

Agent Name:

Date of Interview:

Name:

Spouse:

DOB:

DOB:

Height: ft in Weight: lbs

Height: ft in Weight: lbs

SSN:

SSN:

Drivers License #:

Drivers License #:

Address:

Anniversary Date:

Phone #:

Children & Ages:

### Medical Expenses

Do you own a medicare supplement plan? ☐ Yes ☐ No Are you enrolled in Medicare A&B? ☐ Yes ☐ No

Company:

Plan:

Premium:

What do you like and dislike about your plan?

Tell me about your health in the past five years:

What medications are you currently taking?

### Extended Care

Do you own a long-term care insurance plan? ☐ Yes ☐ No

Daily Benefits:

Elimination Period:

Benefit Period:

Inflation Protection ☐ Yes ☐ No

Company:

Premium:

Most people have 4 concerns regarding LTC: remaining independent, having choices, protecting assets, and staying at home.

Please tell me what your concerns are:

### Life Insurance

Do you own any personal life insurance? ☐ Yes ☐ No Amount of coverage? \$

Type of life insurance? ☐ Term ☐ Whole Monthly Premium \$

Do you have anything that acts like life insurance (self insured)? ☐ Yes ☐ No Amount? \$

Check all that apply: ☐ 401k ☐ IRA ☐ Roth IRA ☐ CD ☐ Annuity ☐ Brokerage Account

# Retirement Income

Please list any and all monthly income for you and your spouse

|                 |        |           |
|-----------------|--------|-----------|
| Employment      | You \$ | Spouse \$ |
| Social Security | You \$ | Spouse \$ |
| Pension         | You \$ | Spouse \$ |

Transfers? ☐ Yes ☐ No

Who do you consult when making a financial decision?

Agent Notes:

Materials Used:

Presentations Used:

I have participated in the presentation and I have provided an accurate picture of my current medical and financial situation in this Confidential Need Analysis. I understand that any recommendations are based on these responses.

Date: Signature: Date/Time for follow-up appointment (if appropriate)