Phone:
Specialty:	
2. Name:	Phone:
Specialty:	
3. Name:	Phone:
Specialty:	
4. Name:	Phone:
Specialty:	

Home Health Aide or Caregiver

Name:	
Phone:	Cell Phone:
Name:	
Phone:	Cell Phone:

Geriatric Care Manager or Social Worker

Name:	
Phone:	Cell Phone:
Name:	
Phone:	Cell Phone:

Pharmacy

Name:
Phone:

Health Insurance Information

☐ **Medicare**	Policy Number:
☐ **Medicaid**	Policy Number:
☐ **Social Security Disability**	Policy Number:
	Sponsor Name:
☐ **Other Disability**	Name of Entity:
	Sponsor Name:
	Policy Number:
☐ **Veterans Coverage**	Name of Entity:
	Sponsor Name:
	Policy Number:
☐ **Other Coverage**	Name of Entity:
	Sponsor Name:
	Policy Number:
☐ **Other Coverage**	Name of Entity:
	Sponsor Name:
	Policy Number:

Private Insurance Coverage

☐ **Company:**	
Group/Policy Number:	
Sponsor Name:	Phone:
☐ **Company:**	
Group/Policy Number:	
Sponsor Name:	Phone:
☐ **Company:**	
Group/Policy Number:	
Sponsor Name:	Phone:

Information for Life™

Medical Advance Directives

This form is intended to provide information about medical advance directives.

Powers of Attorney

Speak to a legal professional for clarification of various powers of attorney.

Power of Attorney

Name: Phone:

Location of original document:

Durable Power of Attorney for Health Care

Name: Phone:

Location of original document:

Health Care Directives

Do Not Resuscitate Order (DNR) – In-Hospital

Location of original document:

Do Not Resuscitate Order (DNR) – Out-of-Hospital

Location of original documentation:

Organ Donor Card

Location of original document:

Living Will/Five Wishes (www.agingwithdignity.org)

Location of original document:

Psychiatric Advance Directive

Location of original document:

Other: _____

Location of original document:

Helpful Advance Directive Contacts

Attorney (medical): Phone:

Physician: Phone:

Emergency Contact: Phone:

Other: _____ Phone:

Other: _____ Phone:

Medical Advance Directives

Please review the information in this section.

Introductory Guide to Advance Directives

What is an Advance Directive?

If you become unable to make decisions for yourself, an advance directive tells healthcare providers what kind of treatments you want and what kind of treatment you don't want. The directives also provide guidance and peace of mind for family members and friends, because your wishes are clearly indicated.

Individuals 18 years of age or older can prepare advance directives so their wishes are known in case of an accident or the sudden onset of an illness. Advance directives are typically prepared by people who are terminally or seriously ill.

Advance directives are different in each state and can take various forms. Be sure to check with your state when preparing your advance directives.

Preparing Advance Directives

- Get thorough information about the various life-sustaining treatments.
- Make a decision about what treatment(s) you prefer.
- Talk to your family and/or healthcare providers about your preferences.
- Use a form provided by your doctor, write down your directives yourself, or talk with an attorney.
- Follow your state-specific guidelines, which can be found at the state health department or state department on aging.
- Have the document(s) signed by appropriate witnesses or a notary.
- You do not need a lawyer to prepare advance directives, but be sure to follow your state's guidelines.

Storing Advance Directives

- They must be easily accessible and protected from theft, fire, flood, etc.
- Make several copies and distribute to your doctors, a trusted family member or loved one, your Health Care Agent, your attorney, and for your personal files.

Types of Advance Directives:

1. **Living Will** – A written legal document that expresses your decisions for medical treatment or life-sustaining treatments in the event you are incapacitated. This document does not let you designate someone to make decisions for you like a Durable Power of Attorney for Health Care does.
2. **Durable Power of Attorney for Health Care** – This document asserts whom you have chosen to make health care decisions for you. It is activated when you become unconscious or not able to make decisions for yourself. Because this person will be making significant decisions for you, select a person whom you trust and who knows you well, such as a family member or close friend.
3. **Do Not Resuscitate Order (DNR)**

   In-Hospital DNR - This specifies to doctors and hospital staff that you do not want to be given CPR (cardiopulmonary resuscitation) if your heart stops or if you stop breathing. If you tell your doctor prior to being admitted to the hospital that you do not want to be resuscitated, the doctor will put a DNR order into your chart. DNR orders are recognized in all states.

   Out-of-Hospital DNR – This document allows individuals to specify that if they should stop breathing and their hearts stop beating while in their own home, out in their community, or in a medical care facility or hospice setting, they do not want to be resuscitated by emergency medical services personnel. The document allows people to declare that certain resuscitative measures will not be used on them.
4. **Organ Donor Card or Form** – A driver's license has organ donor preferences on the back side. You can also fill out an organ donor card or form, downloadable at organdonor.gov.
5. **Funeral Plan** – A plan for funeral and final arrangements can take many forms. The purpose of gathering final arrangement information is to guide loved ones in planning your funeral and writing your obituary at the time of your death. (See the "Funeral Planning" section.)

Information for Life™

Medical Conditions & History

Use this form to provide basic and important medical condition information.

Name: _____

Medical Conditions

Neurologic:

- ☐ Cerebral Palsy
- ☐ Epilepsy / Seizure Disorder
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Other:_____

Cardiovascular:

- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Other:_____

Kidney / Urinary:

- ☐ Renal Insufficiency / Failure
- ☐ Urinary Retention
- ☐ Recurrent Infection
- ☐ Other:_____

Gastrointestinal:

- ☐ GERD
- ☐ Dysphagia
- ☐ Constipation
- ☐ Other:_____

Metabolic / Endocrine:

- ☐ Diabetes
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Other:_____

Cancer / Neoplasm:

- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Stomach Cancer
- ☐ Brain Cancer
- ☐ Skin Cancer
- ☐ Other:_____

Respiratory:

- ☐ Pneumonia
- ☐ Asthma
- ☐ COPD
- ☐ Recurrent Infection
- ☐ Aspiration

Musculoskeletal:

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other:_____

Other Conditions

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This section is not intended to replace full medical records.

Information for Life™

Medical Conditions & History

Use this form to provide information about medication or supplements you take.

Medications

Medication/Supplement Name and Description of Pill	Reason for Taking	Frequency and Dosage

Additional Information

This section is not intended to replace full medical records.

Information for Life™

Medical Conditions & History

Use this form to provide additional medical information.

Allergies

1. Allergic to:	
Reaction:	
2. Allergic to:	
Reaction:	
3. Allergic to:	
Reaction:	

Immunizations

1.	**Date:**
2.	**Date:**
3.	**Date:**

Physical Aids

General Aids:

☐ Glasses ☐ Dentures ☐ Hearing Aid ☐ Other: _____

Mobility Aids:

☐ Walker ☐ Cane ☐ Wheelchair ☐ Scooter ☐ Other: _____

☐ Prostheses	Details:
☐ Transfer Aids (sling, belt, etc.)	Details:
☐ Bed Accessories (rails, etc.)	Details:
☐ Bathroom Accessories	Details:
☐ Other Aids	Details:

Additional Information

_____

_____

_____

_____

_____

This section is not intended to replace full medical records.

CSA

Information for Life™

Medical Conditions & History

Use this form to provide information about your family health history.

Family History

Condition	Relationship
☐ Diabetes	
☐ High Cholesterol	
☐ High Blood Pressure	
☐ Heart Disease	
☐ Colon Polyps	
☐ Osteoporosis	
☐ Osteoarthritis	
☐ Stroke	
☐ Cancer	
☐ Other:_____	

Additional Information

This section is not intended to replace full medical records.

Information for Life™

Pet Information

Use this form to provide information about your pet(s) if you become ill or injured.

Pet Care Contacts

Name:	Phone:
Name:	Phone:

My Pets

1. Name:		Type of Animal:
Daily Routine:		
Where food and medicine can be found:		
Where food and water bowls are:		
Food:	Amount:	Times per Day:
Medicine:	Amount:	Times per Day:
2. Name:		Type of Animal:
Daily Routine:		
Where food and medicine can be found:		
Where food and water bowls are:		
Food:	Amount:	Times per Day:
Medicine:	Amount:	Times per Day:

Medical Information

Veterinarian:		Phone:
Address:		
City:	State:	Zip:
Emergency Clinic/Hospital:		Phone:
Address:		
City:	State:	Zip:
Financial arrangements to pay for the care of my pet(s):		
☐ Self-pay		
☐ Pet Insurance	Company:	Policy #:
☐ Other:		

Information for Life™

Home Information

Use this form to provide information about your home if you become ill or injured.

Contacts

Landlord (if applicable):	
Phone:	Email:
Security System Company:	
Phone:	Email:
Home Cleaning Company:	
Phone:	Email:
Garbage Collection Company/County:	
Phone:	Email:
Lawn Services Company:	
Phone:	Email:
Other: _____	
Phone:	Email:
Other: _____	
Phone:	Email:

Key Locations

Mailbox Keys:
House Keys:
Other Keys:
Other Keys:

Mail and Delivery Locations

☐ Primary Residence		Address:
☐ Secondary Residence		Address:
☐ PO Box #: _____		Address:
☐ Mailbox Kiosk	Box #: _____	Address:
Subscriptions: (magazine, newspaper, etc.)		

CSA
Society of
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About the Information for Life™ Kit

One life-changing event or illness that leaves you incapacitated, or the experience of being at the end of your life, can expose how unaware your loved ones are of the information they need to care for you and manage your affairs as you would wish. This can generate endless questions, but with the Information for Life Kit, you can provide answers.

The Information for Life Kit is a tool for putting your critical personal, legal, medical and financial information in one place. It contains checklists, forms and detailed guides that your family members and trusted agents can easily access to understand your wishes, make decisions and act on your behalf, both before and after your death.

Provided by:
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