AmeriEstate DocuBank®
Enrollment Form

We have always stressed to our members that it is important to provide a copy of your Advance Healthcare Directives to your designated agents so that important medical and lifesaving treatment can be authorized in case of emergency or your sudden incapacity. With this free service (a $45 value per member) you will be issued an emergency medical wallet card in 4-6 weeks that will allow doctors and hospitals to retrieve this important lifesaving information 24/7/365.

In order for us to enroll you in this service, please:

1. Finish and sign the DocuBank® Enrollment Form (for 2 members, please copy and fill out 1 for each).
2. Provide us with a copy of your Advance Healthcare Directive(s) located in Tab Section 9 of your Estate Plan.
3. Send the requested documents to AmeriEstate by mail, fax or email to legalplan@AmeriEstate.com.

Personal Information:

Name: (Mr. Mrs. Ms.) _____
(First) (Middle Initial) (Last)

Mailing Address: _____
(Street Address) (Apt. Number)

_____
(City) (State) (Zip Code) (Date of Birth)

Home Tel.: _____ Work Tel.: _____ Cell: _____

Email: _____

Allergies: (optional) _____

Medical Conditions: _____

I am including a list of my medications for storage. (Form available at www.AmeriEstate.com/docubank)

Emergency Contacts: (optional) The names and phone numbers of your emergency contacts and physician will be provided to hospital staff when your directives are requested. You can list up to 3 contacts. They can be the same or different from the people you have listed as your healthcare power(s) of attorney.

Name:_____ Email:_____ Relationship:_____

Home Tel.: _____ Work Tel.: _____ Cell: _____

Name:_____ Email:_____ Relationship:_____

Home Tel.: _____ Work Tel.: _____ Cell: _____

Name:_____ Email:_____ Relationship:_____

Home Tel.: _____ Work Tel.: _____ Cell: _____

Primary Care Physician: (optional)

Dr.:_____ Work Tel.: _____
(First) (Last)

Membership Statement: I have completed an Advance Directive Document(s) (e.g. Living Will, Healthcare Power of Attorney, other Advance Directive) of my own free will and have chosen to enroll in DocuBank® to help make my documents available when requested. To ensure prompt access, I authorize that my document(s), emergency and health information stored with DocuBank® be provided to anyone who produces my DocuBank® member number and PIN. I will notify DocuBank® promptly of changes in all my information stored by DocuBank® and also of the revocation or replacement of my document(s). I understand that DocuBank® is not responsible for the validity or accuracy of any information stored by DocuBank® including the health information that also appears on the face of my DocuBank® card. By accepting my card, I have verified and confirmed the accuracy of all information on the card before carrying the card. I also understand that DocuBank® does not provide legal advice, and that I may cancel this service in writing at any time by written request to DocuBank®.

Signature: _____ Date: _____

Please remember to sign this form and enclose a clear copy of your signed document(s).