

Your retirement checklist

New to Medicare

A simpler way to plan your future

Working Years Benefits	Transitions With You?	Important to Have?	Retirement Years Benefits
HEALTH INSURANCE: Premium: \$ _____ Deductible: \$ _____ Co-insurance/Co-pay: \$ _____ / _____ Max out-of-pocket: \$ _____ HSA: \$ _____ Preventive Benefits: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE SUPPLEMENT: Deductible: \$ _____ Co-insurance/Co-pay: \$ _____ / _____ Max out-of-pocket: \$ _____
DENTAL INSURANCE: Premium: \$ _____ Deductible: \$ _____ Max benefit: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL INSURANCE: Premium: \$ _____ Deductible: \$ _____ Max benefit: \$ _____
EXTENDED CANCER PROTECTION: Benefit amount: \$ _____ Purpose: _____	<input type="checkbox"/>	<input type="checkbox"/>	EXTENDED CANCER PROTECTION: Benefit amount: \$ _____ Purpose: _____
LIFE INSURANCE: Term face amount: \$ _____ Whole face amount: \$ _____ Purpose: _____	<input type="checkbox"/>	<input type="checkbox"/>	LIFE INSURANCE: Term face amount: \$ _____ Whole face amount: \$ _____ Purpose: _____
OTHER BENEFITS: Vision: \$ _____ Hearing: \$ _____ Prescription: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	OTHER BENEFITS: Vision: \$ _____ Hearing: \$ _____ Prescription: \$ _____
INCOME: Working: \$ _____ Other: \$ _____ Other: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	INCOME: Social Security: \$ _____ Pension: \$ _____ Other: \$ _____
RETIREMENT ACCOUNTS: _____ \$ _____ _____ \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	RETIREMENT ACCOUNTS: _____ \$ _____ _____ \$ _____

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Enrolled in Medicare

Find the coverage you need

Which type of plan do you currently have?

Medicare Supplement	MA Plan
Current Company: _____ Company Rating: _____	Current Company: _____ Star Rating: _____
Premium: \$ _____ Deductible: \$ _____ Co-insurance/Co-pay: \$ ____ / ____ Max out-of-pocket: \$ _____ Enhanced Preventive benefits: \$ _____ Attained Age or Issue Age: _____ Two Year Selection Guarantee: _____ Local Agent: _____	Premium: \$ _____ Deductible: \$ _____ Co-insurance/Co-pay: \$ ____ / ____ Max out-of-pocket: \$ _____ Enhanced Preventive benefits: \$ _____ Network: _____ Pre-Authorizations Needed: _____ Local Agent: _____

	Important to Have?		
DENTAL INSURANCE: Premium: \$ _____ Deductible: \$ _____ Max benefit: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL INSURANCE: Premium: \$ _____ Deductible: \$ _____ Max benefit: \$ _____
EXTENDED CANCER PROTECTION: Premium: \$ _____ Benefit amount: \$ _____ Purpose: _____	<input type="checkbox"/>	<input type="checkbox"/>	EXTENDED CANCER PROTECTION: Premium: \$ _____ Benefit amount: \$ _____ Purpose: _____
LIFE INSURANCE: Term face amount: \$ _____ Whole face amount: \$ _____ Final Expenses face amount \$ _____ Purpose: _____	<input type="checkbox"/>	<input type="checkbox"/>	LIFE INSURANCE: Term face amount: \$ _____ Whole face amount: \$ _____ Final Expenses face amount \$ _____ Purpose: _____
OTHER HEALTH BENEFITS: Vision: \$ _____ Hearing: \$ _____ Prescription: \$ _____ Part D Annual Review: _____	<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEALTH BENEFITS: Vision: \$ _____ Hearing: \$ _____ Prescription: \$ _____ Part D Annual Review: _____
INCOME: Social Security: \$ _____ Pension: \$ _____ Other: \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	INCOME: Social Security: \$ _____ Pension: \$ _____ Other: \$ _____
RETIREMENT ACCOUNTS: _____ \$ _____ _____ \$ _____	<input type="checkbox"/>	<input type="checkbox"/>	RETIREMENT ACCOUNTS: _____ \$ _____ _____ \$ _____