Clear Form Data
FILLABLE FORM

Attachment B

DHS-5036-ENG 1-08

Minnesota Department of **Human Services**

Annuity Beneficiary Designation Form

Annuity Owner Seeking Payment of Long-Term Care Services

Purpose: This form is used when you or you and your spouse own an annuity. It is used to tell the annuity company to name the MN Department of Human Services (DHS) as the preferred remainder beneficiary of the annuity. ***Preferred remainder beneficiary*** means the person(s) or entity to whom benefits must first be paid when the death benefit becomes payable.

ANNUITY OWNER(S)		CASE NUMBER	SOCIAL SECURITY NUMBER*
SPOUSE OF ANNUITY OWNER	BIRTHDATE	CASE NUMBER	SOCIAL SECURITY NUMBER*
ANNUITY COMPANY NAME	ANNUITY COMPANY ADDRESS		
CITY	STATE	ZIP CODE	ANNUITY CONTRACT NUMBER

I hereby make the following beneficiary designation on the above-named annuity:

The preferred remainder beneficiary of the annuity is DHS for an amount up to the cost of medical assistance benefits DHS has paid on my behalf or on behalf of my spouse. DHS' interests will be secondary to any of the following person(s) who have been named beneficiary(s) of the annuity:

(a) My spouse, if not living in a medical institution
(b) My child or children who have not reached the age of majority under Minnesota law
(c) 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.

ANNUITY OWNER'S SIGNATURE	DATE	ANNUITY OWNER'S SIGNATURE	DATE

By signing this form I name DHS as the preferred remainder beneficiary for my annuity.

COUNTY ADDRESS			DHS (BENEFICIARY)
WORKER NAME			Minnesota Department of Human Services P.O. Box 64995 540 Cedar Street St. Paul, MN 55164-0995 Phone Number: (651) 431-3100 (select options 3-3) Fax Number: (651) 431-7431
COUNTY ADDRESS			
CITY	STATE	ZIP CODE	
PHONE NUMBER	FAX NUMBER		

*SSN is being requested since annuity issuers use it to identify annuity contracts.

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice), or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Authorization for Release of Annuity Information

Authorization/Consent: I/We authorize the Minnesota Department of Human Services (DHS) to release the following information to the annuity company named on the reverse side:

- Information about an annuity that may be subject to federal and state Medicaid laws
- Information needed to determine eligibility for health care programs

The information will be used to determine my current and future eligibility for Minnesota Health Care Programs.

Consequences: I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to the release of this information
- That generally, I must give my written consent for DHS to give out the information
- If I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization
- This consent will end one year from the date I sign it, unless the law allows for a longer period

OWNER NAME		ADDRESS		
CITY	STATE	ZIP CODE	BIRTH DATE	CASE NUMBER

OWNER NAME		ADDRESS		
CITY	STATE	ZIP CODE	BIRTH DATE	CASE NUMBER

CLIENT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE	☐ CLIENT ☐ AUTHORIZED REP	DATE

ANNUITY OWNER'S SIGNATURE	DATE
ANNUITY OWNER'S SIGNATURE	DATE

Attention. If you want free help translating this information, ask your worker.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية.

កំណាត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកការ៉ាន់សំណុំរឿងរបស់អ្នក ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker).

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານ.

Hubaddhu. Yo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị.

LBF-0001 (1-08)