

Medicare Client Needs Assessment  
Email: info@medicareformyparents.com  
Fax: (785) 783-5326

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Referred by: \_\_\_\_\_

Full Address: \_\_\_\_\_

Email: \_\_\_\_\_ Medicare ID/Number: \_\_\_\_\_

1. Do you currently have (Part A and/or Part B)? \_\_\_\_\_
  - a. If you do have Part A, what date did it start? \_\_\_\_\_
  - b. If you do have Part B, what date did it start? \_\_\_\_\_
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? \_\_\_\_\_

