DIVINE INSURANCE SOLUTIONS

Intake Questionnaire

Questions apply to all applicants. Attach additional page(s) in needed.

Name: _____

DOB: _____ Ht. (in.) Wt. (lbs.) Male [ ] Female [ ] Relationship: Primary [ ]

Name: _____

DOB:_____ Ht. (in.) Wt. (lbs.) Male [ ] Female [ ] Relationship: Primary [ ]
Relationship: Child [ ] Other: Male [ ] Female [ ] DOB: Ht. (in.) Wt. (lbs.)
Relationship: Child [ ] Other: Male [ ] Female [ ] DOB: Ht. (in.) Wt. (lbs.)
Relationship: Child [ ] Other: Male [ ] Female [ ] DOB: Ht. (in.) Wt. (lbs.)
Phone: _____
Email:_____

WANTS ASSESSMENT: Every client has a problem they don't want; and a solution they don't have. Their Solution Image.

What do you want to get out of this meeting?

NEEDS ASSESSMENT: What do you require or is a necessity in your plan?

1. If you don't have insurance:
    a. How long have you been without insurance" _____
    b. Last Insured (date): _____
    c. Have you looked in getting insured? Y/N ____
    d. If, Yes, with whom? _____
    e. If, No, may I ask you what was stopping you? _____

2. If you are insured, who is your coverage by?
    a. Your Carrier: _____
    b. What is your Deductible: _____
    c. What is your monthly Premium" _____

3. AFFORDIBILITY:
    a. Is there a budget you need to remain under? Y/N _____
    b. If, Yes, what is it? _____

MEDICAL HISTORY:

1. Are you or were you EVER a tobacco or vape user? [ ] Yes [ ] No. If yes, how long? _____

2. Do you currently have, or had you had any of the following conditions in the past 24 months? Please check all that apply. Or Select None. [ ] None

[ ] Arthritis	[ ] Diabetes	[ ] Diabetes II	[ ] Kidney Disease/Failure
[ ] Heart Disease	[ ] Heart By-Pass Surgery		[ ] Congestive Heart Failure
[ ] Hypertension/High Blood Pressure		[ ] Behavioral/Mental Health	
[ ] Lower Back Pain	[ ] Herniated Disc	[ ] Crohn's Disease	[ ] HIV/AIDS
[ ] Asthma	[ ] Eating Disorder	[ ] COPD	[ ] Hyperlipidemia
[ ] Has anyone been hospitalized in the last 6 months. If Yes, list date(s) below with Diagnosis. If, None, enter NA			

3. Are you or could you be pregnant? [ ] Yes [ ] No

4. Tell me about your current health. How often do you see a doctor per year?
   Your doctor's name/city?

5. If applicable, does anyone else in your family who is enrolling have any of the above conditions/diseases?
   [ ] Spouse [ ] Child 1 [ ] Child 2 [ ] Child 3 Please fill out any dependent medical information.

6. Do you or any of your dependents have or have had cancer? [ ] Yes [ ] No. If yes, how long?

7. Are you or any of your dependents currently, or in the past 6 months, taking prescription medications? [ ] Yes [ ] No If Yes, list them below.

8. Would you be interested in Dental and/or Vision coverage if it's available? [ ] Yes [ ] No

WANTS

You've asked me to find you a plan that was $_____ per month, that was accepted by your doctor. Something with a _____ would be a plus and something that would definitely lower _____.

NOTES

PROPOSAL: I have a plan that is accepted by your doctor. It convers _____ and comes with _____ benefits for $_____ per month.