Names: _____ Birthdate: _____

NEEDS ANALYSIS REVIEW

Children: _____

WEEKLY AMOUNT _____

HOSPITAL ACCIDENTAL BENEFITS

	MEMBER [ ] Tobacco Status	SPOUSE [ ]	CHILDREN
$_____	**Emergency Room Benefit** *Treatment within 72 hours*	$_____	$_____
$_____	**Daily Hospital Benefit** *up to 365 days*	$_____	$_____
$_____	**Intensive Care Benefit** *up to 14 days*	$_____	$_____

FREEDOM OF CHOICE

MEMBER		SPOUSE	CHILDREN
$_____	**FREEDOM OF CHOICE*** *Any cause of death Whole Life Insurance*	$_____	$_____
$_____	**Accidental Death**	$_____	$_____
$_____	**Auto Accident**	$_____	$_____
$_____	**Common Carrier**	$_____	$_____
$_____	**Mortgage Protection**	$_____	$_____
$_____	**College Education**	$_____	$_____
$_____	**Monthly Income** *Any cause of death 10 year R&C*	$_____	
_____		_____	

EMERGENCY FUND
Whole Life Insurance

PAID UP BENEFITS

TERMINAL ILLNESS RIDER
Whole Life / Monthly Income

STRIKE WAIVER
Up to 1 Year

LAY-OFF WAIVER
3 Months

BENEFITS GUARANTEED & NON-CANCELLABLE
Once approved

PROTECTIONS

Cancer Protection CNM
Medical Expenses
Lifetime Coverage
$_____

C20
Lump Sum
$_____

Critical Illness
CI Lump Sum
$_____

COMMENTS:

** Life Insurance; in the event of suicide within first two years, the benefits will not be paid*

Your Representative: _____

Email: _____

Phone: _____