

INSURANCE EVALUATION DATA FORM

This Form is designed to help us evaluate whether insurance may or may not make sense in your situation to help alleviate any concerns you may have.

CLIENT INFORMATION – PERSONAL AND FAMILY	
Mr. / Dr. _____	Date of Birth ___ / ___ / ___
Mrs. / Ms. / Dr. _____	Date of Birth ___ / ___ / ___
Address _____	Phone # (____) ____ - ____

Children (Names) _____	Date of Birth ___ / ___ / ___
_____	Date of Birth ___ / ___ / ___
_____	Date of Birth ___ / ___ / ___
_____	Date of Birth ___ / ___ / ___
Grandchildren (Number) or Other Heirs _____	

CLIENT INFORMATION – HEALTH HISTORY	
(All questions pertain to BOTH husband & wife where applicable...Please specify to whom the "YES" responses apply...Provide as much detail as possible)	
Any Tobacco Use in the past 12 months? Yes or No (H); Yes or No (W) (Circle One)	
Have you EVER been treated for cancer, insulin dependent diabetes, heart attack, chest pain, stroke, central nervous system disorder, muscular disorder or respiratory disorder?	

In the past 5 years have you had or been treated for a nervous or psychological disorder, epilepsy, emphysema, kidney failure, liver disorder or been advised to have treatment for alcohol or drug abuse? _____	

Have you ever been declined or rated for life insurance? Yes or No (H); Yes or No (W)	

INSURANCE NEEDS ANALYSIS DATA FORM

This Form is designed to help us evaluate what insurance options may or may not make sense in your situation to help alleviate any concerns you may have.

EXISTING LIFE INSURANCE

Own	Ins'd	Bene	Carrier	Type	Policy Date	Yrs to Pay	Premium	Cash Value	Death Benefit	Changes?

Owner/Insured/Beneficiary: Client (C), Spouse (S), Trust (T), Children (CH). If premium payor is different from owner please indicate. Type: Term (Years) (T/Y), Whole Life (WL), Universal Life (UL), Variable Life (VL), Survivor Life (SUR). Change: None (N), Move to Trust (T), Stop Policy (S).

Please attach your most recent statements from insurance carriers on these policies

Generally, what is this insurance designed to do? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Replace Income | <input type="checkbox"/> Kids/grandchildren education | <input type="checkbox"/> Pay debts/last expenses |
| <input type="checkbox"/> Pay Mortgage | <input type="checkbox"/> Supplement retirement income | <input type="checkbox"/> Maximize family wealth transfer |
| <input type="checkbox"/> Estate/income taxes | <input type="checkbox"/> Equalize inheritances w/heirs | <input type="checkbox"/> Other (explain below) |

If you were to buy more life insurance would it be for the same or different reason? _____
Explain, if different _____

What is your objective for this insurance review? _____

OTHER INSURANCE

Do you have sources of income or assets to retain your lifestyle if you are sick or hurt and are unable to work? _____ If so, for how long? _____

Do you currently have disability insurance? _____ Personal or Group (work)? _____

Please describe coverage (carrier, monthly benefit, annual premium, waiting period for benefits, benefit period, optional benefits) _____

Do you have any concerns about not being able to take care of yourself as you get older that may require home assistance or nursing home care? _____

Do you have long-term care insurance? If so, please describe coverage (carrier, daily benefit, annual premium, waiting period for benefits, benefit period, optional benefits)

Please include copies of any disability or long-term care policies