



# POLICE AND FIREMEN'S INSURANCE ASSOCIATION

101 East 116th Street • Carmel, IN 46032 • 800-221-7342 • www.pfia1913.org

## LIFE INSURANCE POLICIES

IT IS HIGHLY RECOMMENDED THAT YOU HAVE AT LEAST FIVE TIMES YOUR ANNUAL SALARY IN LIFE INSURANCE, IN CASE OF YOUR UNTIMELY DEATH. THIS INFORMATION IS COURTESY OF CONCERNS OF POLICE SURVIVORS AND THE NATIONAL FIRE CHIEFS ASSOCIATION.

To insure easy access to actual policies, beneficiaries, etc., all policies owned should be kept together in a safe place.

Location of policies:

\_\_\_\_\_

I also own annuity contracts: Yes \_\_\_\_\_ No \_\_\_\_\_

### **DO YOU OWN LIFE INSURANCE?**

Location of contracts:

\_\_\_\_\_

My principal life insurance advisor is

\_\_\_\_\_

Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of Insurance \_\_\_\_\_

Amount \_\_\_\_\_

Other Insurance on Family Members:

Spouse \_\_\_\_\_

Children \_\_\_\_\_

\_\_\_\_\_

*"Each Other's Keeper"*



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## CONFIDENTIAL LIFE INSURANCE NEEDS ANALYSIS

Prepared for: \_\_\_\_\_ Date: \_\_\_\_\_

Prepared by: \_\_\_\_\_ Agent # \_\_\_\_\_

**TOTAL**

<b>Future Income Needs</b> Gross Annual Income x $\frac{\text{_____}}{\text{years}}$		
<b>Dominant Needs</b> Mortgage Balance		
Education Funds		
<b>Obligations</b> Final Expenses (funeral, medical, etc.)		
Credit Cards		
Installment Loans		
Misc. Obligations		
Future Emergency Needs		
<b>(A) GRAND TOTAL NEEDS</b>		
<b>Liquid Assets</b> Life Insurance		
Cash/Checking/Savings Accounts		
Stocks/Bonds/Mutual Funds		
Retirement Plans (401K, IRA)		
<b>(B) GRAND TOTAL LIQUID ASSETS</b>		

**(A) Grand Total Needs** \_\_\_\_\_

**— (B) Grand Total Liquid Assets** \_\_\_\_\_

**New Life Insurance Needed** \_\_\_\_\_

# **Your Personal/Financial Diary**

## **An Aid for Your Family**

This is the personal financial diary of \_\_\_\_\_

Social Security Number \_\_\_\_\_

This diary was last updated on \_\_\_\_\_

*We strongly suggest this diary be completed in pencil so it can be updated whenever necessary. We also suggest storing the book in a storage bag in your freezer so in case of fire in your residence, the diary will remain safe.*

## **“YOUR PERSONAL/ FINANCIAL DIARY”**

This handbook was developed in November 1995 to be used as an educational tool for Concerns of Police Survivors’ national training sessions. These training sessions were planned to help agencies address the emotional aftermath following a law enforcement officer’s death.

*Concerns of Police Survivors, Inc., gives permission for this handbook to be copied by any person, agency, or organization. COPS would request, however, a credit line be given in the reproduced document.*

This **Your Personal/Financial Diary** is a project of Concerns of Police Survivors, Inc. Printing and distribution of the document are funded through a grant from the U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, grant #95-PS-CX-0001.

Production of this handbook was made easy by modeling it after the “Critical Incident Booklet” published by the Grand Lodge Fraternal Order of Police Auxiliary. Our thanks to them for taking on the task of producing such a booklet for law enforcement families.

## INTRODUCTION

This personal financial diary was planned with the specific intention of giving law enforcement officers, who serve in a high-risk profession, the opportunity to organize their financial business so their families will have this information in an organized fashion should that officer be killed in the line of duty or die at an early age. However, this diary can be used by anyone to organize their personal/financial affairs.

Every day law enforcement officers tend to tedious paperwork. Writing detailed reports can make the difference in court cases, civil cases, and truly affect the outcome of occurrences in peoples' lives. Paperwork is a major part of the law enforcement officer's job.

Having worked with thousands of families that have lost officers in the line of duty, it has become apparent to Concerns of Police Survivors, Inc., that while law enforcement officers handle paperwork every day on the street, they are extremely lax at handling personal paperwork. You see, each year during National Police Week, a time when the law enforcement profession gathers to honor its fallen, we hear of 20 or more families whose officers forgot to up date their beneficiary forms. Imagine finding out after your law enforcement officer spouse has died that you're not listed as the beneficiary on insurance forms! Imagine finding out that although you've been married to this officer for seven years, the former spouse is still listed as beneficiary!

This is a hurt no family should have to suffer. This handbook is designed to address this violation of law enforcement officers' dependents. The diary also encourages those who take the time to organize their affairs to leave a letter stating why the spouse was not their beneficiary if that was their intent. It will eliminate many family traumas and will help the surviving family understand why the deceased left benefits to various individuals other than the spouse.

Take time with your spouse to sit down and complete Your Personal/Financial Diary. It will save you or your survivors hundreds of hours searching for legal and financial documents at some time in the future.

If you're a law enforcement officer, it's the least you can do for the family that loves you and supports you in your profession.

For additional copies, contact:

Concerns of Police Survivors, Inc.  
P. O. Box 3199  
Camdenton, MO 65020  
573-346-4911 -- 573-346-1414 (fax)

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**IN CASE OF EMERGENCY,**

**THESE PEOPLE MUST BE NOTIFIED**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## IMPORTANT BUSINESS/PERSONAL CONTACTS

My Immediate Supervisor: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Spouse's Immediate Supervisor: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Personal Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_

Clergyman: \_\_\_\_\_  
Church Affiliation: \_\_\_\_\_  
Phone: \_\_\_\_\_

Attorney: \_\_\_\_\_  
Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_  
Phone: \_\_\_\_\_

Accountant: \_\_\_\_\_  
Phone: \_\_\_\_\_

Insurance Agent: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Phone: \_\_\_\_\_

Banker: \_\_\_\_\_  
Bank Name: \_\_\_\_\_  
Phone: \_\_\_\_\_

Broker: \_\_\_\_\_  
Investment Company: \_\_\_\_\_  
Phone: \_\_\_\_\_

## PERSONAL DOCUMENTS/INFORMATION

My birth date is: \_\_\_\_\_

My birth certificate is located at: \_\_\_\_\_

I was born in: \_\_\_\_\_

My social security number: \_\_\_\_\_

I was married in: \_\_\_\_\_

On: \_\_\_\_\_ To: \_\_\_\_\_

Children from this marriage: \_\_\_\_\_

I was divorced on: \_\_\_\_\_ State of: \_\_\_\_\_

I was married in: \_\_\_\_\_

On: \_\_\_\_\_ To: \_\_\_\_\_

Children from this marriage: \_\_\_\_\_

I was divorced on: \_\_\_\_\_ State of: \_\_\_\_\_

Marriage certificate(s) are located at: \_\_\_\_\_

Divorce decree(s) are located at: \_\_\_\_\_

Children's birth certificates are located at: \_\_\_\_\_

Children's adoption papers are located at: \_\_\_\_\_

Children's Names

Date of Birth

Residence

<u>Children's Names</u>	<u>Date of Birth</u>	<u>Residence</u>

I served in the Armed Forces: \_\_\_\_\_ Branch: \_\_\_\_\_

Service Serial Number: \_\_\_\_\_

Enlisted on: \_\_\_\_\_ At: \_\_\_\_\_

Discharge Date: \_\_\_\_\_ Discharge papers located at: \_\_\_\_\_

Personal Information (Continued)

Husband's relatives and addresses: (If deceased, indicate after their name)

1. Mother: \_\_\_\_\_  
\_\_\_\_\_
2. Father: \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_
6. \_\_\_\_\_  
\_\_\_\_\_

Wife's relatives and addresses: (If deceased, indicate after their name)

1. Mother: \_\_\_\_\_  
\_\_\_\_\_
2. Father: \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_
6. \_\_\_\_\_  
\_\_\_\_\_

Personal Information (Continued)

Grandchildren:

<u>Name</u>	<u>Date of Birth</u>	<u>Their Parents</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

People who have special meaning to me:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BENEFITS THROUGH EMPLOYMENT**

My employer is: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number of Benefits Division: \_\_\_\_\_

I began employment on: \_\_\_\_\_

The following benefits are provided through my employer:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Health Care Coverage Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Dental Care Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Eye Care Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Disability Insurance Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_

Files bearing employment documents are located at: \_\_\_\_\_

## BANK ACCOUNTS AND INVESTMENTS

Checking Account #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Checkbook is kept at: \_\_\_\_\_

Checking Account #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Checkbook is kept at: \_\_\_\_\_

Savings Account #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Passbook is kept at: \_\_\_\_\_

Savings Account #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Passbook is kept at: \_\_\_\_\_

Savings Account #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Passbook is kept at: \_\_\_\_\_

Certificate of Deposit #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Certificate is kept at: \_\_\_\_\_

Certificate of Deposit #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Signatories are: \_\_\_\_\_  
Certificate is kept at: \_\_\_\_\_

Safe Deposit Box #: \_\_\_\_\_ Bank: \_\_\_\_\_  
Safe Deposit Box is accessible to: \_\_\_\_\_  
Key is kept at: \_\_\_\_\_

Investment/Stock portfolio is located at: \_\_\_\_\_  
Bonds portfolio is located at: \_\_\_\_\_

IRA certificate and file is located at: \_\_\_\_\_  
401(k) Retirement file is located at: \_\_\_\_\_  
Pension (company funded) file is located at: \_\_\_\_\_

## MEDICAL AND DISABILITY INSURANCE

Medical Insurance is provided to me through my work. Yes \_\_\_\_\_ No \_\_\_\_\_

This is the name of the office/person at my place of employment regarding medical insurance issues: \_\_\_\_\_

Phone: \_\_\_\_\_

I have personally acquired medical insurance through the following companies:

\_\_\_\_\_  
\_\_\_\_\_

Location of policies: \_\_\_\_\_

You may need to talk with the State Workers' Compensation office at:

\_\_\_\_\_

Phone: \_\_\_\_\_

## CREDIT CARDS

I have credit cards with the following companies:

<u>Name</u>	<u>Account Number</u>	<u>Location of Statements</u>	<u>Is Insurance Provided?</u>
-------------	-----------------------	-------------------------------	-------------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## TAX RETURNS

Copies of my income tax returns are located at: \_\_\_\_\_

\_\_\_\_\_

Current withholding tax forms and receipts received from my employer at located at:

\_\_\_\_\_

All worksheets and evidence in support of the returns are attached to the returns:

Yes \_\_\_\_\_ No \_\_\_\_\_ Worksheets are located at: \_\_\_\_\_

## MY PERSONAL BUSINESS VENTURES

I own or have an interest in (name of business): \_\_\_\_\_

Address: \_\_\_\_\_

In partnership/co-ownership with: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

The contract concerning the business arrangement is located at: \_\_\_\_\_

Percentage of my share of the business is: \_\_\_\_\_

Tax papers for the business are located at: \_\_\_\_\_

## REAL ESTATE

My residence address is: \_\_\_\_\_

I own my own residence: Yes \_\_\_\_\_ No \_\_\_\_\_

My landlord is: \_\_\_\_\_

Ownership Title bears the names of: \_\_\_\_\_

The mortgage on the property is held by: \_\_\_\_\_

The mortgage payment records are located at: \_\_\_\_\_

The mortgage agreement carried life insurance coverage: Yes \_\_\_\_\_ No \_\_\_\_\_

Homeowners insurance papers are located at: \_\_\_\_\_

The insurance broker is: \_\_\_\_\_

Tax paperwork on my residence are located at: \_\_\_\_\_

I own other real estate at: (list addresses)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Deeds, mortgage information, tax documents and payment records are located at:

\_\_\_\_\_

## **TRUST FUNDS**

I have established a living trust for the benefit of: \_\_\_\_\_

It was established on: \_\_\_\_\_

The Trust Agreement is located at: \_\_\_\_\_

The Trustees are: \_\_\_\_\_

The attorney who drew up the Agreement is: \_\_\_\_\_

I am a beneficiary under a trust established by: \_\_\_\_\_

Papers are located at: \_\_\_\_\_

If I die, my heirs are beneficiaries of trust funds established by: \_\_\_\_\_

\_\_\_\_\_

Papers are located at: \_\_\_\_\_

## **PERSONAL DEBTORS AND CREDITORS**

The following owe money to me: \_\_\_\_\_

\_\_\_\_\_

Exclusive of secured loans, I owe to the following: \_\_\_\_\_

\_\_\_\_\_

I have the following loans covered by borrowers' life insurance: \_\_\_\_\_

\_\_\_\_\_

Copies of notes, loan agreements and receipts are located at: \_\_\_\_\_

\_\_\_\_\_

Are there any law suits you are involved in either as the plaintiff or defendant?

Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

**HOMEOWNER'S AND MORTGAGE INSURANCE**

Company                      Contact                      Phone                      Location of Paperwork

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**AUTOMOBILES AND AUTO INSURANCE**

Make                      Model                      Year                      Registered to                      Status of Ownership

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Company name of auto insurer \_\_\_\_\_  
Agent's Name \_\_\_\_\_ Phone \_\_\_\_\_

**BOATS, TRAILERS, OR OTHER MOTOR CRAFTS  
AND INSURANCE**

Make                      Model                      Year                      Registered to                      Status of Ownership

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**OTHER INSURANCE**

Often credit cards, credit unions, travel agencies, etc. carry insurance policies on clients. List various sources that provide this benefit:

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## MY LIVING WILL

Individuals may execute a “living will” that instructs family members and physicians to not take extraordinary steps to continue your life on life-support machines. You should investigate the legality of the “living will” within your state and take steps to execute the “living will” if you do not chose to be kept alive through mechanical means.

\_\_\_\_\_ I have not executed a “living will”

\_\_\_\_\_ I have executed a “living will”

Since copies of living wills may not be acceptable in some states, an **original, signed** copy of my living will is readily accessible at: \_\_\_\_\_  
Additional copies of my “living will” are on file with my personal physician, attorney, and with my will.

## MY WILL

Your will should address special requests on how you would like insurance money to be spent, who you would like to have your prized possessions, etc. By providing this information in a will, your wishes can be upheld in court. Otherwise, your primary beneficiary will have total control of your assets/possessions. However, if this information is not included in your will, there is a section in this handbook for that information to be provided.

I do not have a will. \_\_\_\_\_. (Often times families incur additional emotional, legal and financial burdens when a loved one dies without having executed a will. We strongly suggest this be a task that you address as soon as possible.)

I have a will that is located at: \_\_\_\_\_

The Attorney who handled my will is \_\_\_\_\_  
at the law firm of \_\_\_\_\_  
Phone number: \_\_\_\_\_

My last will is dated: \_\_\_\_\_

The Executor is: \_\_\_\_\_

## ORGAN DONATION

\_\_\_\_\_ I do not want any of my organs donated.

\_\_\_\_\_ I would like to have organs donated for transplant.

\_\_\_\_\_ I would like to donate the following organs for transplant/research:

\_\_\_\_\_

## FUNERAL DETAILS

Church Preference: \_\_\_\_\_ Religious Affiliation: \_\_\_\_\_

Clergyman: \_\_\_\_\_ Phone: \_\_\_\_\_

Funeral Home to be used: \_\_\_\_\_

Phone: \_\_\_\_\_ I have a pre-paid burial plan. Yes \_\_\_\_\_ No \_\_\_\_\_

Contact: \_\_\_\_\_

(Some funeral homes provide free burial services to a law enforcement officer killed in the line of duty. Check on this benefit through your agency.)

Service to be held at:

Funeral Home \_\_\_\_\_ Name of Funeral Home: \_\_\_\_\_

Church \_\_\_\_\_ Name of Church: \_\_\_\_\_

I prefer: Interment \_\_\_\_\_ Entombment \_\_\_\_\_ Cremation \_\_\_\_\_

My choice of cemetery is : \_\_\_\_\_

\_\_\_\_\_ I have purchased a lot. \_\_\_\_\_ I have not purchased a lot.

Lot is in name of: \_\_\_\_\_

Section \_\_\_\_\_ Lot \_\_\_\_\_ Block \_\_\_\_\_

Location of deed for lot: \_\_\_\_\_

If interment is in another city, give information on the receiving funeral home:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Pallbearers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If cremated, what do you wish done with your ashes? \_\_\_\_\_

Funeral Details (Continued)

Obituary: Yes \_\_\_\_\_ No \_\_\_\_\_

Please list the following in my obituary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am entitled to Veterans Benefits: Yes \_\_\_\_\_ No \_\_\_\_\_

I entitled to Military Honors: Yes \_\_\_\_\_ No \_\_\_\_\_

I would like a "Lodge" service: Yes \_\_\_\_\_ No \_\_\_\_\_

By: \_\_\_\_\_

Flowers: Yes \_\_\_\_\_ No \_\_\_\_\_ Disposal of flowers: \_\_\_\_\_

Donations in lieu of flowers to: \_\_\_\_\_

Musical selections: \_\_\_\_\_  
\_\_\_\_\_

Special requests for service: \_\_\_\_\_  
\_\_\_\_\_

**SPECIAL FINAL REQUESTS**

As stated earlier in this handbook, special final requests should be addressed in one's will so your wishes will be upheld by a court of law. If you have not addressed these special final requests in a will, your primary beneficiary will have total control of your assets/possessions for final disposal. We strongly recommend addressing these issues in your will. If you choose not to, however, complete this section to alleviate your family of the decisions that might need to be made in your behalf.

This is how I would like insurance settlement money to be spent: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This is how I would like real estate to be handled: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This is how I would hope my family would continue/improve their relationships:

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These are my prized possessions and how I would like them to be distributed:

Item

Given to

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I would like my clothing and other general personal effects distributed in this manner:

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Other special wishes: \_\_\_\_\_

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## LIFE INSURANCE POLICIES

To insure easy access to actual policies, beneficiaries, etc., all policies owned should be kept together in a safe place. Premium receipts, loan information, and settlement agreements on these policies should also be filed with the policy.

Location of policies: \_\_\_\_\_

I have made loans against the following policies: \_\_\_\_\_  
\_\_\_\_\_

I also own annuity contracts: Yes \_\_\_\_\_ No \_\_\_\_\_

Location of contracts: \_\_\_\_\_

My principal life insurance advisor is listed in "Important Business/Personal Contacts".

Other insurance advisors include:

Name: \_\_\_\_\_ Company: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Company: \_\_\_\_\_  
Phone: \_\_\_\_\_

*The National Insurance Consumer Help Line can search 100 of the largest life insurance companies for policies of individuals. (Keep in mind there are over 2,000 insurance companies in existence.) There is a \$4.50 charge for this search and it may take up to six months to complete the search. Call 1-800-942-4242 for information.*

I also belong to the various social/fraternal organizations that carry insurance for their membership:

Organization: \_\_\_\_\_ Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Organization: \_\_\_\_\_ Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Organization: \_\_\_\_\_ Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Organization: \_\_\_\_\_ Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## **OTHER CONSIDERATIONS**

This handbook was planned to save as much heartache as possible immediately following the death of a loved one. All the planning and preparation in the world, however, won't save a family serious heartache if someone chooses to keep information about their life from family members. Often times after someone dies, family members are shocked to find out there are other children from outside the marriage and other significant others.

To save your spouse or other family members this heartache and torment, it is suggested that you write a letter to be opened upon your death that will tell your family about the issues you felt you could not discuss with them during your lifetime.

Additionally, we recommend that you discuss with your spouse the beneficiary listings you have chosen on various insurance policies. This will help alleviate the family upheavals that seriously effect the grief process when family members doubt that you meant to leave benefits to the people who received those benefits.

Be proactive and address these issues before it's too late.



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
(HIPAA AUTHORIZATION UNDER 45 C.F.R. § 164.508)**

**A. Statement of Intent.** It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my “Individually Identifiable Health Information” to certain of my family and friends, regardless of my state of health. I am signing this authorization so my Health Care Providers can disclose my health care information to the persons listed below and openly discuss that information with them.

**B. Authorization.** I, \_\_\_\_\_ [insert your name], hereby authorize my physicians, nurses, hospitals and other Health Care Providers to fully disclose my Individually Identifiable Health Information to any or all of the following authorized persons (my “Personal Representatives”):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Further, if I have executed and have not revoked a Medical Power of Attorney and/or a Durable Power of Attorney naming other agents to make health care decisions and/or business and personal decisions on my behalf, then said agents shall be deemed automatically added to the above list of persons to have access to my personal medical records.

The fact that I may have named more than one party to have access to my protected medical records shall not be interpreted as requiring all of their joint consent or signatures. Each person I designated shall have the authority to act individually and without notice to any other designated person.

**C. Authority to Discuss and Answer Questions.** My Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed above and openly discuss with them my condition, treatment, test results, prognosis, and all other information pertinent to my health care, even if I am fully competent to ask questions and discuss my medical condition. This document constitutes a full authorization to disclose any Individually Identifiable Health Information to the Personal Representatives named in this Authorization.

**D. Waiver and Release.** I hereby release any Health Care Provider who acts in reliance on this Authorization from any liability that may accrue from releasing my Individually Identifiable Health Information and for any actions taken by my Personal Representatives.

**E. Termination.** This Authorization is effective as of the date shown as the date of its signing and shall not be affected by my subsequent disability or incapacity. This authorization shall terminate on this first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the Health Care Provider. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the Health Care Provider.

**F. Re-Disclosure.** By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Personal Representatives named in this Authorization and no longer by protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I fully indemnify my Health Care Providers for all consequences which may occur as a result of their good faith reliance and compliance with this Authorization. No Health Care Provider shall require my Personal Representatives to indemnify the Health Care Provider or agree to perform any act in order for the Health Care Provider to comply with this Authorization.

**G. Enforcement.** My Personal Representatives shall have the right to bring a legal action in any applicable forums against any Health Care Provider who refuses to recognize and accept this Authorization. Additionally, my Personal Representatives are authorized to sign any documents that my Personal Representatives deem necessary or appropriate to obtain my Individually Identifiable Health Information.

**H. Conflicts With Other Authorizations.** This Authorization is in addition to other medical release authorizations I may have granted in the past or future; it does not replace them. This Authorization may be relied upon by my Health Care Providers regardless of any real or perceived conflict with any Medical Power of Attorney signed by me, whether prior to or subsequent to the date of this Authorization. I recognize and intend that this may result in multiple persons having the authority to obtain my protected Individually Identifiable Health Information. This Authorization is not intended to replace a Medical Power of Attorney, nor to grant any person the authority to make health care decisions, but merely to obtain information and explanations.

**I. Copies.** A copy or facsimile of this original Authorization may be accepted and relied upon as though it was an original document.

## **J. Definitions**

1. *Individually Identifiable Health Information.* The term "Individually Identifiable Health Information" includes (but is not limited to) the following: All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information, the identity of health care providers and insurers, whether past, present or future, and any other medical information which is in any way related to my health care. In this Authorization, the term also includes the term "Protected Medical Information" as sometimes used in HIPAA.

2. *Health Care Providers.* The term "Health Care Providers" includes (but is not limited to) the following: Doctors (including, but not limited to, physicians, podiatrists, chiropractors, or

osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies, and any other medical providers or affiliates. In this Authorization, the term also includes the term "Covered Entity" as sometimes used in HIPAA.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
[Your Signature]



**ACKNOWLEDGMENT OF NOTARY PUBLIC**

STATE OF \_\_\_\_\_ )  
COUNTY OF \_\_\_\_\_ )

On \_\_\_\_\_ before me, \_\_\_\_\_  
\_\_\_\_\_ (here insert name and title of the officer), personally appeared

\_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of \_\_\_\_\_ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

\_\_\_\_\_  
Signature (Seal)