

Funeral Consumers Alliance of San Mateo/Santa Clara Counties **PLANNING FORM** # _____

P.O. Box 60448, Palo Alto, CA 94306 • (650) 321-2109 phone & fax • Toll-free 888-775-5553 Date _____

INSTRUCTIONS

VERY IMPORTANT: This form is necessary to complete your membership—you must choose a plan and mortuary, and provide information for the death certificate. See the Mortuary Price List and Description of the 5 Funeral Plans. Mail a copy to FCA and keep copies for yourself and next of kin. Use another piece of paper for further wishes.

Member's Mr. Miss Mrs.

Full Name Dr. Rev. Ms. _____
First Middle Last Phone

Address: _____
Street City Zip E-mail

Calif. County: _____ The year I came to this county: _____ The year I came to California: _____

VITAL STATISTICS INFORMATION

(This information will be necessary for the mortuary to complete a death certificate.)

Birthplace (State or Foreign Country) _____ Date of birth: _____ Citizenship: _____
Social Security Number: _____ Years of education: _____ Sex: M F
Principal life occupation: _____ Longest Employer: _____ Kind of business: _____
Years in occupation: _____ U.S. Veteran? Yes No Serial No. _____ Branch of service: _____
No. of years in service: _____ Date of enlistment: _____ Date of discharge: _____
Father's full name: _____ Father's birthplace: _____
Mother's full maiden name: _____ Mother's birthplace: _____
Race: _____ Marital status: (Divorced/widowed/married/never married/life partner) _____
Surviving spouse or partner: _____
first middle last (if wife, maiden name)

ARRANGEMENT INFORMATION

Mortuary chosen: _____
Name Phone
Address City Zip

Choose one (see Instruction Sheet for what is included):

- Type C1:** Direct Cremation.
- Type C2:** Direct Cremation, plus scattering ashes at sea.
- Type B1:** Direct Burial: Cemetery costs additional.
- Type B2:** Type B1 plus Graveside Service.
- Type B3:** Body Burial and Funeral Ceremony: Cemetery costs additional.

Note: Hoping that I may help others, I have also made separate arrangements for donating my body or parts on the condition that they are needed and are medically acceptable upon my death. I attach details on a separate sheet of paper.

Signed

FINAL DISPOSITION: Ground burial ___ Cemetery Niche ___ Scattering at Sea ___ Return to next of kin ___ Leave decision up to next of kin ___ If Cemetery is chosen, please specify name: _____ City _____

STATEMENT OF DESIRE TO BE CREMATED

I request and authorize that my remains be cremated. Yes No

(Signature) Date

Witnessed by a relative or friend. Also can be authorized by person with Durable Power of Attorney for Health Care.

(Signature) Relationship Date Telephone

NEXT OF KIN OR PERSONS DESIGNATED TO AUTHORIZE DISPOSITION

Name: _____ Telephone: (_____) _____ Relationship: _____
Address: _____
Street City State Zip
Name: _____ Telephone: (_____) _____ Relationship: _____
Address: _____
Street City State Zip