



PERSONAL & CONFIDENTIAL

For Agent Use Only

FACT FINDER

CLIENT PROFILE

Client Name: _____ U.S. Citizen? YES NO

DOB: _____ MALE FEMALE Height: _____ Weight: _____ Tobacco Use? YES NO

Email: _____ Phone: _____ Self Employed? YES NO

Occupation: _____ Estimated Annual Income: _____

Subsidy Eligible? YES NO Estimated Subsidy: \$ _____

Spouse Name: _____ U.S. Citizen? YES NO

DOB: _____ MALE FEMALE Height: _____ Weight: _____ Tobacco Use? YES NO

Email: _____ Phone: _____ Self Employed? YES NO

Occupation: _____ Estimated Annual Income: _____

CHILD(ren) Name	DOB	Gender	Height	Weight
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		
		<input type="checkbox"/> Male <input type="checkbox"/> Female		

Primary Residence Address

Address	City	ST	ZIP	County
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Preferred Mailing Address (if different than primary)

Address	City	ST	ZIP	County
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	Phone Number	Best Time to Call
Home		
Mobile		
Work (Client/Spouse)		
Email Address		

What type of insurance coverage do you currently have? (check all that apply) Employer Individual

- ACA Marketplace Short-Term Health Sharing Ministry Life Disability LTC Medicaid
 Dental MEDICARE PARTS A & B MEDICARE ADVANTAGE MEDIGAP (MEDICARE SUPPLEMENT)

NEEDS ANALYSIS

Review of Your Current Health Plan

Insurance Company: _____ Monthly Premium? _____

Doctor(s): _____ Visits per year (avg)? _____

Co-Pay: \$ _____ Deductible: \$ _____ Rx Expense: \$ _____ Annual Rx Costs: \$ _____

Are you currently expecting a child or planning on having children in the near future? YES NO

Why are you looking for coverage at this time? _____

Do you have a Special Enrollment Period (SEP) qualifying event? YES NO If Yes, why? _____

Rank the following from 1 – 3 in order of importance with 1 being the most important:

___ Lower monthly premium ___ Lower deductible ___ Large network of doctors and hospitals

To Determine Your Additional Supplemental Insurance Needs/Wants

History of ...	ME	SPOUSE	CHILD	Family		ME	SPOUSE	CHILD	Family
Cancer						Injury			
Heart Attack						Hospitalization			
Stroke						Major Surgery			
Diabetes						ER Visit			
Other Chronic Illness						Current Prescriptions			
List chronic illnesses:	List prescriptions taken within the last 12 months:								

If a major illness or injury caused you to miss work, how long would you be able to continue to pay your monthly bills without income? _____

	YES	NO
Is access to cash at the time of a critical illness to pay deductibles, copays, daily necessities important?		
Is continuing to receive income if you are sick or hurt important to you and your family?		
Have you had dental coverage in the past?		
Would you like dental coverage again?		
Do you have any major dental work that needs to be done in the next 6 months?		
Does anyone in your family wear glasses or contacts?		
Do you get annual eye exams?		
Are costs associated with hearing loss a concern?		

To Determine Your Additional Life Insurance & Retirement Needs/Wants

Do you feel you/your family have enough life insurance? YES NO How much do you have? _____

How much are you paying monthly? _____ What type of policy is it TERM PERMANENT

Can you collect on your insurance while you're living YES NO Is coverage through employer? YES NO

PROTECTION FOR LIFE

Life Needs Analysis (D.I.M.E.)	YOU	SPOUSE
Debt (Auto, Student Loans, Credit Cards, etc.)	\$	\$
Income (At least 5 – 10x annual income)	\$	\$
Mortgage (How much left to pay off house?)	\$	\$
Education (How much would it cost to send child to school of choice?)	\$	\$
Total T.I.M.E. (Debt + Income + Mortgage + Education)	\$	\$

To Determine a Budget

What monthly price range are you hoping to stay around for your health and financial protection? \$ _____

Financial Snapshot

Date for policy review? _____

Please rate the following concerns by importance

1=Not at all 5=Very Important

	1	2	3	4	5
Providing education funds for my child(ren)	1	2	3	4	5
Planning for retirement/Saving a fixed percentage of income	1	2	3	4	5
Providing long-term care funds, such as nursing home for myself or my parents	1	2	3	4	5
Having insurance on my spouse and/or children	1	2	3	4	5
Paying off mortgage and other debts in the event of my death	1	2	3	4	5
Allowing my family to maintain their current standard of living after my passing	1	2	3	4	5
If Self-Employed: Business continuity if you retire, die, or become disabled	1	2	3	4	5

Do you expect any major life changes within the next year YES NO If Yes, please explain:

Referrals

Because we spend our time and energy helping people like you, we have less time for finding our next happy client. We rely on our satisfied customers to provide our next appointments. If you agree that we have done a good job for you and your family, please allow us to help your friends and family.

Ideas, people who have:

Moved Married Had a child Lost Insurance Changed jobs Lost coverage
 Started to plan for retirement Lost money in the stock market

Name	Phone	City/State	Relation	Will you introduce me?
1				
2				
3				
4				
5				

Notes



RETIREMENT PLANNING CHECKLIST

Are you ready for retirement?

How do you know?

Let's Do a Quick 10-Minute Review

Areas of Concern for Most People: (check all that concern you)

- | | | |
|--|---|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Enough Retirement Income | <input type="checkbox"/> Freedom to Travel |
| <input type="checkbox"/> Help w/ Medicare Costs | <input type="checkbox"/> Investment Income Stability | <input type="checkbox"/> Physical Fitness |
| <input type="checkbox"/> Life Insurance | <input type="checkbox"/> Social Security | <input type="checkbox"/> Long-Term Care |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Stock Market Losses | |
| <input type="checkbox"/> Cancer/Heart/Stroke History | <input type="checkbox"/> Lowering Taxes | |
| <input type="checkbox"/> Outliving Your Money | <input type="checkbox"/> Leaving a Legacy to kids/other | |

What Are Your Top 5 Questions We Can Answer Today?

1

2

3

4

5

Comments

Give us a call to schedule an appointment today?

Appointment Date:

Time: