

WHAT WOULD YOU LIKE TO DISCUSS IN YOUR CONSULTATION TODAY?

ANNUITIES

- ► 401K Rollover
- ► Retirement Planning
- Safe Money Accounts (Upside Potential w/out the downside risk)

ACCIDENT MEDICAL / ACCIDENTAL DEATH

▶ Benefits Paid in the Event of an Accident

BUSINESS OWNERS

- ► Buy Sell Agreement
- ▶ Business Succession Planning
- Key Employee Coverage

CRITICAL ILLNESS

Cancer, Heart Attack, Stroke, etc.

DENTAL, VISION, HEARING

► Can be Individual or Combined Together

DISABILITY

- ► Individual
- Business Overhead Expense Coverage
- Key Employee

EMPLOYEE BENEFITS

Life, Accident, Hospital, Cancer, etc.

HEALTH INSURANCE

- ▶ On / Off Exchange
- ► Short Term Medical
- ► Christian Health Share
- ► Group Health

HOSPITAL INDEMNITY PLANS

► Reimburses for Hospital Stays, Ambulance, Emergency Room, etc.

LIFE INSURANCE

- ► Term Life (1, 5, 10, 15, 20, 25, 30, 35, 40)
- ► Universal Life (UL, GUL, IUL)
- ► Whole Life (Final Expense, Traditional)

LONG TERM CARE

- Nursing Home, Home Health Care, Assisted Living Facility
- ► Hybrid LTC / Life Insurance

MEDICARE ADVANTAGE PLANS

- ▶ Most Plans are Zero Premium
- ► Extra Venefits (Dental, Vision, Hearing, OTC, Gym Membership, etc.)
- ▶ Network Based
- Plans Vary Based on County

MEDICARE SUPPLEMENTS

- ▶ Plan G Pays 100% of Medicare Approved Charged After Part B Deductible
- NO Networks

PRESCRIPTION DRUG PLANS

▶ Plans Vary Based on County and Prescriptions

PROPERTY & CASUALTY

- Personal (Home, Auto, Renters, Umbrella, Motorcycle, Rec. Vehicle, Watercraft, Pet)
- Commercial (Business Auto, General / Professional Liability, Workers Comp, Business Owners Package, Bonds, EPLI)



| Client Legal Name: | | | | |
|---------------------------------|--------------|-----------------------------------|-----------|------------|
| Date of Birth: | | | | |
| Residential Address: | | | | |
| County of Residence: | | | | |
| Tobacco/NonTobacco user | · | | | |
| Medicare/Medicaid ID: | | | | |
| Effective Dates: | Α | | В | |
| Do you currently have a Me | dicare Plan? | | | |
| If yes, provide plan informa | tion: | | | |
| | | | | |
| | | | | |
| Primary Care Physician: | | | | |
| Specialist(s): | | | | |
| | | | | |
| Facilities or Hospitals: | | | | |
| Preferred Pharmacy: | | | | |
| | | | | |
| | | RIPTION INFORMA BELS TO ENSURE | | |
| Prescription Drug(s) Full Name: | | Dosage: | Quantity: | Frequency: |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |