AGENT NAME _____ **DATE**_____

Name_____ Date of Birth _____ Age _____

Occupation_____Company_____ Years of Service _____

Spouse Name_____ Date of Birth _____ Age _____

Occupation_____Company _____ Years of Service _____

Address_____

Phone *(home)* ( ) – Phone *(work)* ( ) –

Phone *(cell)* ( ) – Fax ( ) –

Email_____

Emergency Contact Name_____ Phone ( ) –

MEDICAL EXPENSES

1. Many people are concerned about their health and the high cost of healthcare. What are you doing to protect yourself? What type of health insurance do you have now?
Company_____Plan_____Riders_____Premium_____

Prescription Coverage Yes___ No___ Recent Agent Contacts_____

Company_____Plan_____Riders_____Premium_____

Prescription Coverage Yes___ No___ Recent Agent Contacts_____

2. What are your concerns about the gaps in Medicare? _____

_____

Hospital Indemnity

4. How much is your copay, coinsurance, or deductible for an in-patient hospital stay?_____

5. Would having to come up with the hospital copay, coinsurance, or deductible put you in a financial bind?

_____

6. What are your plans for paying for hospital stays, ambulance rides, durable medical equipment, etc.?

_____

_____

_____

FINAL EXPENSE/SURVIVORS' INCOME

Do you own any life insurance? Yes___ No___

Face Amount *Insured*_____ *Spouse* _____

Beneficiary *Insured* _____*Spouse* _____

Company *Insured* _____ *Spouse* _____

Premium *Insured* _____ *Spouse* _____

7. What are your plans for life insurance? _____

Why do you have it? _____

Do you think you have enough life insurance? Yes___ No__ _____

8. What do you have in place to help with funeral planning and funeral needs? _____

_____

9. Do you have a designated contact if something were to happen (other than your spouse)? Yes___No___

CANCER

10. Do you currently have a supplemental cancer policy? Yes___ No___

11. If you were to get a diagnosis of cancer from your doctor, how would you pay for travel to get treatment, experimental medications, copays/coinsurance/deductibles, missed time from work, etc.?_____

_____

DENTAL

12. Do you have dental coverage? _____

_____

13. If so, what would you change about your current dental coverage?_____

_____

_____

REFERRALS

_____

_____

_____

_____

_____

_____

The information I have provided in this Needs Assessment provides an accurate picture of my current situation and beliefs. I understand that any recommendations made by the agent are based on these responses.

Signature_____ Date_____

In a presentation conducted by _____ , I recommended the following insurance products._____

_____

Agent Signature_____ Date_____

After considering the presentation and a careful assessment of my insurance needs, I have decided not to apply for the insurance products recommended to me by the agent.

Signature_____ Date_____