Client Demographic – Under 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 Tobacco Use: Y N

City/ST/Zip: _____ DOB: _____ SS#_____

County: _____ Social Security/Disability Y N

Secondary Contact/Power of Attorney: _____

Phone: _____ Email: _____

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

	Health
	Dental
	Vision
	Short Term Med
	Travel
	Life
	Misc

Current Coverage:					Individual	Group
		Cobra			State Continuation	Travel
Carrier Name:						
SEP:						
GROSS Income:	$					
Household #:						
Loss Cov. Date:						

	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		

Family/Personal History				
Name	DOB	Gender	Relation	SS#
		M / F		
		M / F		
		M / F		
		M / F		
		M / F		

Results of Consultation

Carrier:	
Plan:	

Notes: