Medicare Supplement Insurance Client Questionnaire

Craig Darnell, CFP®

Date: _____ Client Phone: _____

Section I.

Name:_____ Date of Birth: _____

Name:_____ Date of Birth: _____
(Provide second name only if spousal coverage requested)

Are you or will you be covered by both Medicare Parts A and B: Yes No

Type of coverage: HMO PPO (co-pay)

Prescription coverage wanted: Yes No

Do you travel outside the U.S.? Yes No

When do you want the policy to become effective? _____

Section II.

Basic underwriting issue: Client 1 Client 2

Do you currently have coverage? (Y or N) _____ _____
If yes, please provide a summary of coverage for your policy and monthly premium.

Please list any health issues that you have no or have had (i.e. surgeries, heart issues, arthritis, cancers, high blood pressure, etc.). Also list prescription drugs currently used:

Client 1 _____

_____

_____

Client 2 _____

_____

_____

Special Notes _____

_____

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