UNDER 65 PERSONAL NEEDS ASSESSMENT

Leslie S. McMillian // leslie@lsminsurance.net // 919.271.6869 // secure portal

NAME	
PHONE NUMBER	
EMAIL	
YOUR DATE OF BIRTH	
HOME ADDRESS	
CITY, STATE, ZIP	
COUNTY	
LAST DAY OF CURRENT INS.	
TARGET DAY FOR NEW INS	
CURRENT HEALTH CARRIER	
CURRENT MONTHLY PREMIUM	
EST FAMILY INCOME IN 2026	
# OF PEOPLE ON TAX RETURN	

SPOUSE NAME	BIRTH DATE	GENDER	SMOKER	INCLUDE IN QUOTE(S)
CHILD NAME	BIRTH DATE	GENDER	SMOKER	INCLUDE IN QUOTE(S)
CHILD NAME	BIRTH DATE	GENDER	SMOKER	INCLUDE IN QUOTE(S)
CHILD NAME	BIRTH DATE	GENDER	SMOKER	INCLUDE IN QUOTE(S)
CHILD NAME	BIRTH DATE	GENDER	SMOKER	INCLUDE IN QUOTE(S)

FIRST & LAST NAME OF DOCTOR(s)	OFFICE ADDRESS

Please provide as much detail as possible (syringe/capsule/pill/ # of cartons per month etc.). Or send us your electronic med list.

PRESCRIPTION NAME	DOSAGE/FREQUENCY	PRESCRIBED FOR
PREFERRED PHARMACY		