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: _____ Wating 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: _____ Wating Period: _____

Name and Address of Insurance Company:

_____ Phone number: _(___)_____

_____

_____

Disability Income Insurance

Person covered: _____

Policy or Plan number: _____ Issue date: ___/___/___

Premium due: $ _____ Due Date/Frequency: ___/___/___ _____

Monthly Benefit: _____ Waiting period before benefits begin: _____

Name and Address of Insurance Company:

_____ Phone number: _(___)_____

_____

_____