

ALCOR LIFE EXTENSION FOUNDATION

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 Membership Information (877) GO-ALCOR • info@alcor.org • http://www.alcor.org



Submit with this application:

- Application fee of \$200. There is an additional one-time fee of \$100 which covers all additional family members who apply. Extended application fees apply after three months.
- A recent photo, if available.

MEMBERSHIP APPLICATION

I. PERSONAL INFORMATION

The shaded questions in Section I are required for completion of Vital Statistics forms.

| | | | | | | | | | | |
|--|--|----------------------------------|---|------------------------|-------------------------------|---|--|---|--|--------------------|
| 1. Full Legal Name (no initials) | | | | 2. Date of Birth | | 3. Place of Birth (City, County, State/Province, Country) | | | | |
| 4. Mailing Address | | | 5. Street Address | | | 6. City | | 7. State/Province/Country | | 8. Zip/Postal Code |
| 9. Home Phone | | 10. Work Phone | | 11. Cell Phone | | 12. Electronic Mail | | | | |
| 13. Birth Name (if different from above) | | 14. Race or Ethnicity | 15. Spanish or Hispanic? | 16. Citizen of Country | | 17. Social Security Number | | 18. U.S. Military Service, branch? from (year) to (year) | | |
| 19. Marital Status | 20. Occupation (include number of years) | | 21. If unemployed, what was occupation? | | 22. Employer name and address | | | | | |
| 23. Father's Name | | | 24. Father's birthplace | | 25. Mother's maiden name | | | 26. Mother's birthplace | | |
| 27. Total years of formal education | | 28. Are you a full-time student? | | 29. Wife's maiden name | | | | | | |
| 30. What prompted you to apply for membership? | | | | | | | | | | |
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| | | | | | | | | | | |

List your spouse, children, mother, father and siblings. If deceased, write "deceased" and the date of death after the person's name. Please also provide the date of birth for the deceased individual. It is beneficial for Alcor to have the names of your next of kin and a feeling for their attitudes about cryonics. Do not delay submission of your application in an attempt to provide all the requested data. Relative's Affidavits (not applicable if the relative is a minor) are entirely optional and are sent directly to you for distribution to your relatives at your discretion. We will not contact your relatives unless requested. If the applicant is under 18, all legal guardians must be shown.

II. NEXT OF KIN

| | | | | | | | | | |
|--|--|---|--|------------------|--|---------------------------|--|--------------------|--|
| 1. Name | | 2. Relation | | 3. Date of Birth | | 4. Phones (home and work) | | | |
| 5. Street Address | | | | 6. City | | 7. State/Province/Country | | 8. Zip/Postal Code | |
| 9. Is he/she willing to sign a Relative's Affidavit? | | 10. Any comments about his/her attitude toward cryonics or possible cooperation with Alcor? | | | | | | | |
| 1. Name | | 2. Relation | | 3. Date of Birth | | 4. Phones (home and work) | | | |
| 5. Street Address | | | | 6. City | | 7. State/Province/Country | | 8. Zip/Postal Code | |
| 9. Is he/she willing to sign a Relative's Affidavit? | | 10. Any comments about his/her attitude toward cryonics or possible cooperation with Alcor? | | | | | | | |
| 1. Name | | 2. Relation | | 3. Date of Birth | | 4. Phones (home and work) | | | |
| 5. Street Address | | | | 6. City | | 7. State/Province/Country | | 8. Zip/Postal Code | |
| 9. Is he/she willing to sign a Relative's Affidavit? | | 10. Any comments about his/her attitude toward cryonics or possible cooperation with Alcor? | | | | | | | |
| 1. Name | | 2. Relation | | 3. Date of Birth | | 4. Phones (home and work) | | | |
| 5. Street Address | | | | 6. City | | 7. State/Province/Country | | 8. Zip/Postal Code | |
| 9. Is he/she willing to sign a Relative's Affidavit? | | 10. Any comments about his/her attitude toward cryonics or possible cooperation with Alcor? | | | | | | | |

Do you need help finding non-family member witnesses?

Yes No

III. HEALTH AND EMERGENCY INFORMATION

A. Do you have a personal physician or Health Maintenance Organization (HMO)? (If not, write "None" and skip to Part B.)

| | | | | |
|---|----------|------------------------|------------------------|-----------------|
| Name | Hospital | Phones (home and work) | | |
| Street Address | | City | State/Province/Country | Zip/Postal Code |
| To what extent will this person or organization cooperate with Alcor? | | | | |

B. Medical Information: List all medical problems, including diseases and disabilities, heart or circulatory problems, blood pressure, arthritis, and any clinical psychiatric problems. Please be honest, specific, and detailed. Alcor does not disqualify people on the basis of health. We need this information to enable and enhance your cryopreservation not to deny it. If necessary, please attach a separate sheet labeled "Section III. Health and Emergency Information, Continued."

| |
|--|
| Sex (circle): M F Height: Weight: Blood Type: |
| Health Problems: _____ |
| History of Infectious Diseases (TB, Hepatitis, Aids, etc.): _____ |
| Allergies (including to drugs): _____ |
| Medications currently or recently taken: _____ |
| Identifying scars or notable characteristics: _____ |
| Do you have any artificial appliances, implants or prosthetics? (Examples: contact lenses, glasses, dentures, hearing aid, pacemaker, heart valve, artificial joint or limb, silicone implants, cranial plate, etc. Failure to note this could cause delays or actual damage during transport or perfusion.) _____ |
| Past medical history (including major illnesses, childhood illnesses, injuries, operations, hospitalizations, etc. Use extra sheets if necessary.) _____ |
| Are there any hereditary illnesses or tendencies in your family? (Examples: diabetes, heart disease, arthritis or other auto-immune conditions, a specific type of cancer, Alzheimer's Disease, Huntington's Disease, etc.) _____ |

IV. CONTACTS

C. Are there any persons or organizations we should contact in case of your death or other emergency? Put your "significant other" here if you have a relationship with someone who is not your legal spouse or list close, cooperative friends and nearby cryonicists who might be helpful in an emergency. You may find it useful to provide Alcor with names for your Attorney, Health Care Representative (Medical Surrogate), the Executor of your estate, or other personal representatives. If necessary, please attach a separate sheet labeled "Section IV. Contacts, Continued."

| | | | | |
|----------------|------------------------|-------------------------|------------------------|-----------------|
| Name | Phones (home and work) | Purpose for contacting: | | |
| Street Address | | City | State/Province/Country | Zip/Postal Code |
| Name | Phones (home and work) | Purpose for contacting: | | |
| Street Address | | City | State/Province/Country | Zip/Postal Code |

V. METHOD OF PROVIDING CRYOPRESERVATION FUNDS

Type of cryopreservation funding (check one): Life insurance Trust Prepayment Annuity Other means

LIFE INSURANCE. Most Alcor Members use life insurance because it requires no sizeable, up front assets. ***If you use life insurance, you must make Alcor Life Extension Foundation the owner of the policy as well as the beneficiary.*** The purpose of this is to make sure that Alcor receives notification if there is any problem with your policy. Also, making Alcor the owner may prevent the policy being drained for hospital bills for a terminal illness (under government regulations). ***If you have chosen life insurance, you must also send Alcor a complete copy of the policy and any related documents (such as schedule of beneficiaries, the application, etc.)***

| | | | | |
|---------------------------|---------------|---------------|------------------------|-----------------|
| Company Name | Policy Number | Policy Type | Date Issued | Face Amount |
| Street Address of Company | | City | State/Province/Country | Zip/Postal Code |
| Your Agent's Name | Telephone(s) | Other details | | |

TRUST FUNDS. If you wish to fund your cryopreservation using a trust, consider using Alcor's pre-approved template trust. Private trusts are reviewed by an attorney, at the expense of the applicant, and approval by Alcor's Board of Directors will be required. Contact Alcor's Membership Coordinator for more information.

VI. WILLS

Alcor does not require that you have a will in order to become a Member. However, if you *already* have a will which has provisions contrary to the goals of cryonics (for example, if your will states that you do not want cryopreservation, or if it requires cremation, burial, or other disposition of your human remains after your legal death), *these provisions may invalidate your Cryopreservation Agreement*. If you have a will, it is your responsibility to change it through a new codicil or a new will; otherwise your cryopreservation arrangements may not be valid.

Do you have a will? Yes No If "Yes," does it include any provisions contrary to cryonics? Yes No

VII. MEMBERSHIP COSTS

Members can pay dues for the duration of their membership or become a Life Member on a 20-year payment plan. A 50% discount on dues applies to additional family members and full-time students, and a 75% discount applies to those under 18.

Standard Membership Dues/CMS (check one): \$598 Annually \$299 Semi-annually \$150 Quarterly \$51 Monthly
Life Membership (check one): \$1100 Annually \$285 Quarterly \$100 Monthly \$20,000 Lump Sum

This includes a payment of \$120 per year for Comprehensive Member Standby (CMS) for members in the US and Canada. (Waived for members under 18 and full-time students under 25.)

Check here if you have a family member living within the same household who has already joined Alcor.

VIII. EMERGENCY ALERT SYSTEM

An essential aspect of Alcor's rapid response capability is the Emergency Alert bracelet/necktag, which notifies medical personnel and Alcor in the event you are disabled and unable to speak for yourself in a medical emergency. Members receive one necktag, one bracelet, and two wallet cards. To receive an additional set of Emergency Alert tags (bracelet and necktag), please submit an additional \$15.00 with your application.

IX. DECISIONS CONCERNING YOUR CRYOPRESERVATION

These are the specific legal decisions which you must make as part of your **Cryopreservation Agreement**.

METHOD OF CRYOPRESERVATION. Alcor offers two options for cryopreservation: 1) Neurocryopreservation, wherein the Member's brain or entire head is cryopreserved using current vitrification protocols, 2) Whole Body Cryopreservation, wherein the Member's brain is vitrified and the body is partially vitrified.

Whole Body Cryopreservation Neurocryopreservation

CREMATION AND DISPOSITION OF NON-CRYOPRESERVED PORTION OF HUMAN REMAINS. The non-cryopreserved portion of the Member's remains will be cremated. All Members, whether selecting Whole Body Cryopreservation or Neurocryopreservation, must make a selection below:

I wish Alcor to retain or dispose of the cremated portion of my remains as it chooses, consistent with legal requirements (*default decision*).

I wish the person named below to receive possession of the cremated non-cryopreserved portion of my human remains.

| Name | Street Address | City | State/Province/Country | Zip/Postal Code |
|------|----------------|------|------------------------|-----------------|
| | | | | |

(If this person cannot be located and your next-of-kin refuse to accept your remains, Alcor will scatter them at sea or retain them as it chooses.)

I wish to make other arrangements for disposal of the cremated non-cryopreserved portion of my remains. (Please attach an explanation.)

CRITERIA FOR CRYOPRESERVATION. You might die under circumstances which would cause considerable damage to your remains. If you wish to specify conditions under which your remains should *not* be cryopreserved, contact Alcor's Membership Coordinator.

I wish Alcor to place into cryopreservation any biological remains that they may be able to recover, regardless of the severity of the damage from such causes as fire, decomposition, autopsy, embalming, etc. Similarly, members who have chosen Neurocryopreservation will have any remains of their brain placed into cryopreservation regardless of damage (*default decision*).

I wish Alcor to place into cryopreservation any remains of my brain that they may be able to recover, regardless of the severity of damage. If none of my brain tissue is recoverable, do not proceed with my cryopreservation.

If no brain tissue is recoverable, I wish Alcor to place into cryopreservation samples of as many organs as are available.

CRYOPRESERVATION NOT POSSIBLE. You might die under circumstances that make it impossible to cryopreserve you. These circumstances might include legal or medical barriers or the inability of Alcor to locate or recover your remains. In that event, Alcor would take from your Cryopreservation Fund an amount equal to expenses incurred in an attempted location or recovery. Under these circumstances, or if for any other reason, cryopreservation of your human remains is not possible, Alcor will pay over the remainder of the Cryopreservation Fund to your **estate** (*default decision*). If you wish Alcor to allocate the remainder of the Cryopreservation Fund differently, please initial and complete the following (the "%" means the percent of the remainder of the Cryopreservation Fund).

To the: General Operating Fund _____% Patient Care Trust _____% Alcor Research Fund _____% Reserve Fund _____%

To the following person(s) _____ %
 _____ %

Other (specify) _____ %

TOTAL SHOULD EQUAL 100%

CRYOPRESERVATION ENDANGERMENT CONTACT(S). In case of large financial expenditures being required to fight legal attacks on your cryopreservation, general financial or legal set-backs which threaten the cryopreservations of all Members in cryopreservation, or the dissolution of Alcor (see **Cryopreservation Agreement, Section IV, CONTINGENCIES**), it may be necessary for Alcor to convert the cryopreservation from Whole Body Cryopreservation to Neurocryopreservation or to terminate the cryopreservation. As a safety measure, you may designate certain individual(s), organization(s), and/or institution(s) as **Cryopreservation Endangerment Contact(s)** (see **Cryopreservation Agreement, Section IV, CONTINGENCIES, Article 3**). Such a designation does not create a contract with the **Cryopreservation Endangerment Contact(s)** on the part of either the Member or Alcor. Such Contact(s) might include individuals or organizations you have left funds with for the specific purpose of providing a back-up fund for your cryopreservation.

| | | | |
|----------------|------|------------------------|-----------------|
| Name | | Phones (home and work) | |
| Street Address | City | State/Province/Country | Zip/Postal Code |

PUBLIC DISCLOSURE. To promote a better public understanding and acceptance of cryonics, it is useful if Alcor can release the names of persons who are members or who have been placed into cryopreservation. However, we realize that many people wish to retain their privacy and not have their choice of cryopreservation revealed. Please select one or more of the following:

I give Alcor permission to freely release my information at its discretion.

I give Alcor permission to release my name and number only to other Alcor Members.

I give Alcor permission to release my name and number only to other Alcor Members prior to my cryopreservation. After my cryopreservation, Alcor is authorized to freely release my information at its discretion, including information Alcor deems appropriate about my cryopreservation.

I instruct Alcor to maintain reasonable confidentiality pursuant to the provisions of Attachment I.

ALLOCATION OF CRYOPRESERVATION FUNDING OVER THE REQUIRED MINIMUM AMOUNT. If you have provided Cryopreservation Funding over the minimum required amount, and if all cryopreservation expenses have not been met by the minimum required amount, Alcor will apply funding above the minimum to payment of those expenses. If funds above the minimum required amount remain after payment of all cryopreservation expenses, Alcor will place 50% of this money into the Patient Care Fund, and 50% into the General Operating Fund (*default decision*). If you wish Alcor to allocate cryopreservation funds over the minimum differently, please initial and complete the following (the “%” means the percent of the amount over the required minimums). **Total should equal 100%.**

| | |
|--|---|
| <input type="checkbox"/> To the Patient Care Trust _____% | <input type="checkbox"/> To the General Operating Fund _____% |
| <input type="checkbox"/> To the Alcor Research Fund _____% | <input type="checkbox"/> To the Endowment Fund _____% |
| <input type="checkbox"/> Other(specify) _____ % | |

X. APPLICATION FEES – COMPLETION OF THIS SECTION IS REQUIRED.

In the event you have not satisfied all membership requirements and joined as a member of Alcor within three months of your application date, your below credit card will be charged \$100. Additionally, this \$100 charge will be applied each subsequent three-month period you remain an applicant.

I authorize Alcor Life Extension Foundation to charge the below credit card \$100 if I have not joined as a member of Alcor within three months of my application date and each subsequent three-month period that I do not join as a member:

I also authorize Alcor to charge this card for the application fee. (If you do not mark this box, please send a check for your application fee.)

1st Family Member – **\$200**
 2nd Family Member – **\$100**
 Additional Family Member – **Waived**

I also authorize Alcor to automatically charge my credit card for my membership fees, once I am approved as a member. (See Section VII: Membership Costs.)

VISA MC AMEX DISCOVER

 Credit Card Number _____ Exp. Date

 Name (as it appears on credit card – *please print*)

I/We understand and agree that any controversy or claim arising out of or relating to this Application shall be settled in Phoenix, Arizona by binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association and judgment upon the award entered by the arbitrator(s) may be entered and enforced by any court having jurisdiction thereof. Additionally, I/we intend that the arbitrator(s) have power to issue any provisional relief appropriate to the circumstances, including but not limited to: temporary restraining orders, injunctions, and attachments. I/we intend that this agreement to arbitrate be irrevocable and agree that the Alcor Life Extension Foundation is entitled to injunctive relief to quash litigation should I/we breach this agreement. If Member is unable to sign or is an unemancipated minor or otherwise incompetent, appropriate next of kin and/or Legal Power of Attorney must sign below.

Signature(s): _____ Date: _____ Rev. 12/2009