

Dear Member,

Thank you so much for your support of Final Exit Network and its mission. As a FEN member, you have an opportunity to register with the U.S. Advance Care Plan Registry. The Registry is a secure, on-line database where you can store your advance directive and/or organ donor information. Documents can be easily accessed by you, or any health care provider. It is completely confidential, just like a medical record. Once registered, you will receive labels to affix to your insurance card and driver's license stating your advance directive is registered. Take advantage of this great program!

To participate in the Registry, complete the enclosed application form and return it **BY MAIL** to: U.S. Advance Care Plan Registry PO Box 2789
Westfield, NJ 07091-2789

The application form must be returned to the Registry by mail (not email) along with fully executed copies of your health care documents. **Do not send original documents. Do not include your last will and testament. The Registry accepts health care documents only.** Once you are registered and your documents provided, the Registry will provide you with a way to review and update your documents online.

FEN's role in this process is to provide the free member benefit and application form. We do not assist with completion of your documents. Questions should be directed to the Registry at 800-548-9455 or admin@uslivingwillregistry.com.

Final Exit Network offers Exit Guide services at no cost to all competent adults who apply and are approved. Further details are provided on our web site at www.finalexitnetwork.org. If you belong to an organization that would welcome a Final Exit Network speaker, please contact us through our website or phone 866-654-9156.

Membership dues and donations are Final Exit Network's primary source of funds. They fund our Exit Guide Program, our Magazine, our Speakers Bureau, and all the activities that are essential to our continued existence. We need more members, so please help us expand our membership by telling others about us!

We are pleased to have you as a member. Thank you for your support.

Brian Ruder

President

U.S. Living Will Registry® Registration Agreement

Name: First	Re	Registrant's Identifying Information (Please print clearly) SOURCE CODE: 13115502					
Street Address	Na	me: First	 Middle	Last			_ Suffix
City:	Soc	cial Security # _		Date of Birth Month	Day	Year	(4 digits)
Primary Phone:	Str	reet Address	Apt #				
EMAIL address for Registrant or Emergency Contact: * Annual update reminders will be sent via email (email addresses will not be shared or sold) Emergency Contact Name: Relationship: Address: Primary Phone: (Cit	ty:		State:	_ Zip Code: _		
*Annual update reminders will be sent via email (email addresses will not be shared or sold) Emergency Contact Name:	Pri	imary Phone: (_		Alternate Phone: ()		
Primary Phone: (EM	* Annual update reminders will be sent via email (email addresses will not be shared or sold)					
Primary Phone: (En						
I,	Ad	dress:					
West, P.O. Box 2789 Westfield, NJ 07091-2789 ("Registry"), to electronically store a copy of my advance directive(s) provided to Registry with this registration form or subsequently, including but not limited to a living will, health care proxy, durable power of attorney for health care and/or financial matters, Medical or Physician Orders for Life-Sustaining Treatment (MOLST or POLST) organ donation wishes and emergency contact information ("Advance Directives"). I further authorize the Registry to make available a copy of the stored Advance Directive(s) to any health care provider or other person believed charged with giving effect to my Advance Directive(s) or assisting in same, who requests it in conjunction with my care, provided such a request is consistent with the Registry's policies and procedures, or as deemed advisable by the Registry in an emergency situation, or as required by law. The Advance Directive(s) that I am providing is my current, effective Advance Directive(s), and was signed and witnessed in accordance with the law of the state of my residence. I hereby authorize Registry to make available a copy of my Advance Directive(s) to hospitals, physicians, or other health care providers involved with my care, or anyone who has access to the wallet identification ("ID") card provided to me by Registry. I understand this authorization is voluntary. I agree to notify Registry immediately if I decide to revoke or change my Advance Directive(s) stored with Registry and to provide Registry with a copy of any additional Advance Directive(s) that I sign. I understand that unless I terminate this authorization or inform Registry of revocation or changes to my Advance Directive(s), the Advance Directive(s), the Advance Directive(s) to the Advance Directive(s) and practices. I understand that Registry makes no representations about the validity of my Advance Directive(s) under federal or state law and that Registry bears no responsibility for the actions taken by health care providers in relation to my	Pri	imary Phone: (_		Alternate Phone: ()		
until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, I understand that Registry will remove my Advance Directive(s) from its files. I understand that anyone who gains access to my wallet ID card provided by Registry can use it to gain access to my Advance Directive(s) and personal information stored with Registry, and I will not hold the Registry liable for such authorized or unauthorized access. I hereby agree to the terms set forth herein. DATED:/	attorney for organ don a copy of Advance I Registry's Advance I with the later I have been understand Directive(I use and that I have been understand of my Advance I use of my Advance I	or health care an ation wishes and the stored Adva Directive(s) or as policies and productive(s) that I aw of the state of ereby authorize Finvolved with media this authorization is sorted with Respective any and all leading to the state of the state of ereby authorize Finvolved with media this authorization is stored with Respective any and all leading to the state of the state	d/or financial matters, Medica emergency contact information nee Directive(s) to any health sisting in same, who requests it is cedures, or as deemed advisal am providing is my current, amy residence. Registry to make available a conjustry and to provide Registry and to provide Registry and to provide Registry will be provided to health registry makes no representation responsibility for the actions regal claims against Registry for (s) from Registry and for an registry. Registry shall not be a may revoke this authorization or unterface until revoked by me or until depursuant to the Registry's pedvance Directive(s) from its fill yone who gains access to my was formation stored with Registry at terms set forth herein.	al or Physician Orders for in ("Advance Directives"). In care provider or other pet in conjunction with my case be by the Registry in an eleffective Advance Directive and the appropriate of the wallet identification of the wallet identification of the care providers in accord with a copy of any addition gistry of revocation or chain care providers in accord with a copy of any addition of the wallet identification of the care providers in accord with a copy of any addition gistry of revocation or chain care providers in accord with a care providers in accord with a care providers and omissions my damages arising from the loss, destruction at any time by giving writtle terminated in accordance officies and procedures. Wheles, wallet ID card provided by the provided by the care	Life-Sustaini I further auth erson believed are, provided emergency site(s), and was eve(s) to hospitation ("ID") of y if I decide hal Advance I nges to my evith Registry Advance Di riders in relat by any health the transmiss on or unavail eitten notice of the with the agreen egistry can egistry liable	ng Treatment orize the Regid charged wit such a request uation, or as signed and wittals, physiciar card provided to revoke or Directive(s) the Advance Directive(s) und ion to my Ach care provided sion or disclesion disclesion or disclesion disclesion disclesion disclesion disclesion disclesion	istry to make available h giving effect to my t is consistent with the required by law. The itnessed in accordance in s, or other health care to me by Registry. It change my Advance at I sign. I understance to the Advance or federal or state law dvance Directive(s). The itnessed in accordance in the Advance or part of my Advance or part of my Advance in the Registry. This is the me and Registry of ated, I understand that access to my Advance access to my Advance in the Advance of the Advance in the Registry of the Advance in the Registry of ated, I understand that access to my Advance in the Registry of ated, I understand that access to my Advance in the Registry of the Advance in the Registry of ated, I understand that access to my Advance in the Registry of the Registry
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