



INSURANCE ADVISORS  
Be Safe. Anywhere. Everywhere.

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# Needs Analysis Form

## General Information

### Personal information :

Name of applicant	
Address 1	
Address 2	
Telephone	
Mobile phone	
Fax	
E-mail	
Name of employer	
Occupation	

### Please indicate the % of your tasks (Time you spend) :

Administration		%
Manual		%
Supervision		%
Sales		%

### Interested in the following protections:

International health plans	<input type="checkbox"/>
Disability insurance	<input type="checkbox"/>
Life insurance	<input type="checkbox"/>
Critical illness insurance	<input type="checkbox"/>
Travel insurance	<input type="checkbox"/>

### Family Members

	You	Spouse	Child 1	Child 2
Name				
Date of birth				
Nationality (as on passeport)				
Country of residence				
City of residence				
Are you a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please provide us with any personal or medical information that you think is important to evaluate your file :

## Coverage Information (International Protections)

### INTERNATIONAL HEALTH PLANS

Interested in (please check if you would like to have this coverage):

Maternity	<input type="checkbox"/>
War and terrorism coverage	<input type="checkbox"/>
Dental benefits	<input type="checkbox"/>
Vision benefits	<input type="checkbox"/>
Outpatient benefits	<input type="checkbox"/>
Inpatient benefits	<input type="checkbox"/>
Psychiatric treatments	<input type="checkbox"/>

If you are insured :

Name of insurer	<input type="text"/>
Name of plan	<input type="text"/>
Start of insurance (date)	<input type="text"/>
Yearly Premium	\$ <input type="text"/>

### DISABILITY INSURANCE

Income required per month \$  (insured amount should be less than 75% of income)

Waiting period (before payments begin)

<input type="checkbox"/> 1 month	<input type="checkbox"/> 3 months	<input type="checkbox"/> 6 months
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Presently insured?  Yes  No

If yes, amount : \$  Insurer :

### LIFE INSURANCE

Requested benefit amount : YOU : \$  SPOUSE: \$

Do you have life insurance?  Yes  No

If yes, amount : \$  Insurer :

### CRITICAL ILLNESS INSURANCE

Requested benefit amount YOU : \$  SPOUSE: \$