EVEREST HEALTH & LIFE INSURANCE COMPANY LLC

DATE

CUSTOMER PROFILE QUESTIONNAIRE

	Primary Contact Information		Names Requiring Coverage	DOB
Name:		Primary		
Address:		Spouse		
City, State:		Dependent		
Zip Code:		Dependent		
Phone:		Dependent		
Email:		Dependent		

PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AND ACCURATELY AS POSSIBLE

1	Are all individuals requiring coverage US citizens?	
2	Does anyone requiring coverage use tobacco?	
2a	If yes, please list their names below:	
	Name 1	Name 4
	Name 2	Name 5
	Name 3	Name 6
3	What is the household's adjusted gross income?	

CURRENT INSURANCE

4	Do you currently have health insurance?	
4a	If yes, who is your health insurance carrier?	
5	What type of insurance do you have?	
6	What is your individual deductible?	
7	What is your individual max-out-of-pocket?	
8	What is your family deductible?	
9	What is your family max-out-of-pocket?	
10	Is your plan an HMO or PPO?	
11	What is your monthly premium?	
12	Who is your Primary Care Physician(s)?	
	a.	b.
13	Who are your specialists, e.g. OBGYN, Cardiologist, etc.?	
	a.	d.
	b.	e.
	c.	f.
14	How often have you met your deductible?	
15	How often do you go to the doctor?	
16	How are prescriptions covered?	
17	Are you taking any maintenance medications?	
18	How much do you spend on prescriptions in a year?	
19	How much per month do you spend on health insurance?	

CUSTOMER PROFILE QUESTIONNAIRE continued…

20	Why are you looking for coverage at this time?

IF CLIENT DOES NOT HAVE COVERAGE

21	Why are you looking for new coverage at this time?
22	What concerns you most about not having insurance?

FOR ALL CLIENTS

23	What is it you like most about your plan?
24	What is it you wish you could change about your plan?
25	If you could design you own plan what would it include?
26	People purchase insurance for many reasons like catastrophic events or making sure they have access to doctors. What is your main reason for purchasing health insurance that we need to keep in mind?
27	How have you used your coverage in the past?
28	Do you have any chronic health conditions?
28a	If yes, select all that apply:
	Heart Attack · Stroke · Cancer · Diabetes
	Anxiety · Depression · Hypertension · Other
	Describe:
29	How many times have you or a member of your family been admitted to a hospital, had surgery or been diagnosed with a chronic condition in the past five years?

LIST YOUR PRESCRIPTIONS

	Prescription	Dosage		Prescription	Dosage
1			7		
2			8		
3			9		
4			10		
5			11		
6			12		

Notes:

CUSTOMER PROFILE QUESTIONNAIRE continued…	
30	If applicable, do you plan on having more children?
31	Which is more important?

DETERMINING SUPPLEMENTAL NEEDS AND WANTS	
32	Do you have dental coverage?
33	Do you have a dentist?
33a	If yes, what is their name?
34	Does anyone in your family wear glasses or contacts?
35	Do you have your eyes checked annually?
36	Has any member of your extended family had a heart attack, stroke or been
	diagnosed with cancer?
37	How long could you and your family manage financially if you were not working due
	to an accident or illness?
37a	Then what would you do?
38	Do you have the funds to cover health insurance out-of-pocket expenses like the deductible
	and cost sharing in the event of an accident or illness?
38a	If no, how would you pay for those expenses?

LIFE INSURANCE	
39	Do you currently have life insurance?
39a	If yes, how much do you have?
40	Is your policy private or through an employer?
41	What kind of life insurance do you have?
42	How long have you had your life insurance?
43	Have there been any life changing events since you purchased your policy?
43a	If yes, explain…
44	How much do you pay for your life insurance?
45	Notes & Comments:

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