

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 3 Reason For Our Visit Today

1. Deliver and explain your **no cost** hearing & prescription discount cards.
2. Review the 2017 "Medicare you and book" video presentation and answer any questions you may have.
 - Have you received your 2017 "Medicare and you" Book ? Y / N
 - Has a representative ever showed you the Medicare & You overview video? Y / N
3. Help you complete your 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?

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: _____

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. (The Senior Citizen Exemption provides tax relief by reducing the equalized assessed 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 1949,
- a total household income of \$55,000 or less for income tax year 2013,
- owned the property or had a legal, equitable or leasehold interest in the property on January 1, 2013 and January 1, 2014,
- used the property as a principal place of residence as of January 1, 2013 and January 1, 2014, and
- been liable for the payment of 2013 and 2014 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.

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. A disability of at least 70 percent is eligible for a \$5,000 exemption in equalized assessed value (EAV). A disability of at least 50 percent, but less than 69 percent is eligible for a \$2,500 reduction in EAV

- 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,
- have been honorably discharged
- have at least a 50% 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 surviving spouse of the qualified veteran may claim this exemption** as long as the spouse does not remarry. If the surviving spouse sells the residence, the exemption may be transferred to his or her 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 assessment 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.

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 2017 Updated Federal L.I.S. Program (Single - \$1,485 Married - \$2,002)? 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 \$147 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"

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:	Humana Rx Plan					Humana Enhanced Rx				
Premium \$	Premium \$15.70					Premium \$52.80				
Deductible \$	Deductible \$0 1 & 2 / \$320 3 - 5					Deductible \$0				
Tier's 1 – 5 Co Pays	Tier's 1 – 5 Co Pays					Tier's 1 – 5 Co Pays				
	\$1	\$4	20%	35%	25%	\$3	\$7	\$42	44%	33%
Preferred Mail Order 90 days	Preferred Mail Order 90 days					Preferred Mail Order 90 days				
	\$0	\$0	20%	35%	-	\$0	\$0	\$116	44%	-
← Donut Hole / Gap 45% →										

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

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

Agent name: _____

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:	WellCare Classic PDP					WellCare Extra PDP				
Premium \$	Premium \$29.80					Premium \$52.70				
Deductible \$	Deductible \$320					Deductible \$0				
Tier's 1 – 5 Co Pays	Tier's 1 – 5 Co Pays					Tier's 1 – 5 Co Pays				
	\$0	\$13	\$38	\$89	25%	\$0	\$10	\$38	\$89	33%
Preferred Mail Order 90 days	Preferred Mail Order 90 days					Preferred Mail Order 90 days				
	\$0	\$32.50	\$95	\$222.50	-	\$0	\$25	\$95	\$222.50	-
← Donut Hole / Gap 45% →										

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Agent name: _____

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:	BCBS Basic PDP					BCBS Value PDP				
Premium \$	Premium \$26.40					Premium \$48.90				
Deductible \$	Deductible \$320					Deductible \$275				
Tier's 1 – 5 Co Pays	Tier's 1 – 5 Co Pays					Tier's 1 – 5 Co Pays				
	\$1	\$5	\$40	\$90	25%	\$0	\$6	\$39	\$85	25%
Preferred Mail Order 90 days	Preferred Mail Order 90 days					Preferred Mail Order 90 days				
	\$3	\$15	\$130	\$270	25%	\$0	\$18	\$117	\$225	25%
← Donut Hole / Gap 45% →										

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Agent name: _____

MEDICARE ADVANTAGE CO-PAY REVIEW WORKSHEET

HMO-POS In Network Co-Pays

Out of Network Co-Pay 30%

Max Out of Pocket \$6,700

\$0 Basic HMO-POS MAPD CIGNA-HealthSpring	\$ Basic Plan + <i>Partial</i> Coverage	\$ Basic Plan + <i>Complete</i> Coverage
Ambulance \$100 – 20% out of network	Ambulance \$0 + (\$150)	Ambulance \$0 + (\$150)
Chiropractic \$20		
Diabetic Supplies \$0		
Diagnostic Test \$0-\$200		
Lab & Radiology \$0		
X-Ray \$25		
Doctor Visit \$8		
Specialist \$45		
DME 20%		
Emergency Care \$75		
Foot Care \$45		
Hearing Service \$8-\$45		
Home Health Care \$0		
<i>*Mental Health Days 1 - 5 \$275</i>	<i>*Mental Health Days 1 - 5 \$0</i>	<i>*Mental Health Days 1 - 5 \$0</i>
<i>Days 6 – 90 \$0</i>	<i>Days 6 - 90 \$0</i>	<i>Days 6 - 90 \$0</i>
Out Patient Rehabilitation \$0		
Occupational/Physical Therapy \$30		
Substance Abuse Therapy \$40		
Out Patient Surgery \$250		
Prosthetic Devices 20%		
Renal Dialysis \$30		
Urgent Care \$65		
Vision – Limited \$0-\$45		
Preventative Care \$0		
Hospice Care \$0		
<i>*In Patient Hospital Days 1 - 7 \$275</i>	<i>*In Patient Hospital Days 1-7 \$175</i>	<i>*In Patient Hospital Days 1-7 \$0</i>
<i>*Days 8 – 90 \$0</i>	<i>*Days 8 – 90 \$0</i>	<i>*Days 8 - 90 \$0</i>
<i>*Skilled Nursing Days 1 – 20 \$0</i>	<i>*Skilled Nursing Days 1 - 20 \$0</i>	<i>*Skilled Nursing Days 1 – 20 \$0</i>
<i>*Days 21 – 100 \$160</i>	<i>*Days 21 - 100 \$160</i>	<i>*Days 21 - 100 \$0</i>
Prescription Drugs Tier 1: \$7	Tier 2: \$15	Tier 3: \$45
	Tier 4: 37%	Tier 5: 33%

*Note: (Hospital Indemnity Insurance provided by Medico)

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.

BRONZ PLAN - \$6.95

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 \$91

With Plan \$48

* Root Canal Regular \$1000

With Plan \$580

SILVER PLAN W/ TELEMEDIONE -\$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

24 Hour Doctor / \$0 Co-Pay

MD returned call within 3 hours

**** NON-Emergency Prescribed Medicine**

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

1nd year 60% coverage

2rd year 70% coverage

3rd 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**

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Agent name: _____

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.

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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

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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. Who **choose** the amount of Coverage & Type of insurance? You / Agent Why? _____
3. Has the **premium stayed**? Level / Increased / Decreased / Stopped *Have you taken a loan on the policy? Y / N
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?

GUARANTEED ISSUE HOME HEALTH CARE

The following questions are asked only to help us better understand your concerns in the event you need Home Health Care.

1. If you were to need Home Care would you want your spouse and children to be? The **Care Manager** or **The Care Giver**
2. If you were to slip and fall, have a mild stroke, heart attack or battle cancer, **who** would take care of you? _____
3. Describe how that might **impact their life**? _____
4. Do your spouse or children have medical training or are they **physically able** to lift you out of the bath tub or bed? Y / N
5. Are you aware that Medicare, Medicare supplements and Medicare Advantage plans **do not cover** short term and Long Term Care? Y / N **(see important note below for explanation)**
6. 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 lien would be placed on your home and assets if Medicaid were to have to pay? _____
7. Now I have a better understanding about your Home Health Care concerns, let's discuss my recommendation and how it will assist your loved ones to **be the care managers and not the care givers.**

Peace of Mind - Home Health Care DAILY Benefits.

• HOME HEALTH CARE AIDE	\$40	MEDICAL SOCIAL SERVICES	\$100
• SKILLED NURSING	\$75	GENERAL NURSING CARE (LPN OR LVN)	\$60
• PHYSICAL THERAPY	\$75	SPEECH PATHOLOGY	\$75
• OCCUPATIONAL THERAPY	\$75	ENTEROSTOMAL THERAPY	\$50
• RESPIRATION THHERAPY	\$50	CHEMOTHERAPY SPECIALIST SERCVICES	\$60

Monthly Premiums

• Age 55-60	\$27.85	Age 61-64	\$35.65	Age 65-70	\$36.20
• Age 71-75	\$53.10	Age 76-80	\$64.05	Age 81-85	\$79.15

*** **IMPORTANT NOTE for #5:** 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 33 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 stoke 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.

GUARANTEED ISSUE - WHOLE LIFE FINAL EXPENSE COVERAGE

- | | |
|---|--|
| • NO QUESTIONS LIFE APPLICATION | * 120% RETURN OF PREMIUM FIRST 2 YEARS |
| • BUILDS CASH VALUE | * SMOKER / NON SMOKER SAME RATES |
| • PREMIUM IS GUARANTEED TO NEVER INCREASE | * CAN NEVER BE CANCELLED |

CHECK REQUESTED COVERAGE AMOUNT BELOW

\$ 5,000 _____ \$ 10,000 _____ \$ 15,000 _____ \$ 20,000 _____ \$ 25,000 _____

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

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- pages 128, 132)

- **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: _____

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: _____



Household Card Users & Sponsorship

Client Name _____ DOB _____ Phone _____

Address _____

City _____ State _____ Zip _____ Email _____

Servicing Agent _____ Date _____

Authorization for Use and Disclosure (HIPPA form) completed - circle on Y / N

Household Members

	<u>Name</u>	<u>Relationship</u>	<u>DOB</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Family and Friends Sponsorships

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

