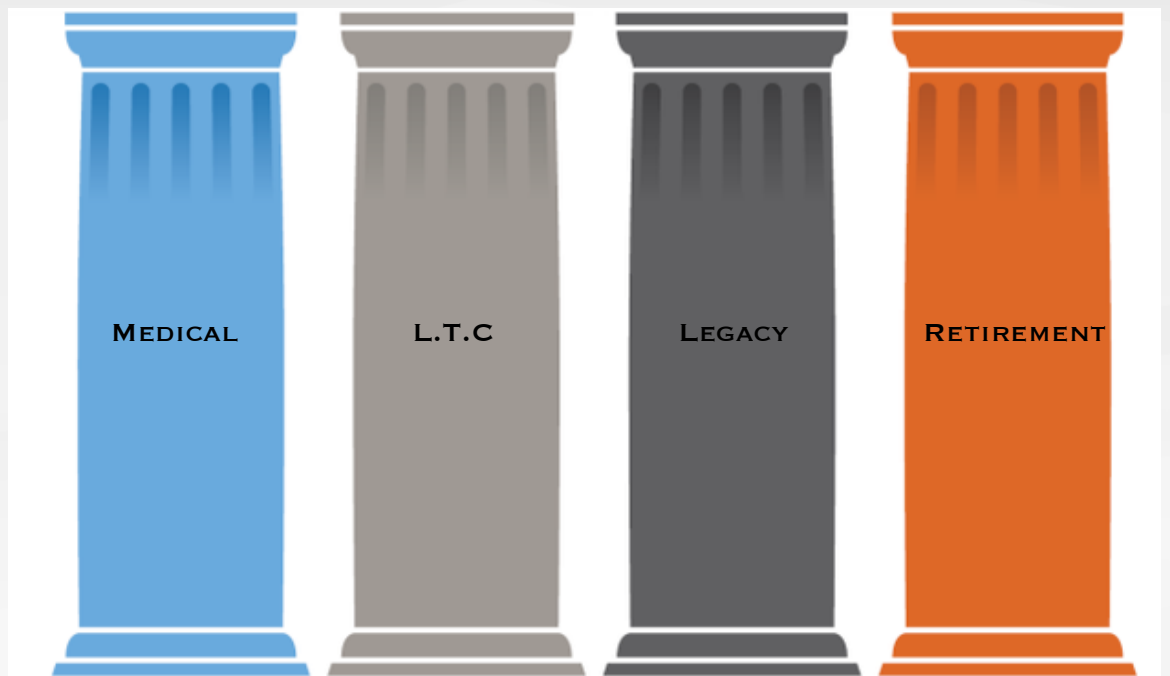


# CONFIDENTIAL NEEDS ASSESSMENT



NAME \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE\_\_\_\_ TOBACCO YES/NO  
 SPOUSE \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE\_\_\_\_ TOBACCO YES/NO  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EMAIL \_\_\_\_\_  
 CHILDREN \_\_\_\_\_ AGE \_\_\_\_\_ GRANDCHILDREN \_\_\_\_\_ AGE \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DO YOU MAKE YOUR OWN FINANCIAL DECISIONS? YES / NO IF NOT THEN WHO \_\_\_\_\_

NAME	HEALTH ISSUE/DIAGNOSES	PRESCRIPTIONS

**MEDICAL EXPENSE / HISTORY**

MANY PEOPLE ARE CONCERNED ABOUT THEIR HEALTH AND HIGH HEALTH CARE COST, WHAT TYPE OF HEALTH INSURANCE DO YOU CURRENTLY HAVE?  
 COMPANY \_\_\_\_\_ PLAN \_\_\_\_\_ RX \_\_\_\_\_ PREMIUM \_\_\_\_\_ SPOUSE \_\_\_\_\_ PLAN \_\_\_\_\_  
 RX \_\_\_\_\_  
 IF YOU COULD CHANGE ANYTHING ABOUT YOUR CURRENT COVERAGE WHAT WOULD IT BE? \_\_\_\_\_  
 DO YOU CURRENTLY HAVE A SUPPLEMENTAL CANCER OR HEART OR STROKE POLICY? YES/NO IF NO, HOW WOULD YOU PAY FOR TRAVEL, EXPERIMENTAL MEDICATION, COPAYS/DEDUCTIBLES? \_\_\_\_\_

**ASSET PROTECTION**

DO YOU HAVE LTC COVERAGE? YES / NO IF YES, COMPANY \_\_\_\_\_ COVERAGE \_\_\_\_\_ PREMIUM \_\_\_\_\_  
 HAVE YOU OR ANYONE YOU KNOW HAD A LTC EXPERIENCE? \_\_\_\_\_  
 WHAT IS YOUR PLAN FOR LTC EVENT? \_\_\_\_\_ DO YOU HAVE A TRUST THAT IS MEDICAID EXEMPT? YES / NO

**LIFE INSURANCE**

WHO IS YOU CURRENT LIFE INSURANCE WITH?

INSURED	INS. CO	FACE AMT	TYPE	CASH VAL	PREMIUM

WHAT ARE YOUR PLANS FOR YOUR LIFE INSURANCE \_\_\_\_\_



## ADDITIONAL INFORMATION/FOLLOW UP NOTES

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WHAT ARE YOUR BIGGEST CONCERNS WITH REGARDS TO RETIREMENT?

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DO YOU CONSIDER YOURSELF A RISK TAKER?

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IS IT IMPORTANT TO LEAVE MONEY TO YOUR FAMILY?

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AFTER CONSIDERING THE PRESENTATION AND CAREFUL ASSESSMENT OF MY INSURANCE  
NEEDS, I AM ELECTING NOT TO APPLY FOR COVERAGE AT THIS TIME.

CLIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_