LEGALVAULT®

CLIENT ENROLLMENT FORM

To get started, complete the form below and return it to your sponsoring law firm.

First Name	Last Name	Gender	Email Address

Mailing Address	City, State & Zip Code

Date of Birth	Home Telephone	Alternative Telephone

EMERGENCY CONTACTS

First Name	Last Name	Relationship	Home Telephone	Mobile Telephone	Work Telephone

PHYSICIAN INFORMATION

Physician Name	Practice Name	Office Telephone	Office Fax

Physician's Office Address	City, State & Zip Code

MEDICAL CONDITIONS

☐ Alzheimer's ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cancer survivor ☐ Diabetes ☐ Hearing loss ☐ High blood pressure

☐ Heart disease ☐ Low vision ☐ Lung disease ☐ Stroke history ☐ ____________ ☐ ____________ ☐ ____________

ALLERGY INFORMATION

☐ Penicillin ☐ Bee Stings ☐ Shellfish ☐ Sulfa ☐ Latex ☐ Nuts ☐ ________ ☐ ________ ☐ ________ ☐ ________

CARD NOTE *(Ex: "Pets at home", "Diabetic", "Has Pacemaker"; limited to 30 characters, use one letter per space)*

POST MORTEM ACCESS

First Name	Last Name	Relationship

Client Certification: I request that LegalVault electronically store my legal healthcare documents and other healthcare information and to make such information available to my healthcare providers. I am aware that my legal healthcare documents and healthcare information are going to be made available to anyone who has access to my security access code and I will not hold LegalVault or my sponsoring law firm responsible for any unauthorized access. I certify that the information supplied to LegalVault by me on this form is correct and that the stored documents are my current legal healthcare documents and information. I agree to immediately notify LegalVault in writing or by logging on to their secure website in the event I revoke or modify any of my legal healthcare documents or healthcare information or to convey my desire to terminate this service. I will indemnify and hold harmless LegalVault and my sponsoring law firm for any damages resulting from their reliance on these certifications or on any inaccurate information I supply or for any unauthorized use of this service. By providing a fax number for my physician, I am granting LegalVault and my sponsoring law firm permission to provide an enrollment notification fax to my physician. I understand that I am enrolling in this service for convenience of access and not relying on LegalVault or my sponsoring law firm for the exclusive storage of my documents and information.

Signature: ____ Date: ______________________