WILLS FOR HEROES PROGRAM FACT SHEET

As one of the benefits provided to qualified members of our member companies the Maryland State Firefighters Association has implemented a Wills for Heroes Program. The Wills for Heroes Program is intended to provide the opportunity for those who qualify who wish to participate to have the Maryland State Firefighters Association provide such qualified participant with a free last will and testament.

The Wills for Heroes Program is not intended to be a substitute for an individual's estate planning as more particularly described on the advice of rights and disclaimer.

Attached to this fact sheet you will find a set of documents which include the last will and testament, advice of rights and disclaimer, privacy rights notice, and Wills for Heroes Document for your information. Copies of each of the documents are also available on the Maryland State Firefighters Association website (msfa.org).

MARYLAND STATE FIREFIGHTERS ASSOCIATION WILLS FOR HEROES PROGRAM PRIVACY RIGHTS NOTICE

The Maryland State Firefighters Association does not maintain records of persons who participate in the program or the information given to the Maryland State Firefighters Association representatives regarding participation in the program. All information supplied by an individual participating in the program will be used solely for the purpose of the program. No information will be shared or sold with any other person, firm or corporation.

Upon the participating individuals having executed a last will and testament, the sole purpose of the program being to provide such last will and testament to a qualified participating individual, all information received from that individual for the purpose of preparing the last will and testament will be returned to the individual and no copies or records will be kept for any reason or any purpose by the Maryland State Firefighters Association.

MARYLAND STATE FIREFIGHTERS ASSOCIATION
WILLS FOR HEROES PROGRAM ADVICE OF RIGHTS AND DISCLAIMER

This advice of rights and disclaimer by and between the Maryland State Firefighters Association and _____.

WITNESSETH

WHEREAS, the Maryland State Firefighters Association has undertaken to provide without charge certain last wills and testaments of limited scope to qualified firefighters and EMS personnel in the State of Maryland and,

WHEREAS, related to the "Wills for Heroes" program, an individual qualified firefighter or EMS personnel wishing to take advantage of the free last will and testament makes such election with knowledge of the limitations in the scope of the program,

NOW THEREFORE, the parties hereto agree

FIRST; that the Wills for Heroes program is not intended to act as a solicitation by the Maryland State Firefighters Association, Inc. for any additional legal or estate planning services.

SECOND; that the Wills for Heroes program is not intended to be a substitute for legal or estate planning services which the signatory acknowledges are of such a nature as should be inquired into independently.

THIRD; that the Wills for Heroes program provides a "simple" last will and testament only and no further or additional estate planning services the nature of which should be sought by the undersigned by a qualified attorney of his choice should the undersigned so desire.

FOURTH; that the Wills for Heroes program is provided as a benefit to qualified individuals as a benefit of membership in a member company of the Maryland State Firefighters Association, Inc.

FIFTH; a qualified individual is a member in good standing of a volunteer fire, rescue, or EMS company or a recognized Auxiliary of the same, which is itself a member in good standing of the Maryland State Firefighters Association, Inc. or the LAMSFA.

SIXTH; The Maryland State Firefighters Association disclaims any duty or responsibility to provide estate planning counseling beyond the terms and condition of the Wills for Heroes program.

SEVENTH; That although the Maryland State Firefighters Association, Inc., provides the appropriate forms, it is the responsibility of the individual to fill in the appropriate forms, obtain the requisite witnesses, and seek out appropriate legal advice should the individual have any questions regarding the attached document(s).

AS WITNESS the hand and seal of the aforesaid individual this _____day of_____, 20__.

_____
Signature

_____
Witness

LAST WILL AND TESTAMENT
OF _____(name)

I, _____ (FULL LEGAL NAME), late of _____ County, State of Maryland being of sound and disposing memory and disposition do hereby make, publish and declare this as and for my last will and testament hereby revoking any or all other wills and codicils heretofore made by me.

FIRST; I bequeath my body to the ground to be _____ (buried/cremated) and direct my personal representative hereinafter named to pay all costs associated with my funeral and interment. I further direct my personal representative to select a suitable marker to denote my final resting place. My personal representative shall be entitled to carry out this directive without limitation or application to approval by any court for authority.

SECOND; I direct my personal representative to pay, compromise or deny any or all claims made against my estate within his sound discretion and without the necessity of application to approval by any court for any said discretionary termination. I further direct my personal representative to pay from the proceeds of my estate all costs of administration of my estate, inheritance taxes, and all other charges associated with the administration of my estate.

THIRD; I hereby give devise and bequeath all of the rest and residue of my estate of whatsoever kind and wheresoever situate real, personal, and/or mixed unto my _____ (NAME OF BENEFICIARY OR BENEFICIARIES). However, should _____ (NAME OF BENEFICIARY OR BENEFICIARIES) predecease me or should we die in a common disaster in which case for the purpose of administration of my estate it shall be conclusively presumed that he/she predeceased me, then, in that event, I hereby give, devise and bequeath all the rest and residue of my estate of whatsoever kind and wheresoever situate real, personal and/or mixed in equal shares unto _____. NAME OF ALTERNATE BENEFICIARY OR BENEFICIARIES.

FOURTH; I hereby nominate, constitute and appoint _____ (PERSONAL REPRESENTATIVE) as and for personal representative to and of my estate and having trust and confidence of my said designee's ability to administer my estate and carry out all of my directives, I hereby direct that he/she shall be entitled to serve without a bond. My said personal representative shall be empowered to do any actor thing ordinary, necessary, usual or in accordance with the applicable statutes of the State of Maryland to fulfill his duties and carry out my directives as my personal representative.

IN WITNESS WHEREOF, I have here unto set my hand and seal this _____day of _____20_____.

_____(SEAL)

Signature

SIGNED, SEALED, PUBLISHED and DECLARED by the above-named _____ (testator/testatrix), as,_____(his/her) Last Will and Testament, in the presence of us, who at _____ (his/her) request, in _____ (his/her) presence, and in the presence of each other, have hereunto subscribed our names as witnesses.

_____ _____

Name Address

_____ _____

Name Address

Medical Power of Attorney
And Living Will of

_____

PART I: SELECTION OF HEALTH CARE AGENT

I, _____, a resident of _____ County, (State) _____; on this _____ day of _____, 2026, do hereby designate, _____, of (city, county, state) _____, whose telephone number is _____, as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician. That, in the absence of _____, I hereby appoint any or all of the following individuals to act as my agent with all of the powers heretofore described: _____.

Powers and Rights of Health Care Agent:

My agent shall have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be;

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program; and,

4. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

Inspection and Disclosure of Information Relating to My Physical or Mental Health:
Access to Health Information – Federal Privacy Law (HIPAA) Authorization. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

4. Consent to the disclosure of this information.

Additional Powers: Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice";

2. Any necessary waiver or release from liability required by a hospital or physician.

Duration: This power of attorney exists indefinitely from its date of execution, unless I establish herein a shorter time or revoke the power of attorney.

Effectiveness of this Part
(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

✎_____

>>OR<<

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

✎_____

PART II: TREATMENT PREFERENCES ("LIVING WILL")

On this _____ day of _____, 2026, I, _____, being of sound mind, willfully and voluntarily direct that my dying shall not be artificially prolonged under the circumstances set forth in this declaration.

Preference in Case of Terminal Condition
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If, at any time, at least two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

Preference in Case of Persistent Vegetative State
(If you want to state what your preference is, initial **<u>one</u>** only. If you do not want to state a preference here, cross through the whole section.)

If, at any time, at least two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

Preference in Case of End-Stage Condition
(If you want to state what your preference is, initial **<u>one</u>** only. If you do not want to state a preference here, cross through the whole section.)

If, at any time, at least two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

Effect of Stated Preferences
(Read both of these statements carefully. Then, initial **<u>one</u>** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

   ✎_____

   >>OR <<

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

   ✎_____

I am legally competent to make this declaration, and I understand its full import

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____
Name

The declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive. I furthermore state, declare, and aver that I shall not benefit, monetarily or otherwise, directly, by will, or by intestacy upon the death or incapacity of the declarant.

_____ whose address and phone number is:
Witness 1

_____ whose address and phone number is:
Witness 2

STATE OF _____, COUNTY OF _____, TO WIT:

I HEREBY CERTIFY that on this _____ day of _____, 2026, before me, the subscriber, a Notary Public in the State and County aforesaid, personally appeared _____, and acknowledged the aforegoing Power of Attorney or instrument in writing to be her act and deed.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my notarial seal the day and year first written above.

_____
Notary Public

My Commission Expires: _____

DEFINITIONS

Beneficiary – the person or persons whom you want to receive your property;

Alternate beneficiary – the person or persons who would receive property if your original beneficiary predeceases you;

Personal representative – the person who administers your estate upon your passing;

Testator/testatrix – the person making the last will and testament (you).