

Medicaid SPIA Request Form

All information must be completed.

Writing Agent Name: _____

Writing Agent State: _____

Requested by: _____

Send back via: _____

Client Name: _____

Client Sex: _____

Client Married or Unmarried: _____

Client Date of Birth: _____

Client State of Residence: _____

Client Social Security Number: _____

(Not required)

Initial Deposit Amount: _____

Qualified or Non- Qualified: _____

Carrier: _____

*****Payments will be calculated based on client's state of residence Life Expectancy Tables. The only payout option is period certain. If qualified funds you must be sure that the payments meet or exceed RMD Requirements.**

3/1/2007