Life Insurance Information Sheet

Source: _____

Date of Contact: _____

Appt. Date/Time_____

Phone: ( )_____Email: _____

Client/ Spouse: _____

Address:_____City:_____Zip:_____

I. Current Life Insurance: _____ Face amount:_____

II. Occupation:_____Spouse: _____

III. Recreational Activities: _____

IV. Current Health Insurance? Yes Current premium/Deductible:_____

V. Current Health Insurance? No, How long? _____

VI. Access to Group Health Insurance? Yes/No _____

VII. Heart Attack, Stroke, Cancer, Diabetes? Yes_____No_____ Which?_____

VIII. Ages of who needs the coverage? # in household:_____**Tobacco?**_____

IX. Primary (M/F) ____ _____ DOB: _____

Spouse (M/F) ____ _____ DOB: _____

_____

a. _____ _____

b. _____ _____

X. Necessary benefits: **Living Benefits?** _____ **Critical Illness?** _____ **Cancer?** _____

XI. Doctors: _____

_____

XII. RX Plan: YES _____ NO _____

XIII. Current **Medication:**_____

XIV. Current Life Insurance:_____

a. Additional Information/Life Insurance:

_____

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