

NEEDS ASSESSMENT FORM

FOR
AGENT
USE
ONLY

Date: _____

Customer's Name: _____ Age: _____

Spouse's Name: _____ Age: _____

(Children): _____

Target Monthly Premium Range desired: _____

CURRENT HEALTH CARE COVERAGE				
	YES	NO	MONTHLY PREMIUM	COMMENTS
Major Medical				
Basic Hospital				
Limited Medical/Surgical				
Cancer / Critical Illness Insurance				
Home Health Care / LTC				
Medicare Supplement				

CURRENT LIFE OR ANNUITY COVERAGE				
	YES	NO	MONTHLY PREMIUM	COMMENTS
Life / Final Expense				
Annuities			Amount \$	
Certificate of Deposit (CD)			Amount \$	

Agent's Name: _____ Agent's Number: _____

Comments: _____



