IMMEDIATE ANNUITY / PSK PLANNING 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

Care Recipient: _____ Sex: ☐ Male ☐ Female

Care Giver: _____ Sex: ☐ Male ☐ Female

Care Recipient Date of Birth: _____ State: _____

County the Medicaid applicant will be applying for benefits: _____

Term of the Annuity: _____Year(s), **or** _____Month(s), **or** ☐ Medicaid Life Expectancy

Premium Amount: $_____, **or** Desired Payout: $_____

Additional Comments: _____