



HEALTH INSURANCE ANALYSIS

Household Name: _____

Date: _____

PERSONAL INFORMATION

Employer Name

Name

Date of birth

Spouse Name

Spouse Date of Birth

Dependent Child Name & Date of Birth

Dependent Child Name & Date of Birth

Dependent Child Name & Date of Birth

Dependent Child Name & Date of Birth

Name of Insurer (ex. Aetna, United Healthcare, etc.)

Current Plan Rate \$ _____

Employee Only

Employee & Spouse

Employee & Child/Children

Employee & Family

How often are you paying these rates?

Bi-Weekly

Bi-Monthly

Monthly

Other: _____

ALTERNATE PLAN RATES

Plan			
Employee Only	\$	\$	\$
Employee & Spouse	\$	\$	\$
Employee & Children	\$	\$	\$
Employee & Family	\$	\$	\$

MEDICAL INFORMATION

Are there any doctors that you currently need to see or have a preference for?

Yes

No

If yes, _____

Are there any ongoing prescription drugs (name, dosage, frequency), conditions, or claims that you foresee in the next year?

Yes

No

Drug Name	Dosage	Frequency

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