Better Insure It .com

CLIENT DISCOVERY WORK SHEET

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First Name: _____ Last Name: _____ Middle Initial: _____

Current Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Annual House Hold Income (Before Taxes): _____ Total in House Hold: _____

☑ What types of insurance products are you interested in today?

- ☐ Annuities
- ☐ Pensions/401K
- ☐ Business Partner Life Insurance
- ☐ Disability
- ☐ Supplemental
- ☐ Group Benefits
- ☐ Health Insurance
- ☐ Dental Insurance
- ☐ Vision Insurance
- ☑ Life Insurance
- ☐ Short Term Care
- ☐ Long Term Care
- ☐ Final Expense

☑ Are you interested in Financial investments or a Financial portfolio review?

◯ Yes ◉ No

☑ Do you currently have health insurance?

◯ Yes ◉ No If Yes, who is the carrier? Not Applicable

☑ What is the Deductible AND Coinsurance?

Not Applicable

☑ Are you happy with your health benefits?

◯ Yes ◯ No ◯ Neutral If No, why not? Not Applicable

☑ What is your health insurance costing you per month?

Not Applicable

☑ Do you have any preferred physicians or specialists you see?

Names	Specialties	Visits per year	Date of last visit	Reason for visit

☑ Who else would you like to insure?

Names	DOB	Gender	Smoker	Zip-code

☑ If Yes for Tobacco Use, please answer Yes or No for each choice below:

Cigarettes: ◯ Yes ◯ No

Chew: ◯ Yes ◯ No

Gum, Patch, Cigars, Vapor: ◯ Yes ◯ No If yes, what kind: _____

☑ If quit, last date used:

_____

☑ Does anyone take Medications? (mgs/frequency)

Proposed Insured Names	Name of Medication	Mgs	Frequency/day	Date RX'd	Reason for taking

Medical Questions

☑ Is anyone applying for coverage:

- ☐ Now pregnant
- ☐ Expectant father
- ☐ In process of adoption
- ☐ Undergoing infertility treatment?
- ☐ Over 300 pounds if male or over 250 pounds if female?

☑ Within the last 5 years has anyone received any abnormal test results or been diagnosed, treated, consulted a healthcare professional or taken medication(s) for:

- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Amyotrophic lateral Sclerosis
- ☐ Amputation Due to Disease
- ☐ Bone Joint, Muscular Problems
- ☐ Brain Aneurysm
- ☐ Brain or Spinal Cord Tumors
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chest pain
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Cirrhosis of the Liver
- ☐ Crohn's Disease
- ☐ Degenerative Disc Disease
- ☐ Diabetes
- ☐ Double Heart Valve Replacement
- ☐ Emphysema
- ☐ Heart Disease including Heart Attack
- ☐ Heart surgery
- ☐ Hepatitis B, C, D or E
- ☐ Herniation
- ☐ Joint Injections
- ☐ Kidney disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Mixed Connective Tissue Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Disorders
- ☐ Myasthenia Gravis
- ☐ Neurological Disorder
- ☐ Parkinson's Disease
- ☐ Peripheral Arterial Disease
- ☐ Peripheral Vascular Disease
- ☐ Post Polio Syndrome
- ☐ Psychosis or Schizophrenia
- ☐ Pulmonary Hypertension
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Skin Ulcers
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcerative Colitis

☑ Within the last 5 years has anyone been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?

◯ Yes ◯ No

☑ Has anyone seen a psychiatrist more than 5 times during the last 12 months?

◯ Yes ◯ No

☑ Is everyone a US Citizen?

◯ Yes ◯ No

☑ If you are not a US Citizen, do you expect to legally reside in the US for the duration of the coverage? (Private Insurance does not cover expenses incurred outside of the United States or its possessions.)

◯ Yes ◯ No

☑ In the last two years has anyone had surgery or been recommended or scheduled for surgery by a licensed medical professional that has not been completed?

◯ Yes ◯ No

☑ Do you have a handicapped parking tag?

◯ Yes ◯ No If Yes, Why? _____

☑ Have you ever been on Disability?

◯ Yes ◯ No If Yes, Why? _____

☑ Have you ever been turned down for insurance coverage?

◯ Yes ◯ No

If yes, give type of insurance, date declined and reason for decline? _____

☑ Is there a history of heart disease or cancer in your immediate family?

Family	Age if living	Age at Death	Heart Disease or Cancer History?	Cause of Death
Father				
Mother				
Siblings				

Applicant(s) Cancer History

Type: _____ Date Diagnosed: _____

Treatment: _____ Stage: _____

Grade: _____ Lymph Node Involvement?: ◯ Yes ◯ No

Date of Last Treatment: _____ Any Recurrence? ◯ Yes ◯ No

If prostate cancer, please include pre-PSA: _____

Current PSA: _____

Gleason Score: _____

Applicant(s) Mental Illness/Depression/Anxiety History

Name of condition: _____ Date Diagnosed: _____

Severity: _____ Treatment: _____

Seeing a psychiatrist/psychologist: ◯ Yes ◯ No Attempted suicide? ◯ Yes ◯ No If yes, date(s): _____

Applicant(s) Heart Disease History

Heart Attack: ◯ Yes ◯ No If yes, please provide date(s): _____

Stroke: ◯ Yes ◯ No If yes, please provide date(s): _____

TIA: ◯ Yes ◯ No If yes, please provide date(s): _____

A-Fib: ◯ Yes ◯ No If yes, please provide date(s): _____

Bypass Surgery: ◯ Yes ◯ No # of Vessels: _____ Which Vessels? _____ % of Blockage: _____

Angioplasty: ◯ Yes ◯ No # of Vessels: _____ Which Vessels? _____ % of Blockage: _____

Applicant(s) Lung Disorder History

Type of Disorder: ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema

Treatment: _____ Severity: _____

Frequency of attacks: _____ Dates of hospitalizations/ER visits: _____

Applicant(s) Sleep Apnea History

Date Diagnosed: _____ Issued a C-PAP: ◯ Yes ◯ No C-PAP Compliant: ◯ Yes ◯ No

On Oxygen: ◯ Yes ◯ No Condition Degree: _____

Other Treatment: _____

Applicant(s) Diabetes History

Type I Type II: _____ Date Diagnosed: _____ A1C: _____

Any Complications (Retinopathy, Neuropathy, Nephropathy): ◯ Yes ◯ No

Applicant(s) Motor Vehicle Report/Recreational Hobbies/Hazardous Occupation
Driving infractions for the past 10 years

Speeding Tickets: ◯ Yes ◯ No Date(s) of Ticket(s)? _____

Explanation of Penalty (Fines, Community Service, Probation, Jail Time, Etc.) _____

DWI/DUI: ◯ Yes ◯ No Date(s) of DUI/DWI(s)? _____

Explanation of Penalty (Fines, Community Service, Probation, Jail Time, Etc.) _____

Tickets (Reckless Driving, Etc.): ◯ Yes ◯ No

Explanation of Penalty (Fines, Community Service, Probation, Jail Time, Etc.) _____

Loss or Suspension of License? ◯ Yes ◯ No

Dental Needs:

Will anyone require a root canal or crown this year?

◯ Yes ◉ No Name(s): _____

Who requires Dental Insurance?

Name(s): Not Applicable

Name of Dentist:

Not Applicable

Vision Needs:

Who requires Vision Insurance?

Name(s): Not Applicabe

Name of Optometrist:

Additional Information: