Client Demographic – Over 65

ZINN INSURANCE

Name: _____ **New Client/Est. Client** **Date:** _____

Address: _____ **Phone:** _____

City/ST/Zip: _____ **Alt. Phone:** _____

County: _____ **Email:** _____

Mailing Address: _____ **Female / Male** **Married:** Y N

City/ST/Zip: _____ **DOB:** _____

County: _____ **SS#** _____

Height: _____ **Weight:** _____ **Tobacco Use:** Yes No

Secondary Contact/Power of Attorney: _____

Phone: _____ **Email:** _____

Referred By: _____ **Appt Date/Time/Location:** _____

Medicare #:			
Part A			
Part B			
	Med Supplement		**PDP**
	MAPD		**Other**

Current Coverage:		**Individual**		**Group**	
		Cobra		**Travel**	
		State Continuation			
Carrier Name:					
Monthly Premium:			**SEP:**		

	Date	Initials
SOA, RX & Dr. Forms Sent		
AB Updated		
Quotes Ran		
Packet Assembled		
Application Completed & Submitted		
Policy # from Carrier		

	Date	Initials
AB Updated		
Spreadsheet Updated		
Elec Folder Moved to Active		
Terminated OLD Policy		
Informed Client		
Policy # from Carrier		

Results of Consultation

Carrier:		
Plan:		

Notes: