Client Needs Assessment AGENT: _____

NAME: _____ PHONE: _____

DOB: _____ FAMILY NEARBY: _____

EMAIL ADDRESS: _____

1. Have you had any claims in the last 2 years? _____

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?_____

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?_____

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Medication List

Pharmacy Preference: _____

Current Drug Plan: _____

Medication	Dosage & Frequency	Condition

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