A Complimentary tool from Spek Services,
Track information you will want to keep on file,
Print-able for any caregiver, key family members,
or for any coverage consultation.

Name: _____ D.O.B. ___ / ___ / _____
Are you working, retired (when?), or disabled? _____
Primary Occupation: _____ Years of Service: ____

Which do you already have?
Medicare Parts: A, B, C, D, What Part D program do you have? _____
MediGap? which plan letter ____, which company? _____
do you have an income supplement / replacement plan? _____
which company? _____
do you currently have coverage for Vision ____ Dental ____ Hearing ____
which company? _____
do you have an in home Nursing care or Nursing home coverage? ____
which company? _____
Did you get your program(s) from your employer or own your own? _____

Are you receiving S.S., SSI Disability, or Pension? _____
Monthly income range for you _____ for spouse _____

Do you have an "Extra Help" program (LIS, SLMB, QMB, Medicaid)?
Please describe what it does for you _____
State Prescription Drug Assistance Program like (SPDAP, DPAP, PADD)?
Record your State I D number _____

Did you retire from the Federal Government? _____
Did you serve in the military? Date of service ___ / ___ / _____ to ___ / ___ / _____
Did you activate / do you have Veterans Benefits? _____
have you added / looked into Improved Pension Benefits for Veterans? _____
activated VA Burial Benefits? _____
do you have TRICARE ____ TRICARE for Life ____ CHAMP VA _____

Any active / 5 year history of major illnesses that could qualify you for benefits, such as:
Diabetes? ____ Type? _____
Cancer _____ Type _____
Do you have kidney disease? ____ Are you on dialysis? _____
Other? _____

Primary Care Physician's Name:
_____ at _____ in _____

What hospital do you regularly use? ____

What hospital will you not use? ____

What Specialists do you regularly use?

_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________
_______________________________ at _________________________ in ________________

Which pharmacies do you use? ____

Which Pharmacy will you not use? ____

What drugs do you use? Cost of drugs can help find lower cost options:

List of Prescription Medications:	dosage:	frequency:	treating:	current cost:

Does anyone in the family help you with your benefits? _____ who?
Does anyone have legal right to assist you? ____ Who? _____

Do you have the following in place in case you are incapacitated?
Medical Power? ___ Financial Power? ____ Living Will? ____ Last Will? _____
Medical directive? ____ Do Not Resuscitate? _____ Organ Donor? _____

Do you have a Final Expense Program in place? _____

Planning ahead saves the family from having to make choices at a vulnerable time. If you do not plan for it, the family will do it, and may overspend monies they do not Have, or deplete the funds set aside for your grandchildren's futures

Are you planning a Traditional Burial or Cremation? _____
What Funeral Home do you want or does your family use?_____

It is critical the following coverage's do not lapse – if you are incapacitated – family needs to be able to manage & continue payments for you, as well as apply the policies to the costs when the need arises.

How much Term Insurance do you own? $ _____ when does policy end? __ / __/ ____
Company _____ monthly premium _____
Permanent Whole Life? $ _____
Company _____ monthly premium _____
Final Expense Insurance? $ _____ (policy used @ funeral home upon death, no wait)
Company _____ monthly premium _____

Have you completed the following End Of Life Necessity decisions?
1. Last Will and Testament _____
2. Burial / ceremony instructions? _____
3. Trust or policy for funeral home? _____
4. Casket instructions /choice / selection? _____
5. Grave plot & vault selection? _____
6. Opening and Closing of the Grave fees? _____
7. Body preparations, including embalming and clothes? _____
8. Marker? _____
9. Transportation & Flowers? _____
10. Funeral Director Fees? _____
11. Clergy? _____

This record form is Complimentary, from John Spek @ Spek Services, 410-302-4122