LEVEL FOUR® Financial
A DIVISION OF CARR, RIGGS & INGRAM CAPITAL, LLC

Financial Planning Process

HEALTH INSURANCE REVIEW

Please include all benefit summaries and which plan goes with its corresponding rate schedule.
We cannot finalize our analysis without these documents.

Date

PERSONAL INFORMATION

Employer Name	
Name	Date of Birth
Spouse Name	Spouse Date of Birth
Dependent Child Date of Birth	Dependent Child Date of Birth
Dependent Child Date of Birth	Dependent Child Date of Birth
Name of Insurer *(ex. Aetna, UnitedHealthcare, etc.)*	
Current Plan Rate	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child/Children ☐ Employee & Family
How often are you paying these rates?	☐ Monthly ☐ Bi-Monthly ☐ Bi-Weekly ☐ Other

ALTERNATE PLAN RATES

Plan 1	Plan 2	Plan 3
Employee Only	Employee Only	Employee Only
Employee & Spouse	Employee & Spouse	Employee & Spouse
Employee & Child/Children	Employee & Child/Children	Employee & Child/Children
Employee & Family	Employee & Family	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 prescription drugs that you currently take? (If yes, fill out below) ☐ Yes ☐ No

Drug Name	Dosage	Frequency

Are there any ongoing conditions or claims that you foresee in the next year?