CLIENT NEEDS ASSESSMENT

DATE: AGENT NAME:

AGENT PHONE: AGENT EMAIL:

CLIENT INFORMATION

NAME:

PHONE: DATE OF BIRTH/AGE:

SPOUSE NAME: SPOUSE DATE OF BIRTH:

EMAIL: FAMILY NEARBY:

1. HAVE YOU HAD ANY MEDICARE CLAIMS IN THE LAST 2 YEARS? ☐ Yes ☐ No

   DETAILS:

2. WHICH PARTS OF MEDICARE DO YOU CURRENTLY HAVE?

3. DO YOU CARRY A MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE PLAN?

4. WHAT PLAN/COMPANY DO YOU HAVE?

   WHY DID YOU DECIDE ON THAT PLAN?

   HOW MUCH DOES IT COST?

5. DO YOU HAVE A HISTORY OF CANCER, HEART ATTACK OR STROKE IN YOUR FAMILY?

6. HAVE YOU HAD A FAMILY MEMBER USE HOME HEALTH CARE OR GO INTO A NURSING HOME?

   HOW DID THEY PAY FOR IT?

   HOW WOULD YOU PAY FOR IT?

7. DO YOU CURRENTLY CARRY ANY LIFE INSURANCE?

   WHAT IS THE DEATH BENEFIT? WHAT IS YOUR PREMIUM?

   WHAT IS THE CASH VALUE?

   IF YOU HAVE LIFE INSURANCE, WHAT PURPOSE DOES IT SERVE?

   ☐ Income Replacement ☐ Final Expenses ☐ Outstanding Debts ☐ Help Family Financially

8. HAVE YOU MADE ANY ARRANGEMENTS TO TAKE CARE OF FINAL EXPENSES?

9. ARE YOU SATISFIED WITH THE PRESENT RATE OF RETURN ON YOUR INVESTMENTS? ☐ Yes ☐ No

   DETAILS

   ARE YOU DEALING WITH THE STOCK MARKET OR THE BANK?

10. DO YOU HAVE A 401K? HAVE YOU ROLLED OVER YOUR 401K?

    IF YES, WHAT DID YOU ROLL IT INTO?

MEDICATION LIST

PHARMACY PREFERENCE:

CURRENT DRUG PLAN:

MEDICATION	DOSAGE & FREQUENCY	CONDITION

NOTES/OTHER INSTRUCTIONS: