

Medicare Client Needs Assessment

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Full Name: _____ Phone: _____

Date Of Birth: _____ Family Nearby: _____

Full Address: _____

Email: _____ Medicare ID/Number: _____

1. Which Parts of Medicare do you currently have (Part A and/or Part B)?
 - a. If you do have Part A, what date did you get it? _____
 - b. If you do have Part B, what date did you get it? _____
2. Do you currently have a Medicare Supplement Plan **OR** Medicare Advantage Plan? _____
 - a. If so, what Supplement Plan do you have or what Medicare Advantage Plan Do you currently have? _____
 - b. If so, what is your current monthly premium? _____
 - c. If so, why did you pick that particular Medicare Supplement OR Medicare Advantage Plan?

3. Do you have a history of **Cancer, Heart attack** or **Stroke** in your family? _____
4. Have you had a family member use home health care or go into a nursing home? _____
 - a. If so, how did **they** pay for it? _____
 - b. How would **you** pay for it? _____
5. Do you currently carry Life Insurance? _____
 - a. What is the **Death Benefit?** _____ What is your **premium?** _____
What is the **Cash value?** _____
 - b. If you have life insurance, what purpose does it serve for you and your family?
Income replacement Final expenses Outstanding debts Help family financially
6. Have you made any arrangements to take care of final expenses? _____
7. Are you satisfied with the present rate of return on your investments? _____
 - a. Are you dealing with the stock market OR the bank? _____
 - b. Do you have a 401k / 403B / 457? _____ If YES, what did you roll it into?

8. Would you like to have us quote insurance for your **Home , Auto , Boat**, etc to see if we can save your some premium dollars in addition to insuring you have proper coverage? _____
 - a. If YES, please provide your most current **Declaration pages** for your Home, Auto, Boat, etc. **AND Driver's license Number** by Email or FAX or regular mail.
9. Would you also like quotes for **Dental / Vision** and **Hearing Insurance?** _____
10. Who else (family, friends...etc) do you think could benefit from learning about their options for Medicare (i.e Medicare Supplement, Medicare Advantage, Part D Prescription Drug) ?

11. Do you currently have a Long-Term Care (LTC) Policy in place? _____
 - a. If YES, would you like it reviewed? _____
 - b. If NO, would you like for us to quote options for you? _____

