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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