

**ADVANCE ORDER TO DISCLOSE FINANCIAL RECORDS FOR
ELDER CUSTOMERS (60 YEARS OF AGE OR OVER)
OF _____ BRANCHES IN SHEBOYGAN COUNTY**

1. All of my references to “I” or “me” or “mine” in this document refer to:

Name: _____
Address: _____
City, Zip Code: _____

2. All of my references to “you” or “your” in this document refer to:

Financial Institution: _____
Address: _____
City, Zip Code: _____

3. This order covers the following Account(s) and all Accounts that I may subsequently open in my name alone or with others or that may be opened in my name by a trustee of my revocable living trust.

4. I give you the following direction:

- A. If you are concerned about unusual activity in my account(s) which is not consistent with the usual pattern of activity in my accounts, I request that you ask me about these transactions first, if feasible.

- B. If my response to your concerns does not assure you that my financial well being is secure, or if you are unable to reach me, I direct you to notify the following individuals and/or agencies, in the following order, of your concerns and provide such individuals and/or agencies with information about my account(s).

Advance Order to Disclose Financial Institutions Records

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INDIVIDUALS TO CALL:

TELEPHONE NUMBERS:

(Suggestions of people or agencies to contact can include trusted family members or friends, your attorney, Sheboygan County Health and Human Services, and the police or county sheriff.)

- | | | |
|----|---|--|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | Sheboygan County Health and Human Services
Elder Abuse Office:
Ombudsman Program: | 920-459-3095
800-815-0015 |

If you notify any of the above named people or agencies, I request that you also notify me in writing by certified mail, with return signature requested.

I waive my rights to confidentiality and privacy to the extent that sharing information is reasonably necessary for my financial institution or agent to act under this order. I agree that my financial institution or agent will not be liable for your actions or inactions pursuant to this order. I, for myself, and my heirs, executors, legal representatives, and Assigns hereby agree to hold my financial institution or agent harmless from any damages I incur by reason of your having relied on this order in good faith.

I recognize that my financial institution or agent is not in any way an insurer of the activity in my account(s); that my financial institution or agent may not always be in a position to notify unusual activity; that a willingness to accept this order is not a guarantee that my financial institution or agent will be able to notify the individuals or agencies listed above or that my financial institution or agent will do so. The sole purpose of the authorization is to direct my financial institution or agent in good faith to report perceived suspected abuses, in order to try to prevent their continuance, despite general privacy protections due me.

This order may be revoked at any time that the financial institution receives my signed revocation statement. I have read and understand this Advance Order to Disclose and I voluntarily choose to sign it. A photocopy of this document has the same force and effect as the original.

Signature

Date

Witness Name

Date