

End of Life Planner





1 INCH SPINE

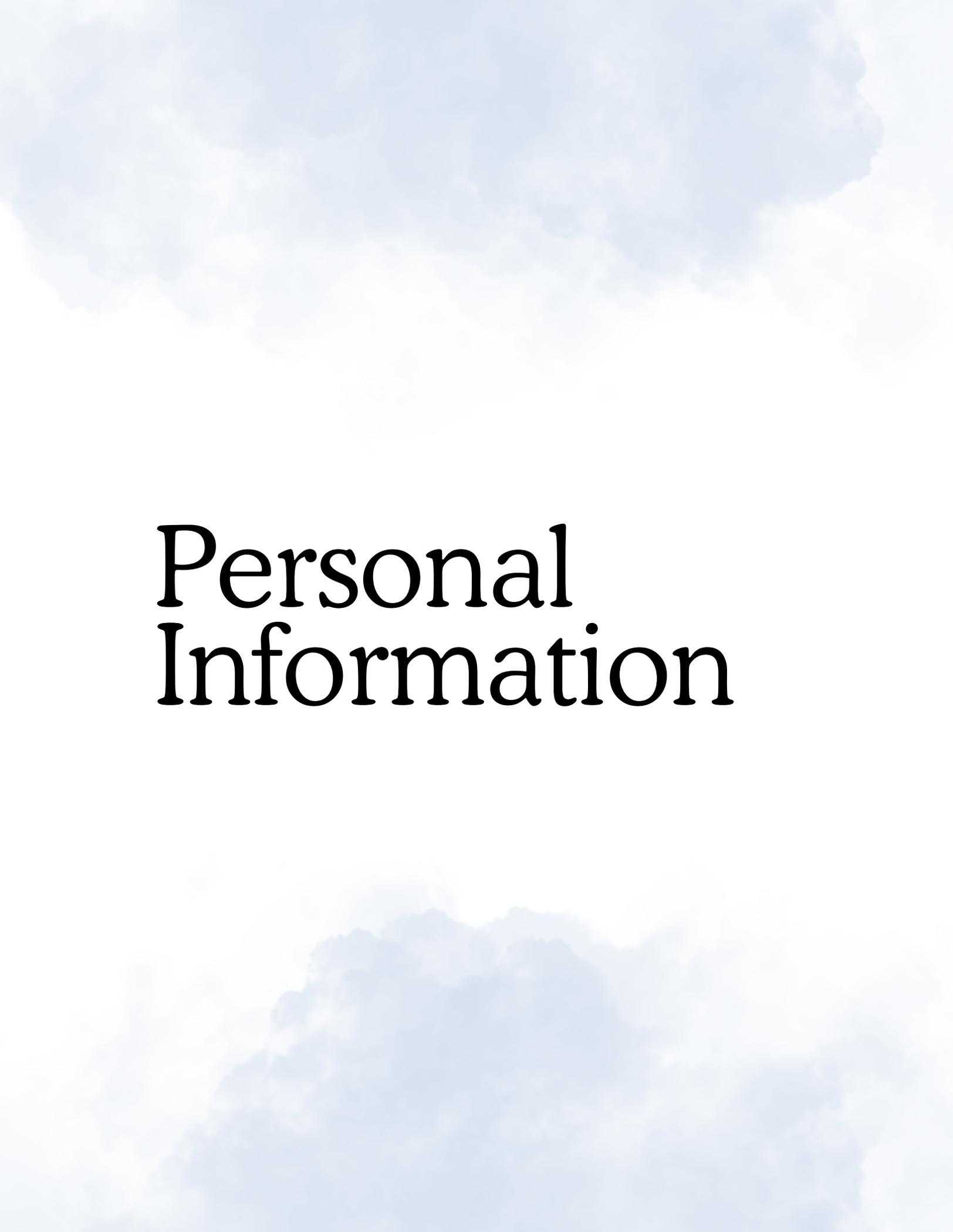
1 & 1/2 INCH SPINE

2 INCH SPINE



3 INCH SPINE





Personal Information

Personal Information

Name:

Address:

City: State: Zip:

Cellphone: Work phone no.:

License no.:

Passport:

Birthday: Place of Birth:

Citizenship:

Father's Name:

Mother's Name:

Offspring:

Identification Information

Nickname: Blood Type:

Height: Weight:

Eye color: Hair color: Skin tone:

Identifying Features

.....

.....

.....

.....

.....

.....

.....

.....

Personal Information

Marital Information

Marital Status: Single Married Widowed Divorced Separated

Date of Marriage: Place of Marriage:

City: State: Zip:

Spouse/Partner Information

Spouse / Partner Name:

Date of Birth: Phone:

Address:

City: State: Zip:

Agreements (If applicable):

Notes:

.....

Tax Information

Tax ID Number:

Social Security Number:

Accountant:

Pension Number: Tax Agent:

Employment Information

Employer:

Position: Start Date:

Phone: Email:

Address:

City: State: Zip:

Child Information

First Name:

Last Name:

Date of Birth:

Phone:

Address:

City: State:

Zip:

Notes:



First Name:

Last Name:

Date of Birth:

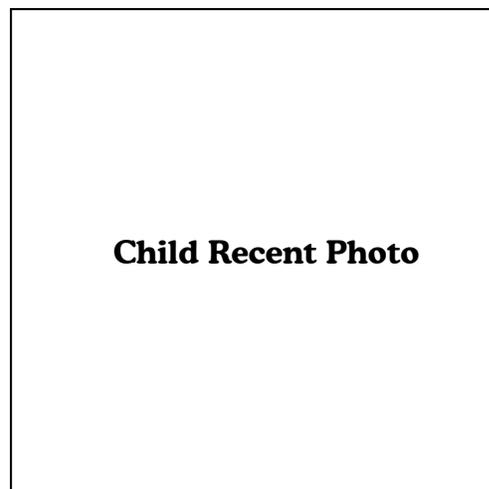
Phone:

Address:

City: State:

Zip:

Notes:



First Name:

Last Name:

Date of Birth:

Phone:

Address:

City: State:

Zip:

Notes:



Home Information

Address	People who live here

Mortgage Details

Mortgage with:

Type of mortgage:

Mortgage start date:

Mortgage end date:

Terms:

Type of property:

.....

Built date:

Age of property:

Home Improvement Plans

Home Insurance Information

Insurance Covers

Rates/Cost

Insurance Company Information

Home Insurance Company:

Contact Number:

Policy Number:

Date of Claim	Description of Claim	Date Paid	Completed

Car Insurance Information

Details

Make:	Model:
Year:	VIN:
Agent Name:	Phone:
Email:	Start Date:
Company:	Policy #:
Make a Claim:	
Notes:	

Details

Make:	Model:
Year:	VIN:
Agent Name:	Phone:
Email:	Start Date:
Company:	Policy #:
Make a Claim:	
Notes:	

Health Insurance Information

Details

Insured Person:		
Company:		Address:
City:	State:	ZIP:
Agent Name:		Phone:
Email:	Start Date:	
Policy #:		
Health Coverage:		
Dental Coverage:		
Vision Coverage:		
RX:		Deductible:
Notes:		

Life Insurance Information

Details

Insured Person:		
Beneficiary:		
Benefit:		
Company:		Policy #:
Address:		
City:	State:	Zip:
Agent Name:		Phone:
Email:	Start Date:	
Notes		

Other Insurance Information

Details

Insurance Type:	
Company:	Policy #:
Agent Name:	Phone:
Email:	Start Date:
Deductible:	Other:
Make a Claim:	
Notes	

Details

Insurance Type:	
Company:	Policy #:
Agent Name:	Phone:
Email:	Start Date:
Deductible:	Other:
Make a Claim:	
Notes	

Pet Information

General Information

Name:.....

Breed:..... Color:

Gender: Weight:

Date of Birth: Age adopted:

Microchip no.:

Collar tag no.:

Special Markings:

Care Information

Food:

Feeding info:

Hygiene info:

Groomer: Phone:

Allergies:

Pedigree information / certificates:

.....

.....

Breed/Seller Information

Name:

Address:

.....

City: State: Zip:

Email:

Phone:



Medical Information

Medical Contact List

Name:	
Specialty:	
Phone 1:	Phone 2:
Email:	
Address:	
Notes	

Name:	
Specialty:	
Phone 1:	Phone 2:
Email:	
Address:	
Notes	

Name:	
Specialty:	
Phone 1:	Phone 2:
Email:	
Address:	
Notes	

Emergency Contact List

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Family Member

Name: _____

Address: _____

Phone: _____

Email: _____

Insurance Information

Insurance Company:

Plan Type: _____

Policy Holder: _____

Group: _____

ID Number: _____

Phone Number: _____

Website: _____

Username: _____

Password: _____

Insurance Company:

Plan Type: _____

Policy Holder: _____

Group: _____

ID Number: _____

Phone Number: _____

Website: _____

Username: _____

Password: _____

Insurance Company:

Plan Type: _____

Policy Holder: _____

Group: _____

ID Number: _____

Phone Number: _____

Website: _____

Username: _____

Password: _____

Insurance Company:

Plan Type: _____

Policy Holder: _____

Group: _____

ID Number: _____

Phone Number: _____

Website: _____

Username: _____

Password: _____

Hospital Information

Address: _____

Specialty: _____

Phone Number: _____

Patient Portal Website: _____

Username: _____

Hospital Name:

Address: _____

Specialty: _____

Phone Number: _____

Patient Portal Website: _____

Username: _____

Hospital Name:

Address: _____

Specialty: _____

Phone Number: _____

Patient Portal Website: _____

Username: _____

Pharmacy Information

Name: _____

Phone: _____

Website: _____

Username: _____

Password: _____

Location: _____

Name: _____

Phone: _____

Website: _____

Username: _____

Password: _____

Location: _____

Name: _____

Phone: _____

Website: _____

Username: _____

Password: _____

Location: _____

Health Providers

Provider:

Name: _____

Provider For: _____

Type of Care: _____

Phone: _____

Email: _____

Address: _____

Notes: _____

Provider:

Name: _____

Provider For: _____

Type of Care: _____

Phone: _____

Email: _____

Address: _____

Notes: _____

Provider:

Name: _____

Provider For: _____

Type of Care: _____

Phone: _____

Email: _____

Address: _____

Notes: _____

Family Medical History

F = Father M = Mother GP = Grandparents S = Siblings

	F	M	GP	S
Acid Reflux				
Alcohol Addiction				
Allergy Problems				
Anemia				
Anxiety				
Artery / Vein Problems				
Arthritis				
Asthma				
Autoimmune Disease				
Bipolar Disorder				
Bladder Irritability				
Bleeding Problems				
Blood Clots				
Cancer				
Cataracts				
Colitis / Crohns				
Chronic Pain				
Depression				
Diabetes				
Drug Addiction				
Esophagitis, ulcers				
Fractures				
Gallstones				
Glaucoma				
Gout				
Headaches				
Hearing Impairment				
Heart Attack				
Heart Disease				
Heart Valve Problems				

	F	M	GP	S
Hepatitis A				
Hepatitis B				
Hepatitis C				
Hernia				
High Blood Pressure				
High Cholesterol				
HIV				
Irritable Bowel				
Kidney Disease				
Kidney Stones				
Liver Disease				
Lung Disease				
Mental Illness				
Migraines				
MRSA				
Osteoporosis				
Skin Infections				
Recurrent UTI				
PTSD				
Seizures				
STD's				
Sleep Apnea				
Stoke				
TB				
Thyroid Disease				
Vision Impairment				

Medical Appointment Planner

Doctor: _____ Date & Time: _____

Contact: _____ Location: _____

Reason for Visit

Prescription

Question/Notes

Next Appointment

Doctor Notes

Date & Time: _____

Reason for Consultation	
Duration	
Communication Method	

Points Discussed

To Do

Surgical History

Procedure	Date
Facility	Physician
Reason for Procedure	

Notes After Surgery

Lab Results Tracker

Test Type: _____

Date: _____

Provider: _____

Results: _____

Test Type: _____

Date: _____

Provider: _____

Results: _____

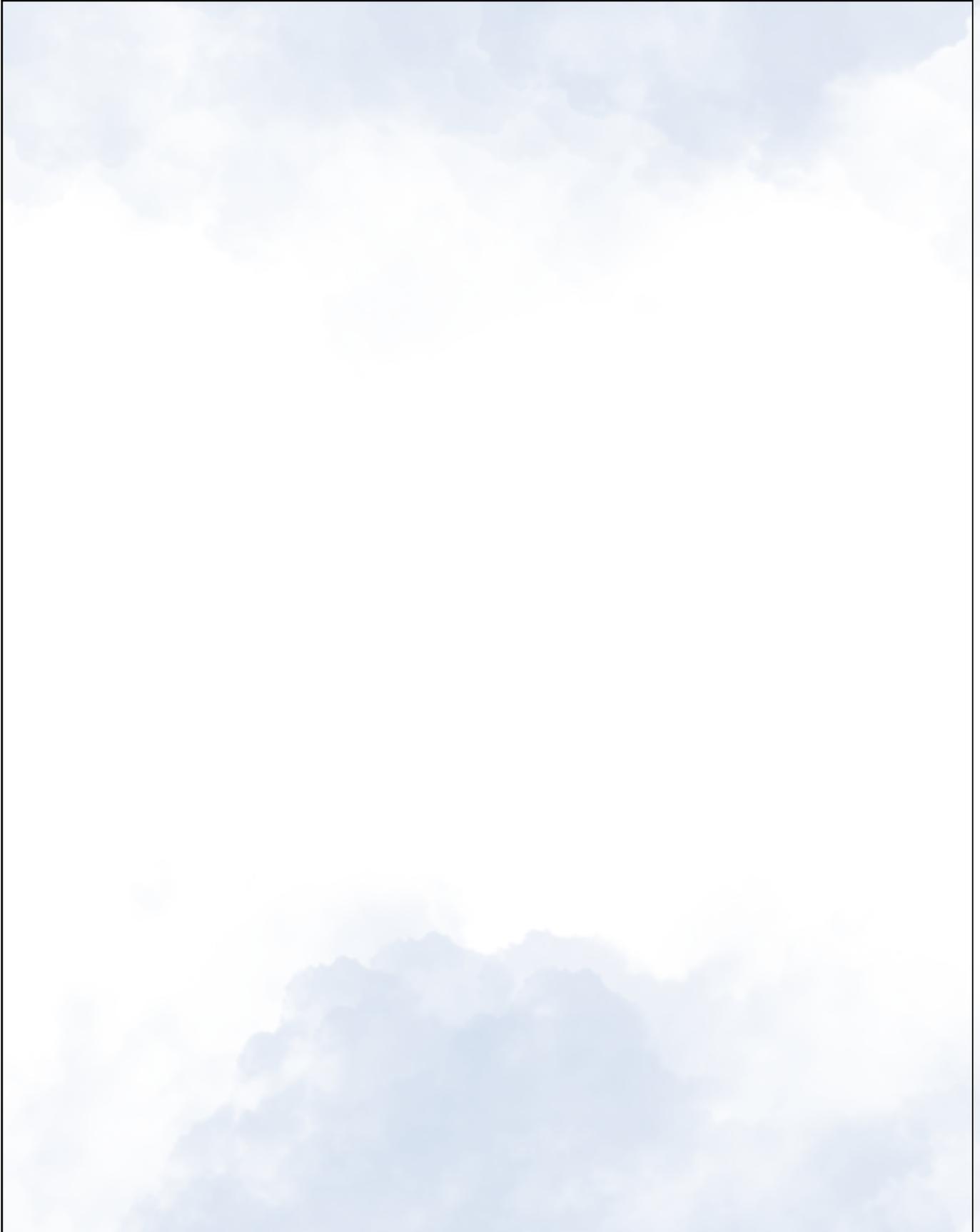
Test Type: _____

Date: _____

Provider: _____

Results: _____

Medical Notes





Financial Matters

Account Tracker

Account 1

Name of Account:	
Account Number:	
Financial Institution:	
Account Type:	Routing/Transit #:
Card Number:	
Notes:	

Account 2

Name of Account:	
Account Number:	
Financial Institution:	
Account Type:	Routing/Transit #:
Card Number:	
Notes:	

Account 3

Name of Account:	
Account Number:	
Financial Institution:	
Account Type:	Routing/Transit #:
Card Number:	
Notes:	

Credit Card Info

Credit Card

Credit Card Number:	Due Date:
Card Number:	
Account Number:	Minimum Payment:
Benefits/Rewards:	
Pay Via: <input type="radio"/> Mail <input type="radio"/> Auto Pay <input type="radio"/> Online-Website	
Username:	Password:
Pay Address:	
City:	ZIP:
Monthly Payment:	

Credit Card

Credit Card Number:	Due Date:
Card Number:	
Account Number:	Minimum Payment:
Benefits/Rewards:	
Pay Via: <input type="radio"/> Mail <input type="radio"/> Auto Pay <input type="radio"/> Online-Website	
Username:	Password:
Pay Address:	
City:	ZIP:
Monthly Payment:	

Investment Info

Investment Account Number 1

Account Type:	
Custodian:	Account Number:
Advisor:	
Phone:	
Website:	
Username:	Password:

Investment Account Number 2

Account Type:	
Custodian:	Account Number:
Advisor:	
Phone:	
Website:	
Username:	Password:

Investment Account Number 3

Account Type:	
Custodian:	Account Number:
Advisor:	
Phone:	
Website:	
Username:	Password:

Retirement Account Info

Account Details

COMPANY:

TYPE OF RETIREMENT:

ACCOUNT / WEBSITE:

ACCOUNT NUMBER:

USERNAME:

PASSWORD:

CURRENT VALUE:

NOTES:

Account Details

COMPANY:

TYPE OF RETIREMENT:

ACCOUNT / WEBSITE:

ACCOUNT NUMBER:

USERNAME:

PASSWORD:

CURRENT VALUE:

NOTES:

Utility Expenses

Type:	Day of Payment Due:
Company:	Account Number:
Payment Address:	
Phone:	Website:
Username:	Password
Current Amount:	Auto Payment? <input type="radio"/> YES <input type="radio"/> NO

Type:	Day of Payment Due:
Company:	Account Number:
Payment Address:	
Phone:	Website:
Username:	Password
Current Amount:	Auto Payment? <input type="radio"/> YES <input type="radio"/> NO

Type:	Day of Payment Due:
Company:	Account Number:
Payment Address:	
Phone:	Website:
Username:	Password
Current Amount:	Auto Payment? <input type="radio"/> YES <input type="radio"/> NO

Type:	Day of Payment Due:
Company:	Account Number:
Payment Address:	
Phone:	Website:
Username:	Password
Current Amount:	Auto Payment? <input type="radio"/> YES <input type="radio"/> NO

Debt Info

Creditor:	
Type of Loan:	
Interest Rate:	Min. Payment:
Debt Amount:	
Date Today:	
Pay Off Debt By:	
Month 1:	Month 7:
Month 2:	Month 8:
Month 3:	Month 9:
Month 4:	Month 10:
Month 5:	Month 11:
Month 6:	Month 12:

Creditor:	
Type of Loan:	
Interest Rate:	Min. Payment:
Debt Amount:	
Date Today:	
Pay Off Debt By:	
Month 1:	Month 7:
Month 2:	Month 8:
Month 3:	Month 9:
Month 4:	Month 10:
Month 5:	Month 11:
Month 6:	Month 12:

Creditor:	
Type of Loan:	
Interest Rate:	Min. Payment:
Debt Amount:	
Date Today:	
Pay Off Debt By:	
Month 1:	Month 7:
Month 2:	Month 8:
Month 3:	Month 9:
Month 4:	Month 10:
Month 5:	Month 11:
Month 6:	Month 12:

Creditor:	
Type of Loan:	
Interest Rate:	Min. Payment:
Debt Amount:	
Date Today:	
Pay Off Debt By:	
Month 1:	Month 7:
Month 2:	Month 8:
Month 3:	Month 9:
Month 4:	Month 10:
Month 5:	Month 11:
Month 6:	Month 12:

Valuables in Storage

Safety Deposit Box

Bank Name:		Box Number:
Address:		
City:	State:	ZIP:
Access Details:		
Description:		

Bank Name:		Box Number:
Address:		
City:	State:	ZIP:
Access Details:		
Description:		

Asset List

Asset Type	Description	Value	Insured?	
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N

Debt Payment Tracker

Creditor:		
Account #:		
Interest Rate:		
Minimum Payment:		
Starting Balance:		
Due Date:		
MONTH	PAID	BALANCE
JAN		
FEB		
MAR		
APR		
MAY		
JUN		
JUL		
AUG		
SEP		
OCT		
NOV		
DEC		

Creditor:		
Account #:		
Interest Rate:		
Minimum Payment:		
Starting Balance:		
Due Date:		
MONTH	PAID	BALANCE
JAN		
FEB		
MAR		
APR		
MAY		
JUN		
JUL		
AUG		
SEP		
OCT		
NOV		
DEC		

Debt Snowball Tracker

		Debt Item	Debt Item	Debt Item	Debt Item
	Starting Balance				
JAN	Payment				
	New Balance				
FEB	Payment				
	New Balance				
MAR	Payment				
	New Balance				
APR	Payment				
	New Balance				
MAY	Payment				
	New Balance				
JUN	Payment				
	New Balance				
JUL	Payment				
	New Balance				
AUG	Payment				
	New Balance				
SEP	Payment				
	New Balance				
OCT	Payment				
	New Balance				
NOV	Payment				
	New Balance				
DEC	Payment				
	New Balance				

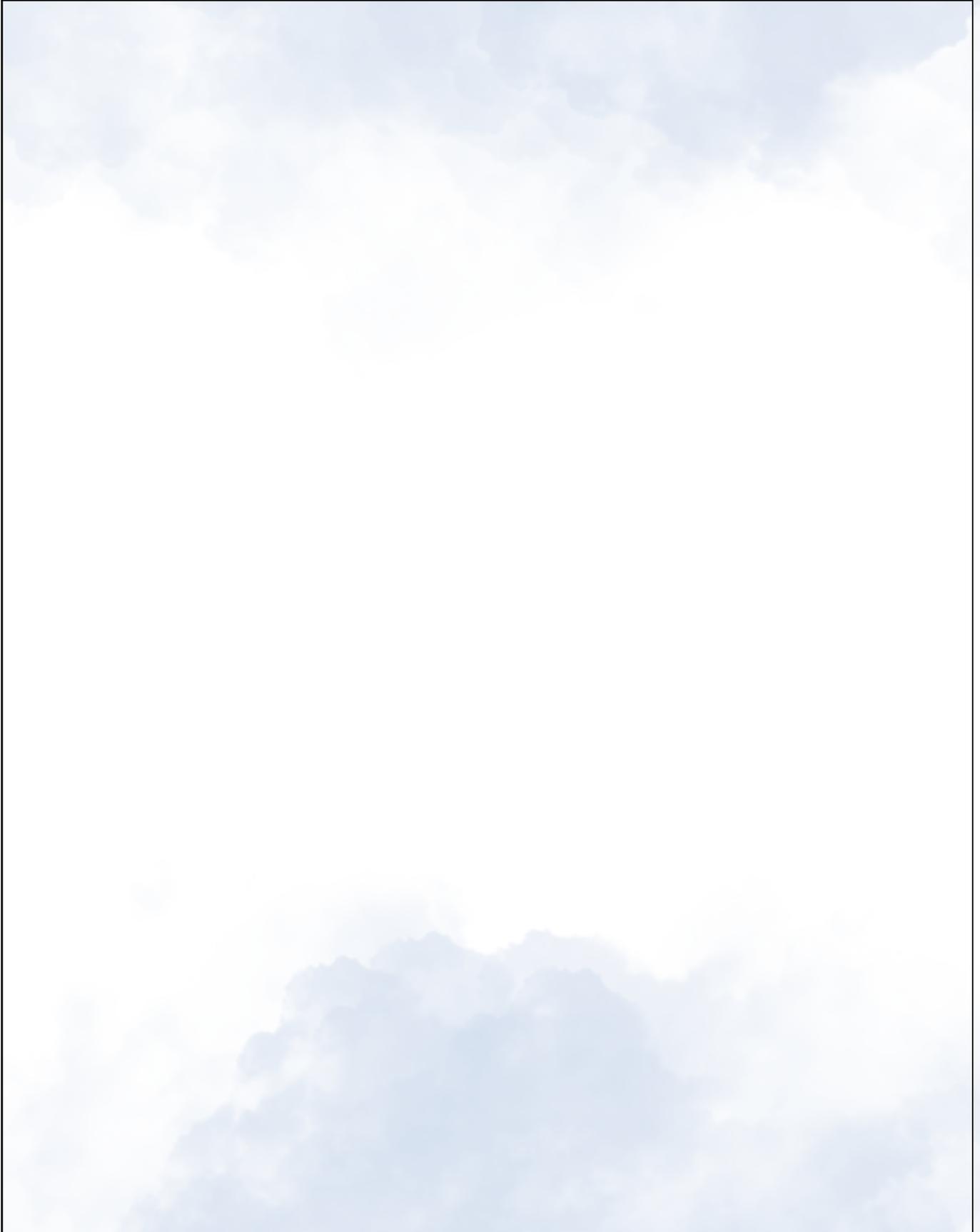


Important Documents

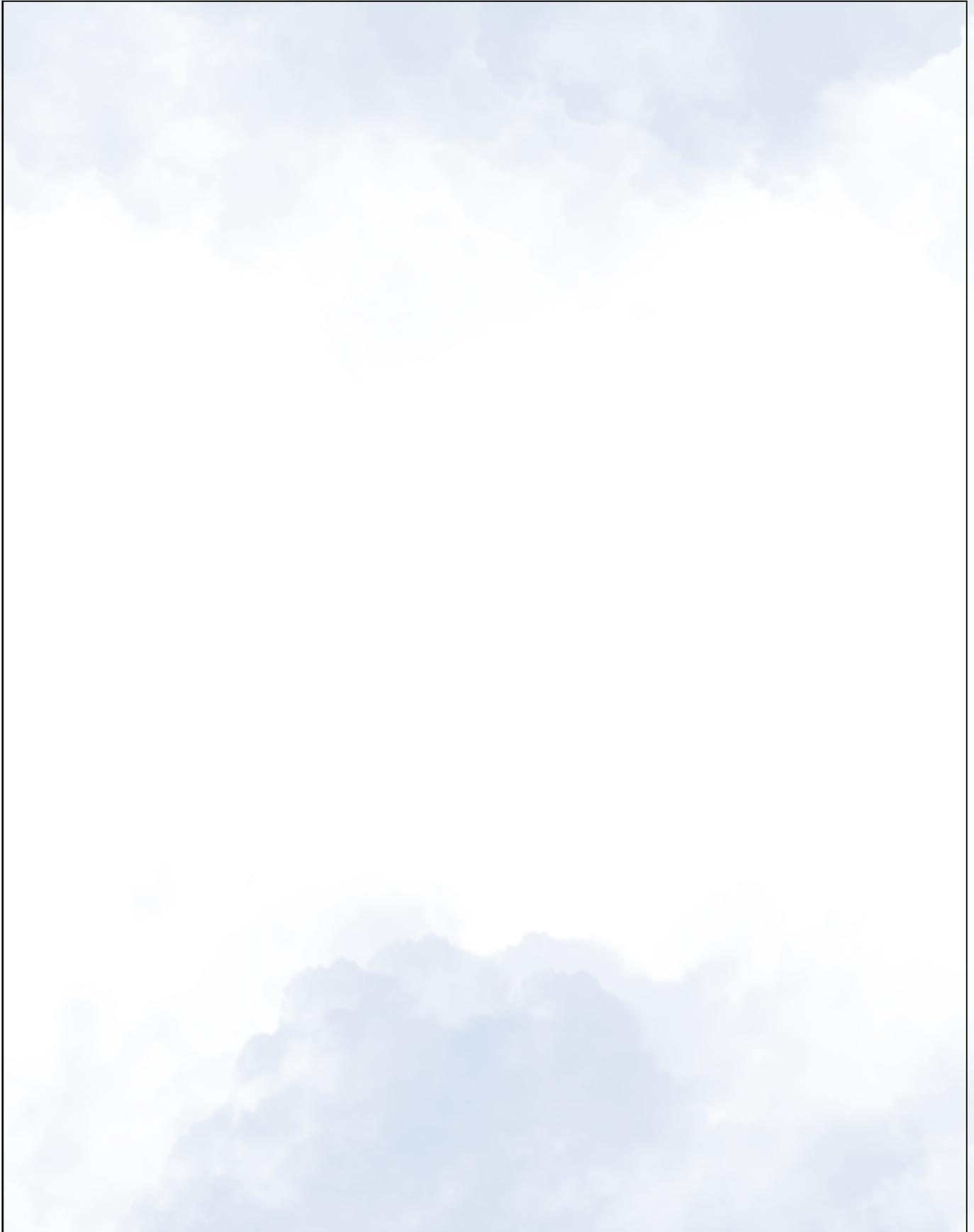
Important Documents

	DOCUMENTS
<input type="checkbox"/>	ID cards
<input type="checkbox"/>	Birth certificates
<input type="checkbox"/>	Marriage certificates
<input type="checkbox"/>	Death certificates
<input type="checkbox"/>	Copies of Wills, Power of Attorney, personal wishes
<input type="checkbox"/>	Immunisation records
<input type="checkbox"/>	Deeds / Titles / Mortgages Information
<input type="checkbox"/>	Immigration papers
<input type="checkbox"/>	Citizenship papers
<input type="checkbox"/>	Copies of passports, licenses, ID cards
<input type="checkbox"/>	Medicare cards
<input type="checkbox"/>	Credit cards
<input type="checkbox"/>	Drivers' licenses
<input type="checkbox"/>	Insurance cards
<input type="checkbox"/>	Vehicle registrations, Titles
<input type="checkbox"/>	Any contracts
<input type="checkbox"/>	

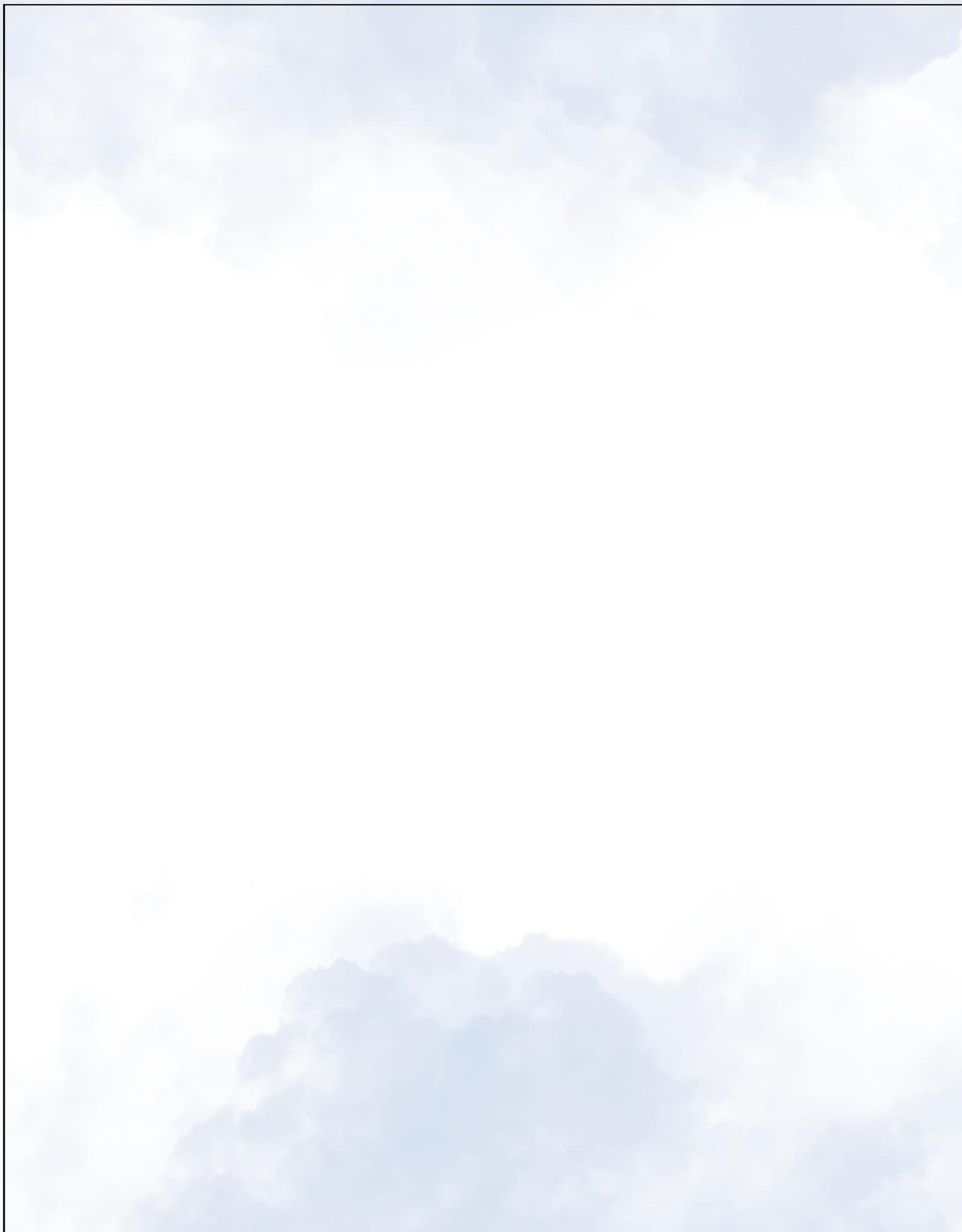
Living Will

A large, empty rectangular box with a thin black border, occupying the majority of the page below the title. This area is intended for the user to write the specific provisions and instructions of their Living Will.

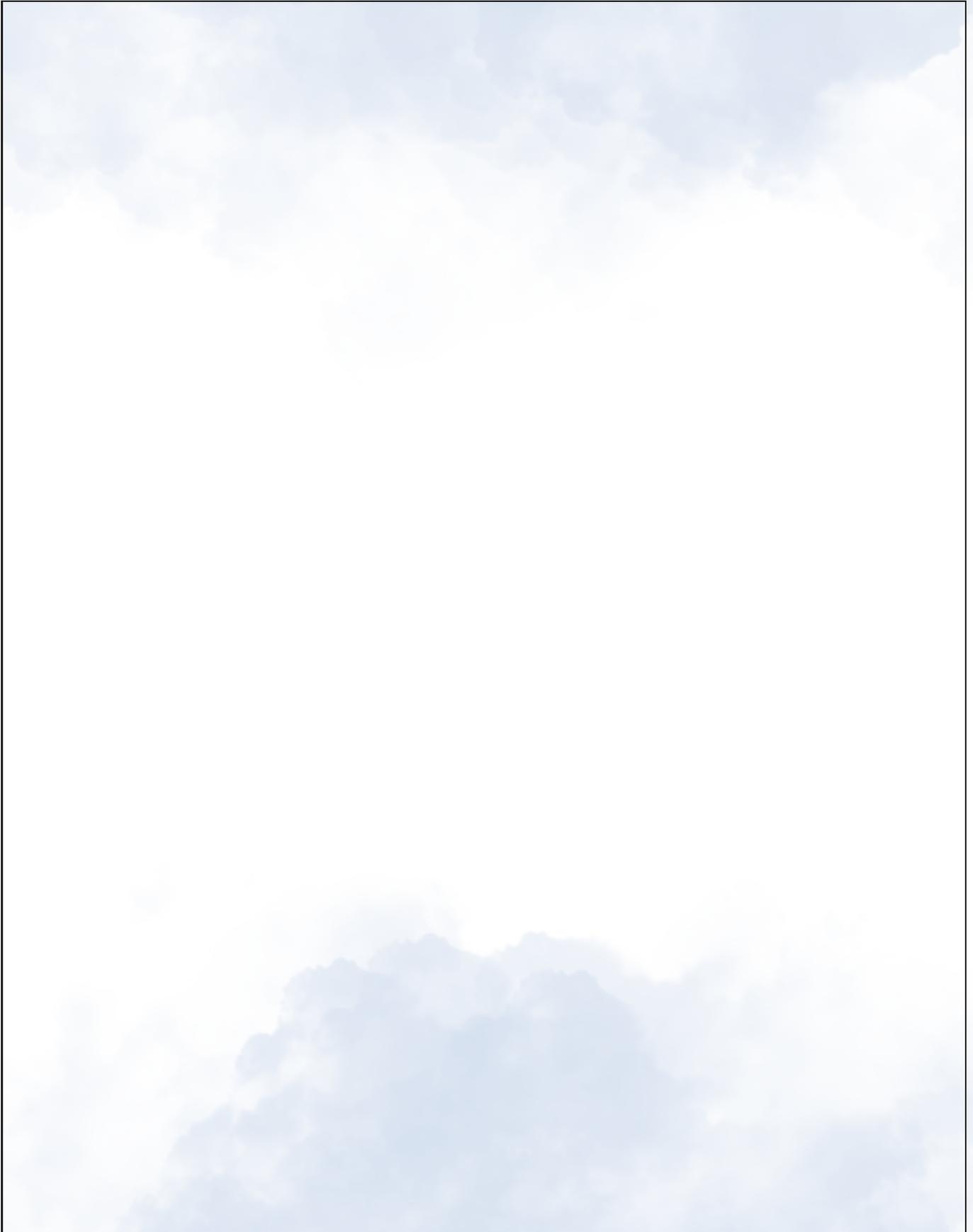
Witness Acknowledgment

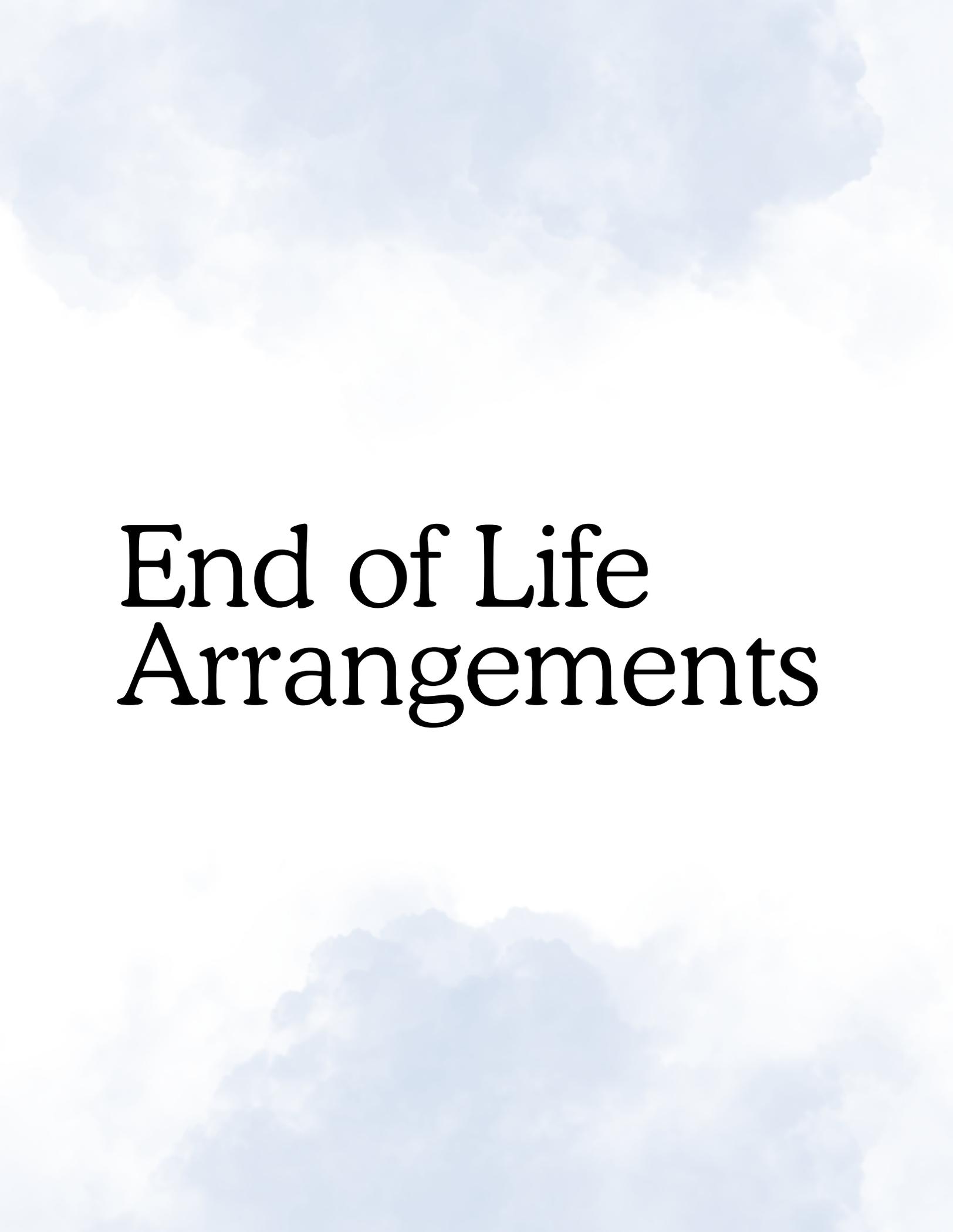
A large, empty rectangular box with a thin black border occupies the majority of the page. It is positioned centrally below the title and is intended for a witness to provide their acknowledgment. The background of the entire page is a light blue sky with soft, white clouds.

Notary Acknowledgment



Last Will and Testament





End of Life Arrangements

People to Contact

Contact

Name:	Relation:
Email:	Phone Number:
Address:	

Contact

Name:	Relation:
Email:	Phone Number:
Address:	

Contact

Name:	Relation:
Email:	Phone Number:
Address:	

Contact

Name:	Relation:
Email:	Phone Number:
Address:	

Contact

Name:	Relation:
Email:	Phone Number:
Address:	

Contact

Name:	Relation:
Email:	Phone Number:
Address:	

Funeral Arrangements

Preferred Funeral Home

Funeral Home Name:	
Contact:	Phone Number:
Address:	

Preferred Funeral Preferences

I want to be : <input type="radio"/> Burried <input type="radio"/> Cremated	Visitation with my Family: <input type="radio"/> Yes <input type="radio"/> No
Service at Church:	Phone Number:
Graveyard Service:	
Paid for:	Phone:
Casket Preferences: <input type="radio"/> Open Casket <input type="radio"/> Closed Casket <input type="radio"/> Not Available	
Clothing to be Selected or Collected By:	
Clothing: <input type="radio"/> New <input type="radio"/> Existing <input type="radio"/> N/A	
Jewelry to be Selected or Collected By:	
Jewelry: <input type="radio"/> New <input type="radio"/> Existing <input type="radio"/> Return After Service <input type="radio"/> Leave On for Burial <input type="radio"/> N/A	
Hair & Makeup: <input type="radio"/> Personal Hairdresser <input type="radio"/> Mortuary Cosmetologist	
Funeral Home Name:	Special Service Veteran:
Flower on Casket:	
Newspaper Notices:	
DVD with Pictures:	Music:
Reading:	Gravemarker:

Funeral Expenses

Policy:	
Company:	Phone Number:
I Have Prepaid Funeral Expenses: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> How Much?	
Payment Method: <input type="radio"/> Prepaid Package <input type="radio"/> Saving Account <input type="radio"/> Life Insurance	
<input type="radio"/> Burial Funds <input type="radio"/> Funeral Trust <input type="radio"/> Funeral Insurance	
<input type="radio"/> Burial Benefits - Approved for Pre-Need Eligibility? :	<input type="radio"/> Other:

End of Life Worksheet

Full Legal Name:

Date of Birth:

Preferred Hospital:

Attending Doctor:

Medical Power of Attorney

I would like to designate a Medical Power of Attorney (POA) to make healthcare decisions on my behalf if I become unable to communicate or make decisions.

Power of Attorney Name:

Relationship:

Contact:

Address:

Notes

Preferred Location for End-of-Life Care:

Individual I Would Like to Have Present During End-of-Life Care and Death:

End of Life Directives

Last Will and Testament

Family Member:	Phone Number:
Location of Document:	
Executor:	Phone Number:
Prepared By:	Phone Number:
Address:	

Trust Agreement

Family Member:	Phone Number:
Location of Document:	
Trustee:	Phone Number:
Prepared By:	Phone Number:
Address:	

Health Care Power of Attorney

Family Member:	Phone Number:
Location of Document:	
Person:	Phone Number:
Prepared By:	Phone Number:
Address:	

Financial Care Power of Attorney

Family Member:	Phone Number:
Location of Document:	
Person:	Phone Number:
Prepared By:	Phone Number:
Address:	

Final Wishes Worksheet

<input type="checkbox"/>	I would like my family and friends to know that I love them
<input type="checkbox"/>	I would like my family and friends to know that I am now at peace
<input type="checkbox"/>	I would like my family and friends to think of me before my illness/injury/dying
<input type="checkbox"/>	I would like my family and friends to focus on the good times we had together
<input type="checkbox"/>	I would like my family and friends to move on and grow and change in their lives without feeling guilty at my absence
<input type="checkbox"/>	I would like my family and friends to make peace with my memory if they are able
<input type="checkbox"/>	I would like my family and friends to seek counseling for any lingering grief
<input type="checkbox"/>	I would like my family and friends to remember me fondly, not with sadness
<input type="checkbox"/>	I would like my family and friends to celebrate my life, not mourn my death
<input type="checkbox"/>	I would like my family and friends to use the inheritance and gifts I have given them to improve themselves, care for their families, and give back to their communities
<input type="checkbox"/>	

I would like to be remembered in the following way:

I would like to be memorialized in the following way:

Final Wishes

Last Wishes	Notes	✓

Final Wishes

In the Following Ways, I Would Like to be Remembered

Recalling My Presence

In the Following Ways, I Would Like to be Memorialized

Commemorate Me

Headstone Planning

Name:	Date:
-------	-------

Epitaph

Headstone

Material:
Size:
Shape:
Font Style:
Color:
Symbol and Meaning:
Maximum Headstone Cost:

Obituary Information

Personal Information

Full Legal Name:

Maiden Name:

Date of Birth:

Place of Birth:

Survived By

Spouse:

Children:

Grandchildren:

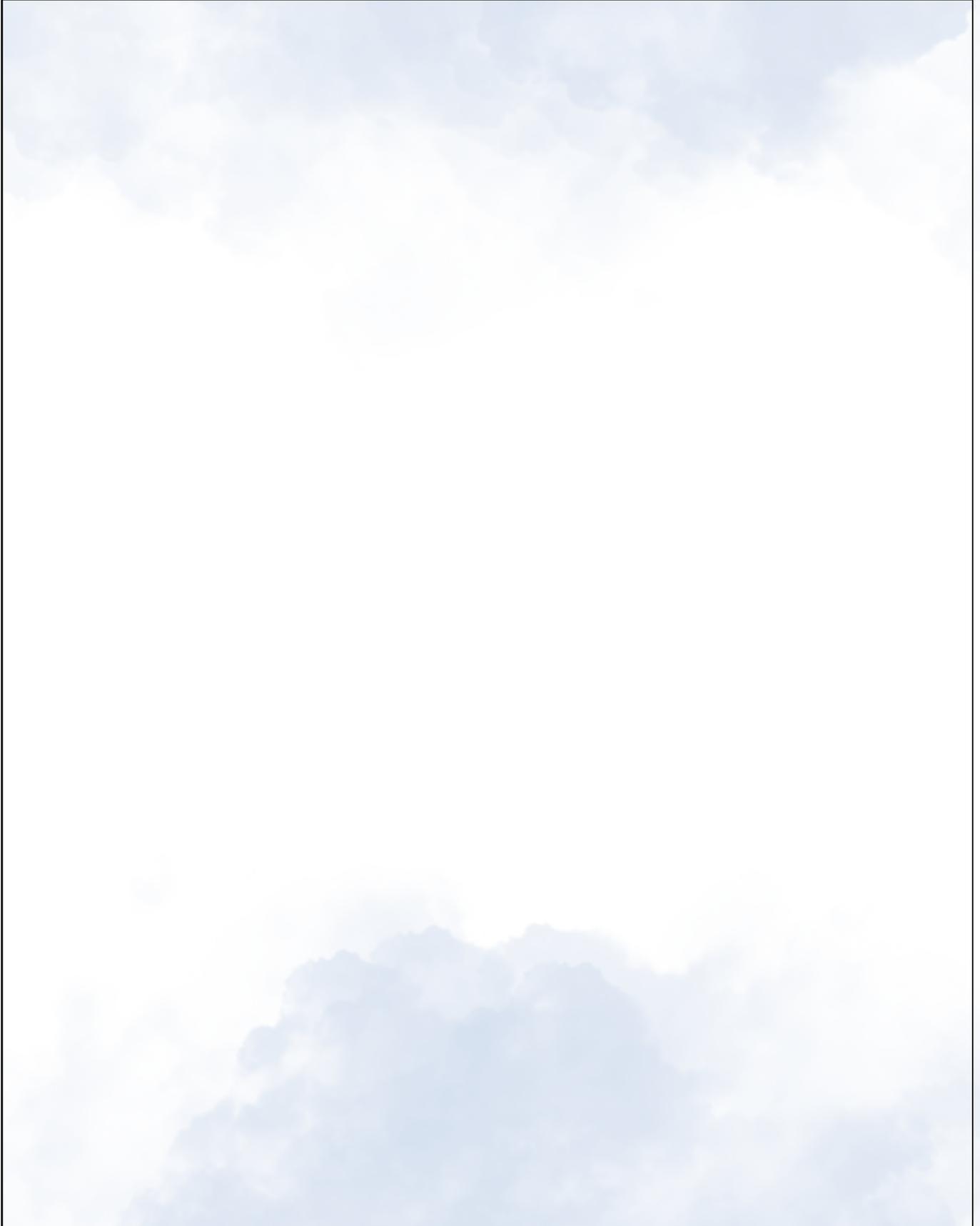
Pets:

Achievements

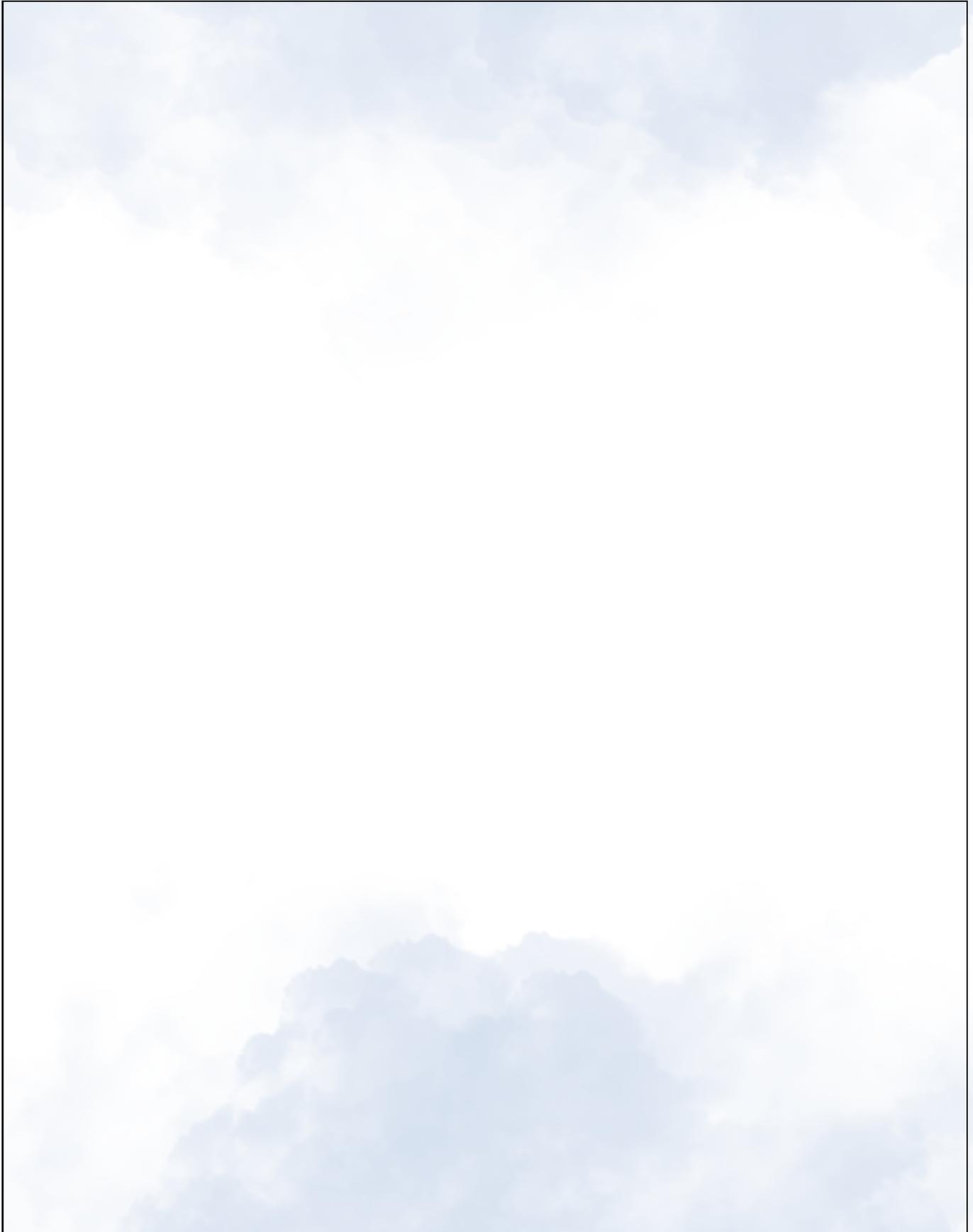
Affiliations

Notes

Obituary Content



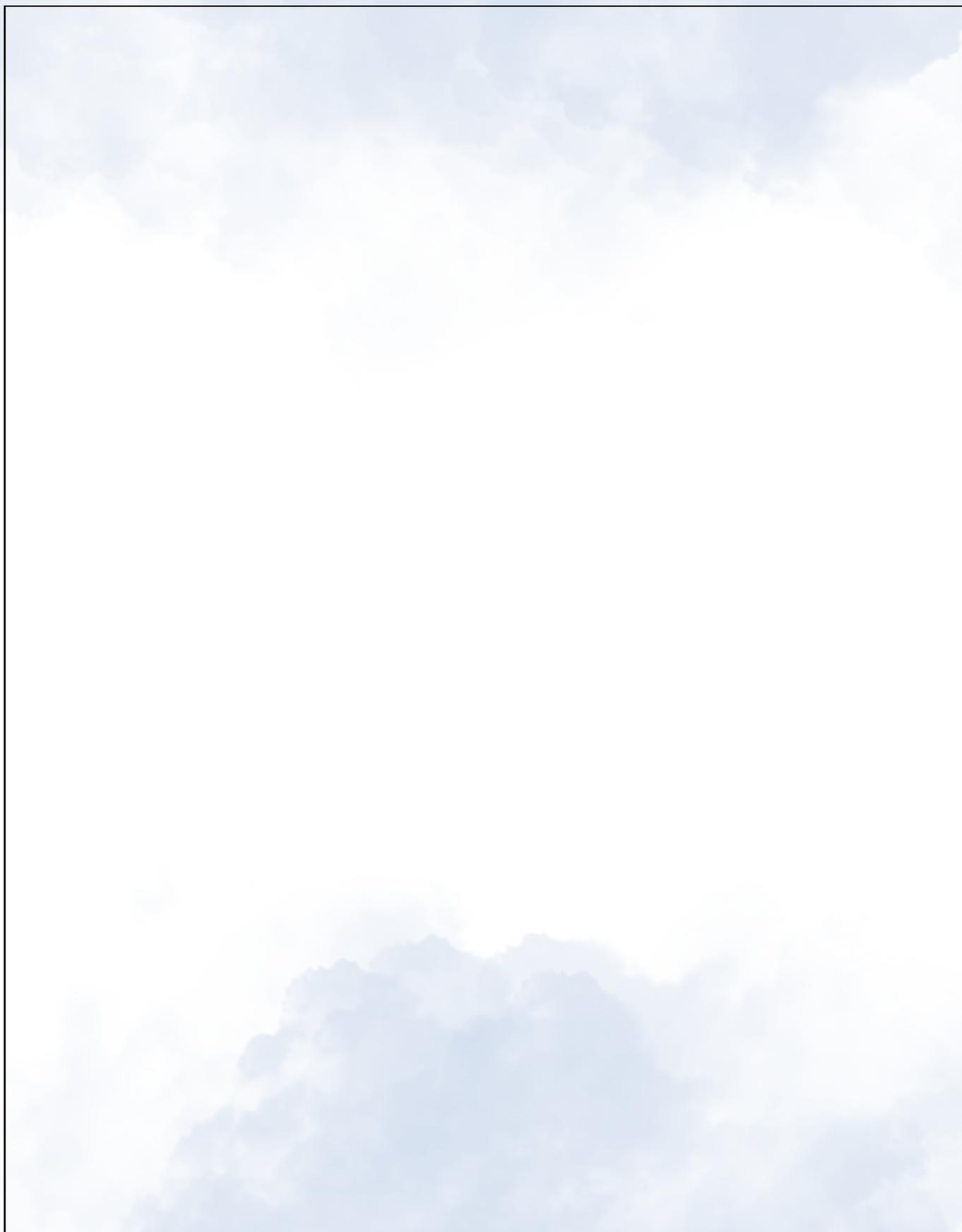
Message for My Beneficiaries



Letter of Intent

A large, empty rectangular box with a thin black border, intended for writing the letter of intent. The background of the entire page is a light blue sky with soft, white clouds.

Letter of Gratitude

A large, empty rectangular box with a thin black border, occupying most of the page below the title. It is intended for the user to write their letter of gratitude. The background of the entire page is a soft-focus image of a bright blue sky with scattered white clouds.

Note to Family Members

