

Insurance Worksheet (Optional)

Current Insurance

<u>Category</u>	<u>Company</u>	<u>Value</u>	<u>Cost/Month</u>

- Categories:**
- Health Insurance Provider
 - Life Insurance
 - Dental Insurance
 - Homeowners/Renters Insurance
 - Auto Insurance
 - Long Term Care Insurance
 - Vision Insurance
 - Medicare Supplemental/Advantage
 - Disability Insurance
 - Business Insurance
 - Other Insurance

Total Costs/M: _____

How would you describe your health?

If you were to get news that you are going to die in a few months what would you do?

How much monthly income would you have if you became disabled today?

Do you have a will or a trust?

Who can we put down as a trusted contact person (name & phone):

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