WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10191 (01/09)
§ 49.47(4)(cr), stats.

ANNC

MEDICAID ANNUITY BENEFICIARY DESIGNATION

Under Wisconsin State Law, if you and/or your spouse, (if married), own an annuity, you must complete this form in order to identify the Wisconsin Department of Health Services, Estate Recovery Program as the preferred remainder beneficiary of the annuity to the annuity company. Preferred remainder beneficiary means the person(s) or entity to whom benefits must first be paid when the death benefit becomes payable. Failure to send in this completed form will result in a denial or termination of Wisconsin Medicaid Long Term Care services.

Name – Annuity Owner (Last, First, MI)		Case Number	Social Security Number*
Name – Annuity Owner (Last, First, MI)		Case Number	Social Security Number*
Name – Spouse of Annuity Owner (Last, First, MI)		Case Number	Social Security Number*
Name – Annuity Company	Purchase Date	Annuity Contract Number	
Address – Annuity Company	City	State	Zip Code

I hereby make the following beneficiary designation on the above-named annuity:
The preferred remainder beneficiary of the annuity is the Wisconsin Department of Health Services, Estate Recovery Program for an amount up to the cost of Medicaid benefits paid on my behalf or on behalf of my spouse. The State of Wisconsin's interests will be secondary to any of the following person(s) who have been named beneficiary(s) of the annuity:

- My spouse, if not living in a medical institution
- My child or children who have not reached the age of majority under Wisconsin law
- My child or children of any age who are totally and permanently disabled, according to the criteria of the Supplemental Security Income (SSI) program

Family members who meet the above requirements can be added or removed as beneficiaries after the date of this designation.

SIGNATURE – Annuity Owner	Date Signed
SIGNATURE – Annuity Owner	Date Signed

By signing this form, I name the Wisconsin Department of Health Services, Estate Recovery Program as the preferred remainder beneficiary for my annuity. **Return this form to:**

Name and Address of Agency	
Worker Name:	
Telephone Number	Fax Number

*Personally identifiable information and Social Security Numbers are used only for the direct administration of the Medicaid program.