



HEALTH INSURANCE ANALYSIS

Household Name: _____

Date: _____

PERSONAL INFORMATION

Employer Name

Name

Date of birth

Spouse Name

Spouse Date of Birth

Dependent Child Name & Date of Birth

Dependent Child Name & Date of Birth

Dependent Child Name & Date of Birth

Dependent Child Name & Date of Birth

Name of Insurer (ex. Aetna, United Healthcare, etc.)

Current Plan Rate \$ _____	Employee Only Employee & Child/Children	Employee & Spouse Employee & Family
How often are you paying these rates?	Bi-Weekly	Bi-Monthly
	Monthly	Other: _____

ALTERNATE PLAN RATES

Plan			
Employee Only	\$	\$	\$
Employee & Spouse	\$	\$	\$
Employee & Children	\$	\$	\$
Employee & Family	\$	\$	\$

MEDICAL INFORMATION

Are there any doctors that you currently need to see or have a preference for? Yes No

If yes, _____

Are there any ongoing prescription drugs (name, dosage, frequency), conditions, or claims that you foresee in the next year? Yes No

Drug Name	Dosage	Frequency

Tracking #LFF-0525-2079