Name: ____

PROPERTY POWER OF ATTORNEY

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

Agents (in order of priority):

1. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

2. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

3. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

4. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

HEALTH CARE POWER OF ATTORNEY

Agents (in order of priority):

1. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

2. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

3. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________

4. Name: ____________________________________ Relation: ______________________

   Address: __________________________________ Phone: ________________________