

Personal Insurance Policies

If you were in an accident or were suddenly hospitalized, would all of your insurance information be easily accessible to you? Would you be able to tell a family member or trusted friend exactly where to find that information? This form will help you organize your life and health insurance information.

Life Insurance Policies

• Life Insurance Policy #1 •

Insured Person: _____	Policy Owner: _____
Type of policy: _____	Policy Number: _____
Face Amount: \$ _____	Issue Date: ___/___/___
_____	Expiration/Maturity Date: ___/___/___
Beneficiaries:	
• _____	• _____
• _____	• _____
Premium Amount: \$ _____	Due Date/Frequency: ___/___/___ _____
Name and Address of Insurance Company:	Phone number: _() _____

• Life Insurance Policy #2 •

Insured Person: _____	Policy Owner: _____
Type of policy: _____	Policy Number: _____
Face Amount: \$ _____	Issue Date: ___/___/___
_____	Expiration/Maturity Date: ___/___/___
Beneficiaries:	
• _____	• _____
• _____	• _____
Premium Amount: \$ _____	Due Date/Frequency: ___/___/___ _____
Name and Address of Insurance Company:	Phone number: _() _____

Medical & Dental Insurance

• Health Insurance •

Policy or Plan number: _____	Issue date: ___/___/___
Premium due: \$ _____	Due Date/Frequency: ___/___/___ _____
If Medicare, date of enrollment: _____	Medicare Insurance #: _____
Name and Address of Insurance Company:	Phone number: _() _____

Personal Insurance Policies cont.

Medical & Dental Insurance cont.

• Supplemental Health Insurance •

Policy or Plan number: _____

Issue date: ____/____/____

Premium due: \$ _____

Due Date/Frequency: ____/____/____

Daily Benefit: _____

Waiting Period: _____

Name and Address of Insurance Company: _____

Phone number: _(____)_____

• Dental Insurance •

Policy or Plan number: _____

Issue date: ____/____/____

Premium due: \$ _____

Due Date/Frequency: ____/____/____

If Medicare, date of enrollment: _____

Medicare Insurance #: _____

Name and Address of Insurance Company: _____

Phone number: _(____)_____

Other Insurance

• Long-Term Care (Nursing Home) Insurance •

Policy or Plan number: _____

Issue date: ____/____/____

Premium due: \$ _____

Due Date/Frequency: ____/____/____

Daily Benefit: _____

Waiting Period: _____

Name and Address of Insurance Company: _____

Phone number: _(____)_____

• Disability Income Insurance •

Person covered: _____

Issue date: ____/____/____

Policy or Plan number: _____

Due Date/Frequency: ____/____/____

Premium due: \$ _____

Monthly Benefit: _____

Waiting period before benefits begin: _____

Name and Address of Insurance Company: _____

Phone number: _(____)_____