Protecting Your Future

Asset Identification and Financial Planning Form

Long-Term Care Expenses

Your Name:	
Today's Date:	
Company:	
Home Address:	
City/State/ZIP:	
Phone:	
Email:	

_____ and _____ have considered and evaluated potential related risks that are associated with a life-changing event, such as an extended need for health care (long-term care).

ESTIMATED CURRENT COST OF LONG-TERM CARE

(Figures based on long-term care in relation to your location*):

At-Home Care:	
Assisted Living:	
Private Nursing Home:	
***Source**	

What assets would you (or the covered individual) like to self-insure against in the event extended health care is needed?

Asset Type	Account Name	Account Balance	Account Number

Life happens and financial circumstances change. As your partner, we will continue to connect with you, review your plans to self-insure as a means to cover long-term care expenses, and empower you with tailored solutions for your needs.

LTCI PARTNERS, LLC

Client Name: _____

(signature)

Client Name: _____

(print)

Client Name: _____

(print)

Client Name: _____

(print)

Advisor Name: _____

(print)

Advisor Name: _____

(signature)

LTCI PARTNERS, LLC