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? _____

Medication List

Pharmacy Preference: _____

Current Drug Plan: _____

Medication	Dosage & Frequency	Condition