

## PURPOSE OF AN ADVANCE FINANCIAL DIRECTIVE FOR COGNITIVE DECLINE

An Advance Financial Directive for Cognitive Decline is a waiver of your expectation of confidentiality under your Financial Open Retainer Agreement. This waiver is executed under limited circumstances that you, the client, direct in advance.

The purpose of an Advance Financial Directive for Cognitive Decline is for you to decide in advance the action(s) you would like your financial advisor to take on your behalf if your financial advisor notices a decline in your financial decision-making capacity.

Together we have developed a unique understanding of your personal approach to making financial decisions and your skills in managing your money. As people age, some display a decline in their mental abilities. Difficulties handling money and making sound financial decisions are often the first signs of decline, even as the individual continues to do well in most other areas. Signs of a decline in financial functioning may occur years before other problems become evident. Therefore, we may be among the first people to notice a change in your behavior that could represent the beginning of a decline in your cognitive abilities.

Often a financial advisor may observe and point out behavioral changes, but financial advisors do not have the training to explain or interpret these observations. Because of our long-term relationship, we want to be able to appropriately express concerns if we see changes in your financial behavior.

The purpose of this Advance Financial Directive for Cognitive Decline is to empower you to instruct us, your financial advisor, on how to proceed if we do notice changes. An Advance Financial Directive for Cognitive Decline gives your permission to contact an individual designated by you to discuss concerns that we may have during the term of our engagement. Your Advance Financial Directive for Cognitive Decline can be used to give us permission to contact family, friends, lawyers, accountants, or medical professionals on your behalf, so that you may be evaluated properly to explain any apparent changes.

As a part of your long-term planning, we recommend that you complete an Advance Financial Directive for Cognitive Decline and review it annually to make sure that it continues to reflect your wishes.

## ADVANCE FINANCIAL DIRECTIVE FOR COGNITIVE DECLINE TO FINANCIAL ADVISOR

(To the client: This form may be used to create a plan of action to guide your financial advisor should you ever exhibit an apparent change in your capacity to manage financial decisions—an eventuality we hope will never occur. This document allows you to dictate your preferences in the event such a situation should arise.)

In the event that, during the normal course of our meetings and interactions, a professional financial advisor of Shore Financial Planning, LLC, should observe several of the triggers listed below, then I, the undersigned, authorize Shore Financial Planning, LLC, through any of its professional financial advisors to follow the instructions on the next page.

### **COMMON FINANCIAL “BEHAVIORAL TRIGGERS”**

- Missed office appointments and/or showing up without an appointment
- Difficulty following instructions
- Increased random calls to the office
- Repetitive speech and/or questions
- Unexplained increase or decrease in spending.
- Confusion about investments
- Unusual investment plan or idea
- Trouble handling paperwork
- Unexplained new credit cards or loans
- Difficulty recalling past decisions or actions
- Unusual or first-time wire transfers, especially to other countries
- Unexplained gifts to casual acquaintances
- Concerns about others stealing money or valuable property
- Appearance of insufficient funds, despite having available financial resources
- Significant changes in goals

INSTRUCTIONS TO MY FINANCIAL ADVISOR

Please choose and initial as many items as seem appropriate:

\_\_\_\_\_ I decline to authorize my financial advisor to raise the issue with me or contact anyone about this issue. I recognize that you may find it necessary to unilaterally terminate our contractual financial planning/investment management relationship immediately, without advance notice.

\_\_\_\_\_ I would like to have the apparent changes raised privately with me first.

\_\_\_\_\_ If, after such a discussion, the concerns are not resolved, I give permission to my financial advisor to contact one or more of the people listed below and discuss the issue with him/her/them.

\_\_\_\_\_ If, after such a discussion, the concerns are not resolved, and if I have not given permission to you to contact one or more of the people listed below, I recognize that my financial advisor may find it necessary to unilaterally terminate our contractual financial planning/investment management relationship immediately, without advance notice.

\_\_\_\_\_ I give permission to my financial advisor to contact one or more of the people listed below and discuss the issue with him/her/them, without necessarily raising the subject with me first, if my financial advisor deems it appropriate.

\_\_\_\_\_ I would want one of the people listed below to arrange for an evaluation by an appropriate specialist (eldercare professional, etc.) at my expense. (To the client: Indicate whom you would be willing to have make such arrangements.)



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### DESIGNATED INDIVIDUALS WHO MAY BE CONTACTED

I have listed below those people I would want my financial advisor to contact under the circumstances referred to above. Designated individuals may include family members, physicians, religious advisors, attorneys, accountants, friends, others.

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>CONTACT INFORMATION</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Specific Instructions:

_____
_____
_____
_____

### OTHER RELATED DOCUMENTS

I have completed and provided a copy of the following documents to my financial advisor:

Durable Financial Power of Attorney                      Yes \_\_\_\_\_                      No \_\_\_\_\_

Power of Attorney for Health Care                      Yes \_\_\_\_\_                      No \_\_\_\_\_

HIPAA Authorization                      Yes \_\_\_\_\_                      No \_\_\_\_\_



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I understand the following:

My providing my financial advisor with this document and our accepting it is not to be construed as a commitment on my financial advisor's part to act as my agent outside of the normal financial planning/investment management role my financial advisor has undertaken and agreed to prior to my completing and presenting my financial advisor with this form.

This is not to be considered a part of the services I have contracted with my financial advisor to perform and I agree, by signing it, that I and my heirs, assigns, and/or other successors in interest will hold my financial advisor harmless if my financial advisor either acts, or fail to act, on these stated preferences based on my financial advisor's own best judgment.

I acknowledge that I have not been influenced by my financial advisor and I understand that my financial advisor is in no way responsible for the competency of the person(s) I have appointed to be contacted under this directive.

I have been advised that I should seek independent advice about whom to appoint when making this choice.

I understand that this directive does not replace the need for other more comprehensive estate planning documents.

I understand that I may revoke this directive by a notification in writing signed and dated by me. This revocation will become effective upon delivery to my financial advisor.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Shore Financial Planning, LLC**

**By** \_\_\_\_\_

**Date:** \_\_\_\_\_



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WITNESSES AND/OR NOTARIZATION

IN WITNESS WHEREOF, I have signed and delivered this Advance Financial Directive for Cognitive Decline this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

WITNESSES:

\_\_\_\_\_  
Residing at \_\_\_\_\_

\_\_\_\_\_  
Residing at \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me, a Notary Public, personally appeared \_\_\_\_\_ who executed the above Advance Financial Directive for Cognitive Decline, and acknowledged the same to be his/her free act and deed.

\_\_\_\_\_  
Notary Public

My Commission Expires:

SEAL