CM BROKER /NEEDS ANALYSIS FORM (under 65)

Name: _____ **D.O.B.** _____

Adress: _____

ZIP CODE: _____ **COUNTY:** _____

PH#: _____ **EMAIL:** _____

_____

INSURANCE QUESTIONS: ***Please, answer these questions to better assess your current situation and recommend the best Plan for you and your Family. Thank You.***

Do you currently have insurance? ____NO ____ IF YES Which carrier? _____
How much is your premium? $_____ **How much is your deductible? $**_____
If known, how much is your Max out of Pocket? $ _____

Are you Married? ___Yes, ___No. What is your monthly budget for Health Insurance? $ _____
Do you use Tobacco? (including vape / chew) ___Yes ___ No. How many Family members to be included in your plan: _____ **If including your Spouse, please, provide**

Name: _____ **DOB:** _____ **Does she/He use Tobacco? ___Yes ___ No**

If including Children, please, provide information bellow:

Name_____ Gender:____ Tobacco user?___**Yes** ___ **No**
Name_____ Gender:____ Tobacco user? __**Yes,** ___ **No**
Name_____ Gender:____ Tobacco user? __**Yes,** ___**No**

Who do you claim in your taxes? _____ _ ___

When would you like to have a plan in place? _____
Medications that you and or your Family take: _____

_____

Is there a Preferred Provider that you are willing to pay more to keep? Y N _____

Any history of Cancer: Yes No, Heart Attack: Yes No, Stroke: Yes No , Diabetes: Yes No

If necessary, please, write any additional Medications or other pertinent information on the back of this form.