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The laws of the State of Texas govern the terms and conditions of use. Any action brought under these terms and conditions of use shall be brought in the State of Texas and you specifically consent to the non-exclusive jurisdiction of the courts of the State of Texas in all disputes arising out of or relating to the use of this document. Use of this document is not authorized or sanctioned in any jurisdiction that does not give full effect to the terms and conditions of use including, without limitation, this section.

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If any part or section of these terms and conditions of use is determined to be invalid or unenforceable pursuant to applicable law the invalid or unenforceable part or section will be deemed superseded by a valid, enforceable provision that most closely approaches the intent of the original section and the remainder of the terms and conditions of use will remain in effect.

ENTIRE AGREEMENT

The terms and conditions of use constitute the entire agreement between you and Gee Insurance Solutions and supersede any and all prior or contemporaneous communications and proposals, whether electronic, oral, or written. Further, a printed version of these terms and conditions of use and any notice given in electronic form will be admissible in judicial or administrative proceedings based upon or relating to these terms and conditions of use to the same extent and subject to the same conditions as other business documents and records originally generated and maintained in printed form.

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In any action brought as result of any alleged violation of the terms and conditions of use the prevailing party shall be awarded its costs and attorney fees incurred in connection with said action.

STATE OF TEXAS

This particular advance health care directive is to be used by Texas residents. To request documents for other states, please visit <http://www.geeinsurancesolutions.com/free-living-will>.

SUMMARY

This service is a publishing service, similar to books offering general legal advice and forms you can buy in a bookstore, and similar to legal forms available on disks available at office supply and computer supply stores, and similar to legal forms available online. All forms provided and produced through this service are meant to provide a guideline for common and standard situations. All documents and services are "as-is."

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ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS: This form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. This form also lets you express an intention to donate your bodily organs and tissues following your death. Lastly, this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named.

I, _____, being of sound mind and at least 18 years of age, declare that:

(1) **END-OF-LIFE DECISIONS:** I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Initial only one box)

- (a) Choice NOT To Prolong Life. I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR
- (b) Choice To Prolong Life. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

(3) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(4) PRIMARY PHYSICIAN: (OPTIONAL)

I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

(OPTIONAL) If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

(5) DONATION OF ORGANS AT DEATH - (OPTIONAL)

Upon my death: (mark applicable box)

- (a) I give any needed organs, tissues, or parts, OR
- (b) I give the following organs, tissues, or parts only.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

I execute this declaration, as my free and voluntary act, on this _____ day of _____, 20____, in the City of _____, County of _____, State of _____.

(Signature)

(INSTRUCTIONS: This advance health care directive will not be valid for making health care decisions unless it is either: (1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (2) acknowledged before a notary public.)

I declare under penalty of perjury under the laws of the state of (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community health care facility, the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under the laws of penalty of perjury of the state of that I am neither related to the patient by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law.

Signed at _____ on this ____ day of _____, 20__.

(name and address of first witness)

(name and address of second witness)

On this the _____ day of _____, 20__, before me, the undersigned, a notary public in and for said County and State, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

(Signature of Notary)

Help Protect Your Family with Final Expense Life Insurance

An important part of planning is helping to protect your family and loved ones from unexpected costs.

It's comforting to know that final expense life insurance may be able to help cover outstanding items such as funeral costs, cemetery costs, and other expenses that may arise at the time of need.

No one knows what the future may hold, but we can take action today to help make sure that our loved ones are cared for in the event of death.

National Average Final Expense Costs	
Funeral Cost Estimates	
● Professional services, embalming, visitation, etc.	\$ 4,265
● Metal casket	\$ 2,295
● Burial vault	\$ 1,195
Cemetery Cost Estimates	
● Cemetery Plot (\$1,000 and up in metro areas)	\$ 800
● Monument (\$500 to \$2,000 and up)	\$ 950
● Opening and Closing of the grave (varies by cemetery)	\$ 1,295
TOTAL ESTIMATED FUNERAL EXPENSES	\$ 10,800
Other Final Expense Estimates	
● Immediate household expenses, rent or mortgage payments, credit card debt, car loans, loss of income, hospital and medical bills not paid by medical insurance, attorney fees, court fees, taxes, etc.	\$ 10,000
TOTAL ESTIMATED FINAL EXPENSES	\$ 20,800

Source: National Funeral Directors Association 2009 General Price List Survey. (Most recent available)

A Solution for Your Final Expenses and More

Some Americans believe that Social Security will pay for their final expense needs, however, the government only pays a lump sum of \$255 for those who qualify*.

With this in mind, a whole life final expense life insurance policy can help give you and your family some *peace of mind* that your family will be protected should the unexpected occur.

Some highlights of this policy include:

- **Your premium will NEVER increase and your benefit will NEVER decrease.**
- **Coverage can NEVER be canceled as long as you pay your premiums.**
- **Coverage builds cash value over time and can be borrowed against.**
- **You may be able to receive an Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement Rider at no additional cost.**
- **Affordable rates that can fit most budgets.**

30-day money-back free look period! If you're not completely satisfied, just return your insurance documents within 30 days of receipt for a full refund of any premiums.

Contact Us Today To Get a Free Final Expense Quote

Getting a quote for final expense life insurance is easy! Just contact us through one of these convenient methods:

- Call us – (682) 305-1527
- Email us – info@geeinsurancesolutions.com
- Contact Form – GeeInsuranceSolutions.com

We look forward to hearing from you!



Gee Insurance Solutions
Arlington, TX

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