Life Needs Analysis

Today's Date:

Agent:

Existing policies in agency? Client Code:

What date do you need coverage effective?

Preferred method of contact? Phone / Email / Mail

Client Name:

Address: County:

City, State, Zip:

Phone Number (best to reach at):

Employer:

Email address:

Date of Birth: Gender: M / F Age:

Height: Weight: Tobacco Use: Yes No

Drivers License #: SS#:

Other Insured Name:

Address: County:

City, State, Zip:

Phone Number:

Employer:

Email address:

Date of Birth: Gender: M / F Age:

Height: Weight: Tobacco Use: Yes No

Drivers License #: SS#:

Do you have any children you would be interested in adding to a child rider on your policy?

Name:	Date of Birth:	Height:	Weight:
Name:	Date of Birth:	Height:	Weight:
Name:	Date of Birth:	Height:	Weight:

Life Insurance

Do you currently have any personal Life Insurance coverage? Y / N

Do you plan to replace any existing life policies? Y / N

If yes, what carrier, death benefit and policy number?

Do you currently have Life Insurance coverage with your employer? Y / N Dollar Amount?

Do you know how much coverage you would need to pay off your debts and allow your family to maintain their current standard of living? Y / N

How much coverage are you interested in?

Are you interested in a Permanent Life policy to build cash value or Term Life for a specific period of time?

If Term, how long of time?

Underwriting/Rate Classification Questions

Has either of your parents, and/or sibling/s, passed or been diagnosed **before the age of 60** with Cardiac or Cancer issues?	Who?
If yes, from what condition?	Age of onset:
Do you have any personal health issues? Yes/No	
Condition:	Onset:
Treatments:	Medications:
If Cancer – Stage: Type:	
Location of cancer:	Diagnosis:
Treatments: Start: Stop:	Reoccurrences?
If Diabetes- onset date:	Sugar Count:
A1C count: Treatment – diet/medication/insulin/etc	
Any seizures?	
If Cardiac – was it a heart attack? Y / N	Multiple heart attacks? Y / N
Was by-pass surgery performed? Y / N	If yes, how many stents? Y / N
Complications?	Is blood pressure under control? Y / N
If mental health – diagnosis:	Any Hospitalizations? Y / N Length:
Any suicide attempts? Y / N	Under the care of physician currently? Y / N
Medications:	Currently employed? Y / N
Do you participate in any hazardous activities / hobbies?	
Do you currently, or have you ever, used illegal drugs? Y / N	When was the last use?
Number of driving tickets in the last 5 years:	
Any DUI/DWI/OWI's in the past 20 years? Y / N	If so, what year(s)?
Do you travel outside of the U.S. or Canada? Y / N	If yes, for what purpose?

Other Insurance

Disability Insurance protects your income in the event that you get injured and are unable to work. May we review your needs and provide a quote for you? (may be an option as a rider to your life policy)	Y / N
Personal Automobile and Homeowners Insurance protects you in the event you hurt someone or damage someone's property. May we review your current policy to make sure you understand your coverages and know how your policy will respond in the event of a loss?	Y / N
Are you enrolled in any voluntary benefits through your employer such as AFLAC?	Y / N

If so, define what type of policies?

Comments:

Referred By:

Agent's Signature
(person who completed the form) **Date:**

Client's Name
(person you completed the form with) **Date:**

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