



Appointment Confirmation

Clients Name: _____ D.O.B _____ Spouse: _____ D.O.B _____

Address: _____ House or Apartment _____ City / Zip _____

Phone: _____ Date of Appointment: _____ Time: _____ Agent Name: _____

Spoke to: _____ Circle: Front Door / Back Door Knock / Door Bell Park in Street / Driveway

Appointment set by: Lead Card - Call in - Out bound call - Referral - Seminar Tele Scope #: _____ / paper scope

The Reason For Our Visit Today

1. Deliver and explain your **no cost** hearing & prescription discount cards.
2. Review the "Medicare you and book" video presentation and answer any questions you may have.
 - Have you received your New "Medicare and you" Book ? Y / N
 - Has a representative ever showed you the Medicare & You overview video? Y / N
3. Help you complete your New "Health Care Planning Document", which is an overview of your current health care coverage. If I see any gaps in your coverage, would you mind if I make a written recommendation and review the options that may be available?
4. PROVIDE A COMPLEMENTRY "LIFE INSURANCE" POLICY UPDATE & REVIEW
 - a. Explain the "Updated Medicaid Estate Recovery Mandate"
 - b. Order your Current "policy value statement"
 - c. Confirm with carriers all policies are accounted for and active.
 - d. Help order duplicate policies if lost from the carriers for your children.

PRESENTATION AND BENEFIT REVIEW

Was the information and benefits we went over today both educational and helpful? Y / N
Is there additional topics that you feel we should have addressed?

If there was one serious like-minded individual like yourself, such as a brother, sister or a close friend that you think these benefits would significantly help. Who would that one person be, that we could call right now?

Name: _____ Phone: _____ City: _____

Health Care Planning Documentation Form

If I see any gaps in your coverage or areas of concern, would you mind if I make a written recommendation and review the options that may be available?

Name: _____ D.O.B. _____ Date: _____
 Spouse: _____ D.O.B. _____ Phone #: _____
 Address: _____ Follow Up: _____
 # of Children: ____ # of Grandchildren: ____ # of yrs. Married: ____ Agent: _____

1. Are you enrolled in Medicare Part A & B? Yes / No Medicaid: Yes / No Do you go to the VA? Yes/ No
2. Have you applied for the Updated Federal L.I.S. Program (Single - \$1,507 Married - \$2,030)? Yes/No
 - Current monthly income: SS \$_____ / _____ Pension \$_____ / _____ Other \$_____ / _____
3. Are you enrolled in a \$0 Premium Medicare Part C Plan? Yes / No Did you add the Advantage Plus rider, which covers your copays and deductible's for Hospital, Ambulance and Skilled Nursing? Yes/ No
4. Are you on a Medicare Supplement Plan? Carrier: _____ Premium \$_____ # of years ____
 - Did you choose \$0 deductible with a **Higher** premium or *the \$183 deductible* with lower premium? F G
 - What would interest you more with your Medicare supplement? Having a **lower monthly premium** with the same Benefits? or Keeping your **premium the same** but adding *more Benefits?* _____
 - Do you take prescriptions? Yes / No Part D (Rx) Drug carrier? _____ Premium \$_____
5. Do you have a Dental, Vision & Hearing coverage? Yes / No If No, how do you pay? _____
6. Does Cancer / Heart Attack / Stroke run in your immediate family? Yes / No Which illness? _____
7. In the event you were to need Home Health Care, do you have a plan that allows your spouse or a family member to be the **Care Manager** and not the **Care Giver**? Yes / No Plan type? _____
8. Do you currently have life insurance? Yes / No Are you still paying? Yes / No Type: WL / TERM / UL
 - Face Amount \$_____ # of years paying? ____ How many policies? ____ Premium: \$_____
 - Are you aware that you may be eligible for a premium reduction or an increase in coverage on you current life insurance policies if your policy has been in force for over 2 years? Yes/ No
 - If you have **No Life or Final expense policy**, Who or How will your burial be paid for? _____
9. Do you have an updated- Will, Living Will, Medical P.O.A as well as Identity Theft protection plan? Yes/No
10. Have you looked into how a Reverse Mortgage can pay off debt, be used to transfer the equity to your children tax free or be used as a guaranteed lifetime income? Yes/No
11. Do you currently have your SAFE / Retirement Savings invested in the following?
 - Would you be interested in learning how to **protect your principal** and transfer your retirement to your **children tax free** when you pass away? Yes / No
 - CD \$_____ Annuities/IRA \$_____ Money Market \$_____ Savings\$ _____ 401k \$_____
 - What is your average interest earned? ____ Do you let it roll over or draw an income from it? _____
 - Are you using your retirement to? Leave to your children / Take an income / Other? _____
 - Are you interested in learning about a **NEW IRA Annuity** that provides **100% principal protection** and pays a **Guaranteed Life Time Income that you cannot out live?** Yes / No
12. Now that we have identified the gaps in your coverage, which are your **biggest concerns?**
 - 1.) _____ 2.) _____ 3.) _____

“Before I make a recommendation, let me ask you a few more questions to make sure I fully understand your current concerns”

CANCER – HEART ATTACK – STROKE QUESTIONNAIRE

The following questions are only being asked to allow me to make the best educated recommendation.

1. Does Cancer, Heart Attack or Stroke **run in your family**? _____
2. Please describe **which family** members and how old were they? _____
3. Which Illness did they have and did they have a long recovery? _____
4. Have you had to **help take care** of a family member or friend with 1 of these illnesses? If so, please describe what type of care they **required**? _____
5. How did it **financially affect** that family member? _____
6. Were they **hospitalized** and if so, for how long? _____
7. If you were to have 1 of the 3 listed illnesses, **how would you pay** for your copays and deductibles on the medical bills, doctor bills, specialist and medications? _____
8. With your family history, **are you concerned** you may face one of these illnesses? _____
9. With Medicare and all Medicare plans not covering **experimental treatments** **how would you pay** for them to have a better chance of recovery? _____
10. While recovering from one of these illnesses **how beneficial** would it be in your recovery to have someone clean your home weekly, make meals for you, assist you with daily activities, have additional money to pay copays and deductibles, be able to alter your home entrance and bathrooms to accommodate your challenges? Please describe? _____
11. Now I have a better understanding of **your family history** with these 3 major illnesses let me make a recommendation that can provide you peace of mind. _____

CANCER PROTECTION

\$ 5,000 Lump Sum

COVERAGE BENEFITS

Invasive Cancer – 100%

Non-Invasive Cancer – 25%

Continuous Coverage Benefit

* Years 2-5 recurrence- 25% / 10%

* Years 5-10 recurrence- 75% / 25%

* Years 10 + recurrence- 100% / 25%

\$ _____ Monthly Premium

HEART ATTACK & STROKE PROTECTION

\$ 5,000 Lump Sum

COVERAGE BENEFITS

Heart Attack – 100%

Heart Transplant – 100%

Stroke – 100%

Artery Bypass Surgery – 25%

Aortic Surgery – 25%

Heart Valve Replacement – 25%

Angioplasty – 10%

Stent - 10%

\$ _____ Monthly Premium

CANCER, HEART & STROKE PROTECTION

\$ 5,000 Lump Sum

COVERAGE BENEFITS

Cancer, Heart Attack, Stroke + Disease

* A.L.S.

* M.S.

* PARALYSIS

* COMA

* E.S.R.D

* SEVERE BURNS

* ORGAN TRANSPLANT

\$ _____ Monthly Premium

*Note: Use monthly premium to increase Lump Sum Coverage in increments of \$5,000.

Contact Us at **630-426-9714** www.theinsuranceadvisor.net (click tab "need help") **Agent name:** _____



Client Servicing Form

I am choosing to have all of my contact information:

- I fully understand that by having my contact information **updated** a licensed agent and health care specialist will notify me of:
- I fully understand that by having my contact information **removed** a licensed agent and health care specialist will no longer notify me of:
 - The yearly coverage and cost changes to Medicare
 - The yearly updates to Medicare Part A (Hospital Insurance)
 - The yearly updates on Medicare Part B (Medical Insurance)
 - The yearly changes to Medicare Part C (Medicare Advantage)
 - The yearly changes to Medicare Part D (Medicare prescription drug coverage)
 - Updates regarding the changes in the Medicare Estate Recovery Mandate which recovers the cash value from life insurance policies owned by the client and /or spouse for the repayment of medical bills

To complete the process and to better serve the members of our community please answer the following question and sign below.

When you decided to enroll the Medicare Advantage Plan, what did you like best about the benefits?

After you enrolled in the benefit what did you like the least about the benefits?

What would you change to make the benefits better for other members?

Who is your Doctor? _____ Is your Doctor in the network ___ Yes / ___ No

Does your Doctor like the plan? ___ Yes / ___ No.

Client Name: _____

Advisor's Name: _____

Client Signature: _____

Date: _____

Client Phone #: _____



DENTAL – VISION – HEARING QUESTIONNAIRE

The following questions are asked so I can better understand your concerns and make an educated recommendation.

1. When was the **last date** you went to the dentist and what did you have done? _____
2. Do you **currently have** any dental work that needs to be done? Describe _____
3. How do you **currently pay** for your dental work? _____
4. When you had a dental plan thru work **did you go** to the dentist more regularly? _____
5. If you needed major dental work would you be able to **pay or would you put it off** if possible? _____
6. If you have false teeth or a crown, **how long** have you had them, have they **needed repaired** and are they getting **worn down or loose**? _____
7. Do you find **yourself not going** to the dentist regularly because you have to pay out of pocket? _____
8. Do you **currently wear glasses** and if so when did you buy your last pair? _____
9. Are your glasses **due** for a new prescription? _____
10. How often do **you buy a new pair** of glasses? _____
11. Do you choose a new pair of glasses **based on the price** because you are paying out of pocket? _____
12. Do you currently have **problems hearing** and if so have you seen a doctor yet? _____
13. If you currently have **hearing problems**, do you find yourself not getting tested or help because of the cost of new hearing aids? _____
14. Do you currently **have hearing aids** and if so when were they purchased? _____
15. Have you looked into **replacing or repairing** your current hearing aids? _____
16. Describe **important benefits** to you in a Dental, Vision and Hearing plan? _____
17. Now I have a better understanding of the type of coverage you need, let me explain the **benefits** provided by the 3 plans currently available in your area.

Bronze Plan-\$9.95

Add Spouse \$5.00

1 time \$20 Enrollment Fee

***FEE BASED PLAN**

NETWORK ONLY PLAN
No Yearly Deductible
20% - 60% Savings Agreement
No Cap and No Limit on Use
No Waiting Period
Sample Fee Schedule
* Cleaning Regular \$118
With Plan \$56
* Root Canal Regular \$1299
With Plan \$676

SILVER PLAN W/ TELEMEDICINE -\$12.95

Add Spouse \$2.00

1 time \$20 Enrollment Fee

***FEE BASED PLAN**

NETWORK ONLY PLAN
No Yearly Deductible
20% - 60% Savings Agreement
No Cap and No Limit on Use
No Waiting Period
<ul style="list-style-type: none"> • 24 Hour Doctor / \$0 Co-Pay • MD returned call within 3 hours • Writes prescription to your local pharmacy

GOLD PLAN

INDIVIDUAL ONLY

Enrollment Fee Waived

\$1,000 / \$1,500 Benefit

**** NO Network ****

AGE	PREMIUM
18 – 54	\$31 / \$41
55 – 64	\$33 / \$44
65 – 79	\$35 / \$46
80 – 89	\$38 / \$49

\$100 yearly deductible
1 st year 60% coverage
2 nd year 70% coverage
3 rd year 80% coverage
Day1- fillings, extraction, eye exam
3 month wait for cleanings & examination X-ray
6 month wait eye glasses, contacts
12 month wait bridge, crown root canal, denture, partials, hearing aid
** Bronze Plan included for free

Contact Us at **630-426-9714**

www.theinsuranceadvisor.net (click tab "need help")

Agent name: _____

No Cost Hearing Benefit and Prescription Discount Card

I would like to sponsor my family and friends to receive these no cost benefits on my behalf.

Sponsor Name: _____ Date: _____

Signature: _____

No Cost Hearing Benefit Card

<u>Name</u>	<u>Address</u>	<u>Phone</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

No Cost Prescription Card

<u>Name</u>	<u>Address</u>	<u>Phone</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

New Changes In Medicare Benefits

Hello, I am with The Insurance Advisor. How are you today? Great, I am out here today just to introduce myself. We recently mailed you a card about the **New Changes in Medicare Benefits**. I “service the area” and I have “been assigned to you” as your Health Care Specialist and it’s my job is to deliver the information to you.

Do you recall receiving that card in the mail or mailing that card back in? **(Required: Report answer to Home office)**

Returned and waiting for information **Never received the card** **May have thrown away**

- My job is to make sure you receive the current Updates.
- We work by appointment only.
- Please select the information you would like to receive.

- Explanation of the 3 NEW Approved “Dental, Vision & Tela-Med” plans for Illinois
- See if your current Medicare supplement or Health Care qualifies for a reduction in premium
- Explain the Advantage Plus Benefit, which covers Hospital Co-Pays & Deductibles
- Do you qualify for **any** or **all** of the 6 - Home Owner Tax Exemptions
- Help complete your New HCPD Form - A brief overview of Health Care gaps or concerns
 - See if you qualify for the New Federal L.I.S. Prescription Drug Program
- Receive a “Life Insurance” Policy **update** and **review**
 - Explain “Updated Estate Recovery Mandate”
 - Help order your Current “Life policy value statement”
 - Confirm all policies are accounted for and active with your carriers
 - Help order duplicate policies if lost, for your beneficiary.
- Request a Life Insurance Quote for: Myself Spouse Children Grand Children

APPOINTMENT CONFIRMATION

❖ What time would work best to deliver and explain the following information? M T W T F ___a.m. / ___p.m.

Clients Name: _____ D.O.B _____ Spouse: _____ D.O.B _____
 Address: _____ City / ZIP: _____ Phone: _____
 Spoke to: _____ Date of Appointment: _____ Agent Name: _____

I am requesting an appointment to receive information on the Updates and New Plans available. **Initial:** _____



HOME HEALTH CARE QUESTIONNAIRE

The following questions are asked only to help us better understand your family history and concerns that you may have in the event you need recovery care, allowing us to make an educated recommendation.

1. In the event you were to get sick or accidentally fall and be injured and require daily care. Would you **want to receive your care** at Home, in an assisted living or nursing home? Explain _____
2. Have you ever had to help care for a family member or loved one? Yes / No What type of care did they require and **for how long each day?** _____
3. Would you want your spouse and children to be your? **Care Giver or the Care Manager?**
4. If you were to slip and fall, have a mild stroke, heart attack or battle cancer, **who** would take care of you and describe how that might **impact their daily life?** _____
5. Is your spouse or children **physically able** to lift you out of the bathtub, bed and do they have medical training? Yes / No
6. Who would take care of you, while your loved ones took care of their children, ran errands, went to work or did the weekly shopping? _____
7. Would having a plan in place that allowed for family members to be the Care Managers give you better peace of mind? Yes / No
8. Has anyone explained the New Home Health Care Plan with premium prescription reimbursement? Yes / No
9. Now I have a better understanding about your recovery care concerns. Let me explain how a Home Health Care Plan will allow your loved ones to **be the care managers and not the caregivers**. Let's see how much you qualify for in prescription reimbursement which will help cover the home health care plan monthly premiums.

HOW THE PREMIUM PRESCRIPTION DRUG REIMBURSEMENT WORKS

\$10 Generic Reimbursement	\$10 Generic Reimbursement	\$10 Generic Reimbursement
\$25 Brand Reimbursement	\$25 Brand Reimbursement	\$25 Brand Reimbursement
*Total \$300 Drug Reimbursement	*Total \$600 Drug Reimbursement	*Total \$600 Drug Reimbursement

Choose the Peace of Mind Plan that best fits your needs

<u>Peace of Mind- Bronze</u>	<u>Peace of Mind- Silver</u>	<u>Peace of Mind- Gold</u>
Up to 9.5 Hours Daily x 1 Year	Up to 19 Hours Daily x 1 Year	Up to 24 Hours Daily x 1 Year
*Day 1 coverage	*Day 1 coverage	*Day 1 coverage
\$40 Per Day Home Aide	\$80 Per Day Home Aide	\$120 Per Day Home Aide
Up to \$150 Per Day Home Benefit	Up to \$300 Per Day Home Benefit	Up to \$450 Per Day Home Benefit
6 Month Restoration Benefit	6 Month Restoration Benefit	6 Month Restoration Benefit
*Total \$54,000 of Home Care	* Total \$108,000 of Home Care	*Total \$162,000 of Home Care
\$ _____ Monthly Premium	\$ _____ Monthly Premium	\$ _____ Monthly Premium

Client name: _____ Address: _____ phone: _____ Agent name: _____



ILLINOIS 6 - HOME OWNERS TAX EXEMPTIONS

1. The Homeowner Exemption: Provides tax relief by reducing the equalized assessed valuation of an eligible residence. You can receive the Homeowner Exemption if you own or have a lease or contract which makes you responsible for the real estate taxes of the residential property. It must also be used as your principal place of residence for the year in question.

2. The Senior Citizen Exemption: Provides tax relief by further reducing the equalized valuation of an eligible residence. This savings is in the form of a deduction on the second-installment real estate tax bill.

***State law requires that senior citizens reapply annually for the Senior Exemption.**

*** Must be 65 or older – Own the property or responsible for the real estate taxes & must be your principal residence.**

3) The Senior Freeze Exemption: Allows qualified senior citizens to apply for a freeze of the equalized assessed value (EAV) of their properties for the year preceding the year in which they first apply and qualify for this exemption.

- been born prior to or in the year 1951,
- a total household income of \$55,000 or less for income tax year 2015,
- owned the property or had a legal, equitable or leasehold interest in the property on January 1, 2015 and January 1, 2016,
- used the property as a principal place of residence as of January 1, 2015 and January 1, 2016, and
- been liable for the payment of 2015 and 2016 property taxes.

4) The Home Improvement Exemption: Allows you to increase the value of your home with up to \$75,000 worth of improvements without increasing your property taxes for at least four years. You will automatically receive the exemption when our office field checks the building permit for the improvement. To learn whether you may qualify for the Home Improvement Exemption, call your County Assessor's Office.

ILLINOIS 6 - HOME OWNERS TAX EXEMPTIONS

5) Disabled Veterans Exemption: Veterans with a service connected disability as certified by the U.S. Department of Veteran Affairs are eligible for this annual exemption.

Taxable Years	% of Disability	Exemption Amount
2011 – 2014 (Tax Years)	70% and greater	\$5,000
	50 – 69%	\$2,500
2015 and thereafter (Tax Years)	30% - 49%	\$2,500
	50% - 69%	\$5,000
	70% and greater	Total Exemption

- be an Illinois resident who has served as a member of the U.S. Armed Forces on active duty or on active duty in the state of Illinois, Illinois National Guard, or U.S. Reserve Forces and have been honorably discharged
- have at least a 30% service-connected disability certified by the U.S Department of Veterans' Affairs,
- own and occupy the property as the primary residence on January 1st of the tax year in question, and
- have a total EAV of less than \$250,000 for the primary residence, excluding the EAV of property used for commercial purposes or rented for more than 6 months.
- A non-remarried surviving spouse of a disabled veteran may continue to receive this exemption if the same primary residence continues as such for the surviving spouse. Or, the non-remarried surviving spouse may transfer the exemption amount (or less) to a new primary residence.

6) Disabled Persons Exemptions- This exemption provides disabled persons with an annual \$2,000 reduction in the equalized assessed value (EAV) of the property.

- be disabled or become disabled during the Tax year,
- own or have a legal or equitable interest in the property, or a leasehold interest in a single-family residence,
- occupy the property as the principal residence on January 1st of the tax year in question, and
- be liable for the payment of property taxes.

If a person's home previously received the Disabled Persons' Exemption and the taxpayer now resides in a facility licensed under the Nursing Home Care Act, his or her home is still eligible to receive this exemption provided:

- the property is occupied by the spouse, and
- the property remains unoccupied.

Spouse can claim this exemption if Disabled Spouse has passed away and they never claimed when the Disabled Spouse was alive.

WILL–LIVING WILL–HEALTHCARE P.O.A–IDENTITY THEFT

The following questions are asked so I can better understand your concerns and make an educated recommendation.

TERM EXPLANATION: (Medicare and you book)

- **WILL** - Declares who gets your belongings and assets when you die. If you do not have a will, the distribution of your property is left up to the government, and may even end up becoming state property.
- **LIVING WILL** - Outlines specific medical instructions to be applied if you are alive but are unable to communicate your wishes for yourself. (Limited to deathbed concerns only, your wishes if there’s no hope of recovery. Example- DNR)
- **HEALTHCARE POWE OF ATTORNEY** – Empowers a family member or friend to make decisions regarding **healthcare** and **medical** treatment. (Covers all health care decisions, and lasts only as long as you are incapable of making decisions for yourself.)
- **IDENTITY THEFT** - Crime in which an imposter obtains **YOUR** personal information, Medicare or healthcare information, Social Security or credit information in order to steal your identity. **ALSO** most common is corporate breaches, like the recent Anthem/BCBS medical info breach and Walmart credit card information breach.

Do you feel it is important to have a will, living will & medical power of attorney?..... Yes / No

1. Have you discussed a DNR – (do not resuscitate) in the case of a medical emergency? Yes / No
2. If you do not have a will, living will or medical p.o.a., is cost the reason you have not done so? Yes / No
3. If you have a will, when was it last updated? _____ How much would it cost to update? _____
4. Do you have access to a trusted law firm that works with multiple different issues? Yes / No
5. If you were to have a legal issue that required a lawyer, could you afford one at this time? Yes / No
6. Would you like to have access to a Law Firm 24 hours a day to review documents, answer questions you may have, send letters on your behalf and represent you in court if ever required? Yes / No
7. Have you ever been a victim of identity theft? Yes / No Explain: _____
8. Do you have concerns or are you worried about being a victim of identity theft? Yes / No
9. Who would you call if your identity, purse or wallet was stolen to get help? _____
10. Now I have a better understanding about your concerns, let me make a recommendation that can provide you with a peace of mind these issues are taken care of.

<u>LEGAL SHIELD</u>	<u>IDENTITY THEFT</u>	<u>LEGAL SHIELD W/ IDENTITY THEFT</u>
*Primary member	*Primary member	*Primary member
*Spouse	*Spouse	*Spouse
*Children under 21/ college 23	*Children under 21	*Children under 21
Will, Living Will & Healthcare P.O.A. (Updated annually)	Complete credit restoration	**Benefits of Legal Shield
Unlimited Legal Advice	Correct identity theft issues	**Benefits of Identity Theft
Unlimited Letters & calls on your behalf	Triple bureau credit monitoring	
Review Contracts & Documents	Proactively search your credit	
Traffic court violations / DL issues	Proactively search your name	
50 hours of IRS audit assistance	Lost wallet assistance	
300 hours of Trial defense	Provide fraud alerts	
24/7 Emergency Lawyer access	Internet Monitoring	
Online legal forms	Corporation breach protection	
25% Preferred member discount	Corporation breach protection	
<u>\$19.95 Monthly Premium</u>	<u>\$14.95 Monthly Premium</u>	<u>\$29.95 Monthly Premium</u>

Contact us at 630-400-5445

www.theinsuranceadvisor.net

Agent name: _____

FINAL EXPENSE & LIFE INSURANCE QUESTIONNAIRE - REVIEW

The following questions are asked only to make an educated recommendation.

(If you currently have NO COVERAGE, start with question # 10)

1. What type of **Life Insurance Policy** do you have? Whole Life / Term / U.L / Not Sure – Date Purchased? _____
2. Has the **premium stayed?** Level / Increased / Decreased / Stopped *Have you taken a loan on the policy? Y / N
3. Who **choose** the amount of Coverage & Type of insurance? You / Agent Why? _____
4. When was the **last time** you did a **Full Review and Update** of your life insurance policies? _____
5. Have you ordered your current **cash value, paid-up and loan value** statement for 2015 yet? Yes / No
6. Have you **ever** called the carrier and confirmed your policy **WILL NOT lapse** before you pass away? Yes / No
7. Do you understand the **paid-up insurance option** on your current Policy? Yes / No
8. Are you aware of “The New Estate Recovery Mandate” which forces seniors to cash in their Life Insurance policies with cash values over \$1,500 in 2015? Yes / No
9. What would interest you more? **Reduce** your monthly premium and **keep** the **same face amount?** **Keep** the same monthly premium but **increase** the face amount on your life policy? Reduce premium / Same premium
10. **What do you think the Cost of a Funeral or Cremation is Today?** \$ _____ / \$ _____
What about 5 Years Ago? \$ _____ **Estimate it will be in 5 Years?** \$ _____
11. Have you ever **helped** plan a funeral? Who? _____ Did they have enough coverage? Yes / No
12. If your policy **did not cover** the full amount, **who** would pay the difference and **how?** _____
13. Besides covering the funeral or cremation is your policy **intended** to cover **any other expenses**, if so please explain? _____
14. One S.S. check and sometimes a pension **ends** when a spouse passes away. How many years of spousal S.S. income would you **need to readjust your life?** 1 year / 2 years / 3 years / + more
15. If you could **leave a tax free financial legacy** to your children or grandchildren would you be interested in learning how you could do that using a tax free final expense policy? Yes / No
16. Now I have a better understanding of your final expense wishes, let’s discuss some recommendation.

New Coverage

<u>Burial Expense Only</u>		<u>Burial + Final Expenses</u>		<u>Burial + Final Expenses + Adj Income</u>	
\$	Premium	\$	Premium	\$	Premium
\$	Coverage	\$	Coverage	\$	Coverage

Existing Coverage “Paid-up Option”

OPTION “A” - Reduce Premium = Same Coverage

\$ _____ Current face amount
 (-) \$ _____ Current Paid-up insurance
 (=) \$ _____ New face amount needed
 (\$ _____) Total **Same face amount**
 * \$ _____ **New reduced premium** for same coverage

OPTION “B” - Same Premium = Increase Coverage

\$ _____ Current Paid-up insurance
 (+) \$ _____ New face amount that the current premium can buy
 (=) \$ _____ **Increased Total face amount** for the **same premium**

**** Which option would you like to do?**

Option “A” Reduce your monthly premium for the same coverage?

Option “B” Keep your monthly premium the Same but Increase your coverage?

Contact Us at **630-400-5445**

www.theinsuranceadvisor.net (click tab “need help”)

Agent name: _____

MEDICARE ADVANTAGE CO-PAY REVIEW WORKSHEET

Basic HMO and HMO-POS	
MOOP \$2,800 - \$6,700	
Primary Care Provider	Up to \$12
Emergency Care	\$80
Specialist	Up to \$50
Urgent Care	Up to \$50
Ambulance	Up to \$325
In Patient Hospital Days 1 – 7	Up to \$500
Skilled Nursing Days 1 - 20	\$0
Days 21 - 100	\$167.50
Outpatient Surgical	Up to \$325
Outpatient Hospital	Up to \$325
Lab Services	Up to \$35
X-Ray	Up to \$50
Diagnostic Radiology	Up to \$325
Therapeutic Radiology	Up to \$325
DME	20%
Prescription Drugs Included	

		Partial Plan	Complete Plan
Emergency Care	\$80	Pays You \$150	Pays You \$150
Ambulance	\$	Pays you \$200	Pays you \$200
In Patient Hospital Days 1 –	\$	Pays Hospital Co-Pay	Pays Hospital Co-Pay
Skilled Nursing Days 1 - 20	\$0		Pays you \$200 per day
Days 21 - 100	\$167.50		for days 1 - 50
		\$	\$



MEDICARE QUESTIONNAIRE

The following questions are asked only to help us better understand your knowledge and concerns with your health care options, allowing us to make an educated recommendation.

1. Have you **read** the entire Medicare and You book? If so when? _____
2. Are you aware, that **you Now** have **2 options** to receive your Medicare coverage? _____
3. Did **you** or an **agent**, choose your **current** Medicare coverage? _____
4. Did you purchase the **partial** or **complete** health care plan? _____
5. Do you meet with a licensed **agent, every year** to learn about the new Medicare changes? _____
6. Have you ever **compared** Medicare supplement company's **premiums**? Which ones? _____
7. Do you understand the **differences** between Medicare supplement **plans F, G, and N**? _____
8. If you could reduce your monthly premium and keep your Medicare supplement, would you be interested in learning more? _____
9. **How long** have you been going to your primary care doctor and specialist? _____
10. How did you **choose**, your primary care & specialist? _____
11. Have you **ever compared** a Medicare supplement vs Medicare Advantage plan? _____
12. If you had **to change** your primary care doctor in order to reduce your premium and get more benefits, would that interest you and why? _____
13. Do you know the **advantages and disadvantages** of a Medicare Advantage plan? _____
14. If you currently have a Medicare Advantage Plan and could reduce or eliminate the copays, would you be interested in learning more? _____
15. Have you compared **prescription drug plans**, to make sure you are taking advantage of all the benefits? _____
16. During AEP, do you compare which drug plan is **best for you** and offers the lowest copays? _____
17. What do you like **best** about your current health care plan? _____
18. What do you like **least** about you current health care plan? _____
19. If you could **add** more benefits to your current health care plan, what would they be? _____
20. Please describe your perfect health care plan benefits? _____
21. If I could show you a plan like the one you have just described would you be interested in learning more about it? _____

Now I have a better understanding of the type of coverage you need,
let me make a recommendation that **provides the benefits** you are looking for in a plan



*** IMPORTANT NOTE:

*** Medicare & Medicare Supplements only cover **Skilled Nursing** for up to 90 days if a Doctor certifies the need. An example would be receiving intravenous injection or daily physical therapy. **Long Term Care & Custodial care ARE NOT** covered, for example hip replacement or intermediate care. The "Medicare & You Book" also explains there must be 3 requirements met to be covered under Medicare and Medicare supplements. 1- Must stay 3 consecutive overnight stays in a hospital room. 2- Must be admitted into **Skilled care only**. 3- Must be showing signs of improvement, which is difficult for stroke victims after 2 or 3 weeks a lot of times they become stable and therefore coverage stops.

***Medicare Advantage Plans **do not require** any hospital stays for skilled nursing to be covered.

MEDICARE SUPPLEMENT QUESTIONNAIRE

The following questions are asked only to help us make an educated recommendation.

1. Did **your agent show you or compare all of the different** Medicare Supplement Plan options? Yes / No
2. What made you choose your current supplement plan? _____
3. Have you **compared** other Medicare supplement company's **premiums for the same plan**? Yes / No
4. Do you understand the **different benefits offered** between supplement **plans F, G, and N**? Yes / No
5. During AEP, do you compare which Part D drug plan is **best for you** and offers the lowest copays? Yes / No
6. How many of your prescriptions are? _____ generics _____ brand name / 30 day or 90 day supply

Original Medicare part A & B Co-Pays & Deductibles	Current Plan Premium	Recommended Plan Benefits and Premium		
	\$	\$	\$	\$
Benefits		F	G	N
Medicare Part A coinsurance and hospital cost (up to an additional 365 days after Medicare benefits are used)		100%	100%	100%
Medicare Part B Coinsurance or copayment		100%	100%	100% \$20 DR / \$50 ER
Blood (first 3 pints)		100%	100%	100%
Part A hospice care coinsurance or copayment		100%	100%	100%
Skilled nursing facility care coinsurance		100%	100%	100%
Part A deductible		100%	100%	100%
Part B deductible		100%	(you pay \$147)	(you pay \$147)
Part B excess charges		100%	100%	(15% limiting charge)
Foreign travel emergency (up to plan limits)		80%	80%	80%

Prescription Drug Rx Card

Current Rx Carrier:														
Premium \$					Premium \$					Premium \$				
Deductible \$					Deductible \$					Deductible \$				
Tier's 1 – 5 Co Pays					Tier's 1 – 5 Co Pays					Tier's 1 – 5 Co Pays				
Preferred Mail Order 90 days					Preferred Mail Order 90 days					Preferred Mail Order 90 days				
← Donut Hole / Coverage Gap →														

Contact Us at **630-426-9714** www.theinsuranceadvisor.net (click tab "need help") Agent name: _____

RETIREMENT QUESTIONNAIRE

The following questions are asked only to make an educated recommendation to help protect and enhance your retirement savings.

Name: _____ Address _____

Phone: _____ Agent: _____ Date: _____

- 1.) What is **the source** of you and your spouse's **monthly income**:
S.S. \$ _____ \$ _____ Pension- Half or Full \$ _____ \$ _____ Rental Property \$ _____ Investments \$ _____
- 2.) **Total monthly Income**: \$ _____ (-) **Total monthly Expenses**: \$ _____ (=) **Net Monthly Savings**: \$ _____
- 3.) Do you have **money set aside** for unexpected home repairs, medical expenses or emergencies? **How much** \$ _____
- 4.) What was your **retirement plans** for your money? Has that **changed**? _____
- 5.) What type of investments are your **retirement savings currently in**?
401K \$ _____ Annuities / IRA's \$ _____ Money market \$ _____ Checking & Savings \$ _____
CD's \$ _____ Stocks \$ _____ Rental Properties- Net Equity \$ _____ Reverse Mortgage? _____
Are you expecting any Inheritance? Real Estate \$ _____ Investments \$ _____ Life Insurance \$ _____
- 6.) What do you **like Best** about your current investments? _____
- 7.) What **concerns do you have** about your current investments? _____
- 8.) What type of investments do you feel **Most comfortable with for protecting** your retirement?
 Guaranteed Fixed account earning 1% - 3%
 Indexed account with capped upside gains of 3-8% but **Protection** from a negative downside market with a 0% floor
 Variable Annuity / Stocks account with uncapped gains but also **unlimited losses due to negative downside market**
- 9.) What interest you more? **A Guaranteed Monthly Life Time Income** or Letting your **retirement grow**? _____
- 10.) With the **Guaranteed monthly income** would you:
 Pay your bills set money aside in an emergency account Be interested in learning how to pass your retirement TAX FREE to your beneficiaries Help your children and Grandchildren pay their bills
 Travel Other, please explain. _____
- 11.) If you let your **retirement grow**, would that be for future income or to leave to your beneficiaries? _____
- 12.) Have you looked into **A pension protection** or **social security protection Plan** for your spouse? Y / N Type: _____
- 13.) When **making a investment decision**, do you: A) Discuss it with your children first B) Make your own decisions
- 14.) Are you interested in learning about "**Money Guard**" a product for CD's, Savings and Money Market assets which provides 100% lump sum access to your money without penalty, bypasses probate giving your money tax free to your beneficiaries when you pass away and provides a 6 year long term care policy if needed at no cost? Y / N

Now I have a **better understanding about your retirement goals**, let me do some research on which products **best fits** into your retirement plans and I will return with a written recommendation.

Follow up appointment: Date _____ Time _____

Contact Us at 630-400-5445 www.theinsuranceadvisor.net (click tab "need help") Agent name: _____

SHORT TERM CARE QUESTIONNAIRE

The following questions are asked only to help us better understand your family history and concerns that you may have in the event you need recovery care, allowing us to make an educated recommendation.

1. In the event you need care would you **want to receive** it at home, assisted living or a nursing home?
Explain _____
2. Has a family member **ever received** home care, adult day care, assisted living or nursing home care? Please describe **where and what type of care** they received? _____
3. Have you ever had to **care** for a loved one **or put them** into a nursing home? Who and how did you feel? _____
4. Would you want your spouse and children to be the **care manager** or have them be **the care giver**? _____
5. Is your spouse or children in a position to **quit their job** so they can provide 12 to 24 hour care? _____
6. If you were to slip and fall, have a mild stroke, heart attack or battle cancer, **who** would take care of you? Describe how that might **impact their life**? _____
7. Is your spouse or children **physically able** to lift you out of the bath tub or bed or have medical training? _____
8. With assisted living costing around \$3400 and Nursing homes costing around \$5500 per month. Which of your **assets would you use first** and how many months/years would it take before you had **depleted them all**? _____
9. Do you understand what Medicare, Medicare supplements and Medicare Advantage plans **cover and do not cover** for short term and Long Term Care? (**see important note below for explanation**) _____
10. Were you aware if you needed care and **had NO plan in place** you would have to **spend down all of your assets** first and then a lean would be placed on your home and assets if Medicaid were to have to pay? _____
11. Describe a plan that you would like to **have in place** that would give you peace of mind in the **event you needed** home care, assisted living or nursing home care? _____
12. Now I have a better understanding about your recovery care concerns, lets discuss my recommendation and how it will allow your loved ones to **be the care managers and not the care givers**? _____

*** **IMPORTANT NOTE for #9:** Medicare & Medicare Supplements only cover **Skilled Nursing** for up to 100 days if a Doctor certifies the need. An example would be receiving intravenous injection or daily physical therapy. **Long Term Care & Custodial care ARE NOT** covered, for example hip replacement or intermediate care. Page 39 of the "Medicare & You Book" also explains there must be 4 requirements met to be covered under Medicare. 1- Must stay 3 consecutive overnight stays in a hospital room. 2- Must be admitted into **Skilled care only**. 3- Must be showing signs of improvement, which is difficult for stroke victims after 2 or 3 weeks a lot of times they become stable and therefore coverage stops. 4- Staying in the hospital for observation does not count as a qualifier.

*** **National Average Only Cost, May differ by State:** Home care- \$20 per hour / Adult Day Care- \$65 per day
Assisted Living- \$ 3,300 per month / Nursing home- \$ 6,000 per month / Hospice- \$4,500 per month

Choose the Peace of Mind Plan that best fits your needs.

Peace of Mind- Bronze

\$100 Daily Benefit x 12 months

*Day 1 coverage

5 hr - 1 Year Home Care

100% - 1 Year Adult Day Care

100% - 1 Year Assisted Living-shared

50% - 1 Year Nursing Home Care

75% - 1 Year of Hospice

\$_____ Monthly Premium

Peace of Mind- Silver

\$150 Daily Benefit x 12 months

*Day 1 coverage

7.5 hr - 1 Year Home Care

100% - 1 Year of Adult Day Care

100% - 1 Years Assisted Living-shared

75% - 1 Year Nursing Home Care

100% - 1 Year of Hospice

\$_____ Monthly Premium

Peace of Mind- Gold

\$200 Daily Benefit x 12 months

*Day 1 coverage

10 hr - 1 Year Home Care

100% - 1 Year of Adult Day Care

100% - 1 Year Assisted Living-own room

100% - 1 Year Nursing Home Care

100% - 1 Year of Hospice

\$_____ Monthly Premium

Contact Us at **630-426-9714**

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Agent name: _____