# MEDICAID COMPLIANT ANNUITY QUOTE FORM

## Information of individual completing this form:

Name: ____________________ Company: ____________________

Address Line 1: ____________________ Phone: ____________________

Address Line 2: ____________________ Facsimile: ____________________

City/State/Zip: ________ / ________ / ________ Email: ____________________

Are you, or are you completing this form on behalf of, a licensed insurance agent? ☐ Yes ☐ No

## RETURN COMPLETED FORM TO:

**Krause Group**
1234 Enterprise Drive, De Pere, WI 54115
Phone: (866) 605-7437 Facsimile: (866) 605-7438
info@krause.com

Type of Case ☐ Individual ☐ Community Spouse ☐ Gift/Annuity Plan

Client Name: ____________________ Sex: ☐ Male ☐ Female

Birthdate: ____________________ State: ____________________

County the Medicaid applicant will be applying for benefits: ____________________

Has the applicant previously applied and been approved for Medicaid? ☐ Yes ☐ No

If yes, please explain: ____________________

____________________

**Annuity Term:** ____________________Year(s)

**OR** ____________________Month(s)

**OR** ☐ Medicaid Life Expectancy

**Premium Amount:** $____________________

Qualified Money (IRA, 401K, etc.)? ☐ Yes ☐ No

Month of Medicaid Eligibility (if applicable):

____________________

Gross Monthly Income (if applicable):

$ ____________________

Total Countable Resources (if applicable):

$ ____________________

Daily Private Pay Rate (if applicable):

$ ____________________

**Additional Comments:** ____________________

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