NEW YORK

HEALTH CARE PROXY

OF

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NEW YORK HEALTH CARE PROXY

I, NANCY MILLER NYGREEN, appoint my spouse, GLEN THEODORE NYGREEN, JR., as my health care agent to make all health care decisions for me, if I become unable to make them for myself.

I direct my health care agent to make decisions concerning my health care in accordance with the following statement of my wishes:

Medication and treatment should not be, or should not continue to be, administered to me for therapeutic purposes or to prolong my life if:

(a) I have an incurable or irreversible condition that is likely to cause my death within a relatively short time, or

(b) I am in a state of permanent unconsciousness or a persistent vegetative state, or

(c) it is likely that I will never again live without the aid of mechanical respiration or without the delivery of nourishment or liquids by artificial means.

Whether I am in any of the conditions described above should be determined by a physician (who need not be my physician) selected by my health care agent.

Specifically, I do not want mechanical respiration, cardiopulmonary resuscitation or the delivery of nourishment or liquids by artificial means to be, or to continue to be, administered to me under any circumstances if I am in any of the conditions described above.

I want to be as free from pain or discomfort as is possible. I understand that some forms of medication and treatment, administered for relief from pain or comfort, may have an incidental therapeutic effect or may tend to prolong life. I will accept medication and treatment (other than mechanical respiration, cardiopulmonary resuscitation or the delivery of nourishment or liquids by artificial means) administered for relief from pain or discomfort, even if its effect is incidentally therapeutic.

If I am not in any of the conditions described above, decisions concerning my health care should be made in accordance with the instructions I have otherwise given my health care agent or, if I have not given instructions concerning a particular

aspect of my health care, in accordance with his judgment of what will be in my best interest in that case.

I direct that a written order not to resuscitate me be entered in my medical record upon my admission to any hospital if consistent with my wishes as expressed in this proxy or as otherwise known by my health care agent. I specifically delegate to my health care agent the authority as my surrogate to consent to the issuance of such order.

I confirm that I will be and remain liable to pay for health care services provided to me at the direction of my health care agent, and that my health care agent will have no liability to pay for any health care services contracted for on my behalf.

I agree to indemnify and hold harmless my health care agent from and against all claims, damages, costs and expenses (including reasonable attorneys' fees) with respect to any decision, act, transaction or omission made or done in good faith in his capacity as my health care agent.

I understand that this proxy will remain in effect unless I revoke it. This proxy will not be affected by my subsequent disability or incompetence, but will take effect only if I become unable to make my own health care decisions.

I expect that my family and my physicians will honor my wishes and will respect this proxy as the final expression of my legal right to refuse medication and treatment, including mechanical respiration, cardiopulmonary resuscitation and the delivery of nourishment or liquids by artificial means.

I understand the significance of this proxy and accept the consequences of my refusal of medication and treatment, including mechanical respiration, cardiopulmonary resuscitation and the delivery of nourishment or liquids by artificial means.

HIPAA Release Authority. I intend for my health care agent to be treated as I would [as my personal representative pursuant to 45 CFR Section 164.5021(g)(2)] be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize: any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information

Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my health care agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including, without limitation, all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my health care agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to my health care agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

Dated: 26 August, 2005

Nancy Miller Nygreen
NANCY MILLER NYGREEN

The above declarant is personally known to us and has signed the foregoing document in our presence. We affirm that she has done so of her own free will, without compulsion or duress, and that we believe her to be of sound mind, memory and understanding. We affirm further that we are not the persons appointed as health care agent hereunder.

Witness:

[signature] residing at 22 Old [illegible] Rd.
Scarsdale, NY 10583

[signature] residing at 255 HUGUENOT STREET
NEW ROCHELLE NY 10801

[signature] residing at 17 WEST COURT
DERBY, CT 06418