the KRAUSE AGENCY

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: _____

ONCE COMPLETED, RETURN THIS FORM TO:

The Krause Agency
1234 Enterprise Drive, De Pere, WI 54115
Phone: (800) 255-1932 Facsimile: (805) 683-6313
info@thekrauseagency.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: _____

_____