

County Letterhead

Date

Re: _____
SSN: _____
Re: _____
SSN: _____

Dear Sir/Madam:

We are in the process of determining Medicaid eligibility for the above named individual. The individual and/or their spouse own an annuity issued by your institution. This person is aware that we are conducting this evaluation and has signed his consent for the release of information. Please complete the reverse side of this letter regarding all annuities of these individuals and return as quickly as possible.

Thank you for your prompt assistance in this important matter.

Sincerely,

Caseworker

I give my consent for the release of this information.

Signature of applicant/beneficiary

I give my consent for the release of this information.

Signature of spouse

Consent for release of information on file. Contact the above caseworker with any questions.

Policy Name: _____ Policy number: _____

Policy Value: _____ Payment amount: _____

Please indicate if any of the following have occurred on the above annuity. If so, provide further explanation of that change:

Purchase Date: _____ Value _____

State of North Carolina Medicaid Program named as beneficiary. Date: _____
Explain _____

Value of Annuity on this date:
Date: _____ Explain _____

Is the Annuity Salable? YES NO
Date: _____ Value _____ Explain _____

Is the Annuity Assignable? YES NO
Date: _____ Value: _____ Explain _____

Is the Annuity Non-Assignable? YES NO
Date: _____ Value _____ Explain _____

Is the Annuity Revocable? YES NO
Date: _____ Value: _____ Explain _____

Is the Annuity Irrevocable? YES NO
Date: _____ Value _____ Explain _____

Addition to Principal? YES NO Date: _____
Explain _____

Elective withdrawal? YES NO Date: _____
Explain: _____

Request to change distribution? YES NO Date: _____
Explain: _____

Election to annuitize contract? YES NO Date: _____
Explain: _____

Other change? YES NO Date _____
Explain: _____

Signature and Title of Person Providing Information: _____

Date Form Completed: _____