



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: _____

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

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: _____

