Money Practice

Creating A What If Box

WHAT IF:

My partner died, would I be OK financially?

I became disabled or incapacitated? What would I need to have put together for a friend to be able to help me?

An emergency happened in my life...are my affairs in order?

I held the belief that getting all my vital papers in order, was one of the greatest acts of self love that I could do for myself?

The “What If” Box

I coach many clients in mid-life. I started noticing the women I coach, were often lacking confidence in their ability and knowledge about what documents and information needed to be at their finger tips, in order to keep rowing their financial life boat...in case their partner died or became incapacitated.

I also noticed my single female clients did not have essential vital documents at their finger tips either. Thus, the “**What IF BOX**,” was born.

A Woman’s “**What IF BOX**,” is her security blanket. In a snap of a second, she can touch her vital documents, as the need arises. These documents will help her to access financial agreements, navigate emergency situations, connections to contacts to call to ask for help, and the necessary paperwork to make her life flow with as much ease as possible.

aka: VITAL RECORDS

Keep original documents in fire proof safe at home or safe deposit box at bank. If originals at bank, keep copies in home files!

“HAVING YOUR FINANCIAL HOUSE IN ORDER IS AN ACT OF SELF LOVE”
(and decreases cortisol in your body and brain)

Contents in the "What IF" Box

- Vital Identification: Social Security Numbers of Self + Partner / Marriage Certificate / Divorce Certificate / Birthdates of Self + Partner
- Online usernames, passwords + security questions, to all important accounts (banking, credit reports, social media, websites owned)
- Insurances: home owners / umbrella / auto / health / life. Name of person and phone number to contact for each insurance policy
- Living Trust, Will, Durable Power of Attorney for Healthcare, Durable Power of Attorney for Finance
- Make sure all utilities are in BOTH NAMES, otherwise will be hard to stop a service if in the name of the deceased person only
- Names of all asset accounts, who cares for each account with name of contact + phone number + beneficiaries
- HIPPA release form filled out completely for self + partner + possibly notarized
- Your funeral plans. How you want the remains of your body to be cared for. What celebration you desire to be carried out. Be specific.

What else do you desire to be in your "What IF" Box?

Legacy

Legacy Letters, also known as an "Ethical Will," are hand written, or computer processed, letters of appreciation to people who have made a difference in your life. These letters are from the heart. They share your values, not just your valuables, with those you love.

These letters may share your thanks and appreciation to specific people who have influenced your life. These letters may share your values, that you ask your loved ones to carry forward. These letters may share the lessons + wisdom you have experienced in your life, that you want to pass on.

Writing a legacy letter is a sacred holy act. The receiver of your letter can hold it in their hands and read it over and over again...and have your energetic imprint to cherish and hold through that one letter written to them...forever.

Resources to help you write a legacy letter: *The Forever Letter, Writing What We Believe for Those We Love*, by Elana Zaiman

Dear ones,
I fully expect that I will live for a very long time, to see you well into adulthood and to share your future with you. There is much to look forward to, and I am planning on being part of all the adventures and all the challenges and all the joys. But if for some reason I am not, the most important thing you need to know is how much my love for you created the person that you will remember as me. I made you, but you made me, too. I am so proud of you and so grateful to you. I have had a wonderful life and I don't want you to mourn me – maybe a little, but not too long! Carry me forward with an optimistic outlook and tenacious devotion to what you know is best. Carry me forward and I will be with you always.
Love,
Mom

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date