



*"We help you to find the insurance that best fits your needs!"*

## INSURANCE REVIEW ANALYSIS

Please list your household size:

First & Last Name	Relationship	Date Of Birth	Zip Code

<b>Name:</b>	<b>Email:</b>
<b>Address:</b>	<b>Phone:</b>

Current Health Plan	Current Premium	Health Insurance Carrier
Name: _____ Satisfied <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____ per month Budget for next year: \$ _____ per month	Preferred Insurance Carrier: _____ PPO <input type="checkbox"/> Yes <input type="checkbox"/> No EPO <input type="checkbox"/> Yes <input type="checkbox"/> No HMO <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Current Subsidy:</b>	<b>Modified Adjusted Gross Income</b> (Line #8b of your 2019 1040A tax return):	<b>Tax Filing Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Head of Household <input type="checkbox"/> Married filing jointly <input type="checkbox"/> Married filing Separately

Please pick the one's you are interested in reviewing or need

- |  |  |                          |                          |
|--|--|--------------------------|--------------------------|
| <input type="checkbox"/>                         | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Health Insurance Inside<br>Exchange (Covered CA) | Health Insurance<br>Outside State Exchange | Dental Plan              | Vision Plan              |
| <input type="checkbox"/>                         | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Travel Insurance                                 | Life Insurance Plan                        | Long Term Care           | Cancer/Critical Illness  |

**For Preferred Doctor, Hospital and Drug list please use 2<sup>nd</sup> page**



**Solid Health  
Insurance Services**

**Solid Health Insurance Services**  
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**Please list your Preferred Doctors:**

Doctor's Name	Specialty	Zip code or Address

**Please list your Preferred Hospital:**

Hospital Name	Zip code or Address

**Please list your Medication:**

Drug Name	Brand/Generic	Dosage

**Friends, Family, Coworker and neighbors who you think would like my services:**

#	Name	Phone	Email
1			
2			
3			