

SERFF Tracking Number: ALLE-126409366 State: Arkansas  
Filing Company: Allianz Life Insurance Company of North America State Tracking Number: 44275  
Company Tracking Number: LIFE APPLICATION UL3-02  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application UL3-02  
Project Name/Number: Life Application UL3-02/Life Application UL3-02

## Filing at a Glance

Company: Allianz Life Insurance Company of North America

Product Name: Life Application UL3-02

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: ALLE-126409366

SERFF Status: Closed-Approved-Closed

Co Tr Num: LIFE APPLICATION UL3-02

Author: Patricia Evans

Date Submitted: 12/08/2009

State: Arkansas

State Tr Num: 44275

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/09/2009

Disposition Status: Approved-Closed

Implementation Date:

## General Information

Project Name: Life Application UL3-02

Project Number: Life Application UL3-02

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/09/2009

Deemer Date:

Submitted By: Patricia Evans

Filing Description:

Re: Allianz Life Insurance Company of North America/ NAIC # 90611 / FEIN #41-1366075

Individual Life Filing – AR-UL3-02, et al

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 12/09/2009

Created By: Patricia Evans

Corresponding Filing Tracking Number:

Enclosed for your review are applications that, upon approval, are intended to be used with previously approved life insurance policy forms, and other applicable life insurance products that may be approved in the future.

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- Form AR-UL3-02 is intended to replace Form AR-UL3-R, previously approved by the Department on 4/05/2006, state tracking number 32340, SERFF #SERT-6NBP7H854, and will be used with previously approved Flexible Premium Adjustable Life Insurance policy forms.
- Form AR-TL-02 is intended to replace Form AR-TL-R, previously approved by the Department on 4/05/2006, state tracking number 32340, SERFF #SERT-6NBP7H854, and will be used with previously approved Individual Term Life policy forms.
- Form AR-JSL-02 is intended to replace Form AR-JSL-R, previously approved by the Department on 4/05/2006, state tracking number 32340, SERFF #SERT-6NBP7H854, and will be used with the previously approved Joint Last Survivor policy forms.

Special Note about bracketing in the applications:

There are two types of brackets used in the filing. The first type is the plain bracket, []. The fields that have been bracketed as such denote fields that will be either:

- suppressed upon print if not applicable
- variable only by nature of the insured, i.e., name, social security number, etc.

The brackets are to indicate suppression upon print due to inapplicability, not change in wording. This wording (other than that reflecting the company address) will not change without re-filing the form.

The second type of bracketing is denoted by brackets/braces, {}. The text within these brackets are the plans of insurance that we will use the applications for. These are variable as we may add or remove plans of insurance as necessary. We also consider page numbers and numbers at the beginning of items on a list to be variable.

The primary changes to the applications from the previously approved versions include the following:

- Adding question #s 12 through 19 under Section VIII. Non-medical. These questions were added to determine if the life insurance being applied for is suitable, as well as to identify stranger oriented life insurance (STOLI) cases.
- Deleting "authorization" language under Section X. Allianz Life Insurance Company of North America agreement and permission, as there is a separate form to capture this authorization.
- Revising the "policy delivery receipt" language under Section X. Allianz Life Insurance Company of North America agreement and permission.
- Adding a date field to all insured, owner, and agent signature blocks under Section X. Allianz Life Insurance Company of North America agreement and permission.

Thank you for your consideration of this filing. If you have any questions, or if you need additional information to complete your review, please call me at 800.328.5601, extension 47135, send a fax to me at 763.582.6495, or send a

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note electronically to me at patricia.evans@allianzlife.com.

Sincerely,

Patricia Evans  
 Compliance Analyst  
 Allianz Life Insurance Company of North America

## Company and Contact

### Filing Contact Information

Patricia Evans, Compliance Analyst Patricia.Evans@Allianzlife.com  
 5701 Golden Hills Drive 763-765-7135 [Phone]  
 Minneapolis, MN 55416 763-765-6306 [FAX]

### Filing Company Information

Allianz Life Insurance Company of North America CoCode: 90611 State of Domicile: Minnesota  
 5701 Golden Hills Drive Group Code: 761 Company Type: 05  
 Minneapolis, MN 55416-1297 Group Name: State ID Number:  
 (800) 328-5601 ext. [Phone] FEIN Number: 41-1366075

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation: Three forms @ \$50/ea. = \$150.00

This is greater than the Retaliatory fee of \$125.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Allianz Life Insurance Company of North America	\$150.00	12/08/2009	32566278

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	12/09/2009	12/09/2009

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	Patricia Evans	12/08/2009	12/08/2009
Form	Application	Patricia Evans	12/08/2009	12/08/2009
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## **Disposition**

Disposition Date: 12/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form (revised)	Application		Yes
Form	Application	Replaced	Yes
Form (revised)	Application		Yes
Form	Application	Replaced	Yes
Form (revised)	Application		Yes
Form	Application	Replaced	Yes

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**Amendment Letter**

Submitted Date: 12/08/2009

**Comments:**

I discovered a typo on the applications and have attached revised applications. The typo was in the fraud language, on all three applications. I incorrectly had the word "on" instead of "of" in the phrase "...for payment of a loss or benefit...". I certify that is the only change I made to the revised applications. Thank you.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AR-UL3-02	Application/EApplication	nrollment Form	Initial				50.000	AR-UL3-02.pdf
AR-TL-02	Application/EApplication	nrollment Form	Initial				50.000	AR-TL-02.pdf
AR-JSL-02	Application/EApplication	nrollment Form	Initial				50.000	AR-JSL-02.pdf

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## Form Schedule

### Lead Form Number: AR-UL3-02

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	AR-UL3-02	Application/ Application Enrollment Form	Initial		50.000	AR-UL3-02.pdf
	AR-TL-02	Application/ Application Enrollment Form	Initial		50.000	AR-TL-02.pdf
	AR-JSL-02	Application/ Application Enrollment Form	Initial		50.000	AR-JSL-02.pdf

## Application for Life Insurance

Policy number:

### I. Proposed primary insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### II. Owner (if other than proposed primary insured)

[Same as proposed primary insured]

[Owner's name:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Joint owner's name:

Date of birth:

*(Owners are joint tenants with rights of survivorship)*

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Contingent owner (if applicable):

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

**III. Beneficiary (Percentage must equal 100% for primary and 100% for contingent. If applicable, mode of distribution will be equally or to the survivor(s), unless otherwise noted.)**

Primary beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]

[Contingent beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]]

**IV. Coverage information**

{Plan of insurance:

Specified amount (face amount): \$

Risk class:

[Death benefit option:]

[Minimum Annual Interest Rate:]

[Index crediting method:

[Monthly sum S&P 500 allocation percentage:]

[Monthly sum Nasdaq 100 allocation percentage:]

[Annual point-to-point S&P 500 allocation percentage:]

[Annual point-to-point Nasdaq 100 allocation percentage:]

[Monthly sum EURO STOXX 50 allocation percentage:]

[Monthly average blended allocation percentage:]

[Annual point-to-point EURO STOXX 50 allocation percentage:]

[Annual point-to-point blended allocation percentage:]

[Interest allocation percentage:]

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**Rider coverage:**

[No rider selected]

[Waiver of Monthly Deduction Rider or Waiver of Specified Premium Rider or Waiver of Premium Rider

Waiver Amount: \$]

[Additional Term Rider –

Rider specified (face) amount: \$]

[Other Insured Term Rider –

Proposed other insured 1

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

-----  
[Proposed other insured 2

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

-----  
[Proposed other insured 3

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

-----  
[Proposed other insured 4

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Long Term Care Accelerated Benefit Rider (LTC ABR)

Rider specified amount: \$

LTC monthly benefit: [ ] % of rider specified amount]

[Child Term Rider

Units:

Children coverage (list name, date of birth, and gender of each child being insured under this rider):

Name:

Gender:

Date of birth:]]

[Enhanced Liquidity Rider  
Liquidity Percentage: [ ] %]

[Enhanced Cash Value Rider]

[No Lapse Guarantee Rider]

[Loan Protection Rider]

This policy may be purchased with the intention of accumulating cash value on a tax-free basis for some period (such as, until retirement) and then periodically borrowing from the policy without allowing the policy to lapse. The aim of this strategy is to continue borrowing from the policy until its contract value is just enough to pay off the policy loans that have been taken out and then relying on the Loan Protection Rider to keep the policy in force until the death of the insured. Anyone contemplating taking advantage of this strategy should be aware that it involves significant risk. This strategy has not been ruled on by the Internal Revenue Service (the "IRS") or the courts and it may be subject to challenge by the IRS on the grounds the policy has effectively lapsed or been exchanged. It is thus possible that loans under this policy may be treated as taxable distributions when the rider is exercised. In that event, assuming policy loans have not already been subject to tax as distributions, a significant tax liability could arise. Anyone considering using the policy as a source of tax-free income by taking out policy loans should, before purchasing the policy, consult with and rely on a competent tax advisor about the tax risks inherent in such a strategy.}}

**V. Payment of premium**

Planned premium amount: \$

Total amount submitted: \$

Billed excess amount: \$

Total billed amount: \$

Frequency:

Total lump sum amount: \$

**VI. Replacement**

Does the proposed primary insured have existing:

Annuity contracts?  Yes  No

Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [ ]

[Name of company: ]

Long term care insurance (LTCi) policies?  Yes  No

Will the LTCi being considered replace or change existing LTCi contracts or policies?  Yes  No

[Does the proposed other insured(s) have existing:

Proposed other insured

**# 1**

**[# 2**

**[# 3**

**[# 4**

Annuity contracts?  Yes  No

Yes  No

Yes  No

Yes  No

Life insurance?  Yes  No

Yes  No

Yes  No

Yes  No

Will the life insurance being considered replace or change existing contracts or policies?

Proposed other insured

**# 1**

**[# 2**

**[# 3**

**[# 4**

Yes  No

Yes  No

Yes  No

Yes  No

Amount of life insurance in force:

Name of company:

Amount of life insurance in force:

Name of company:

Amount of life insurance in force:

Name of company:]

**VII. Occupational/financial information**

Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income: \_\_\_\_\_

[Proposed other insured(s)]

#1 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income: \_\_\_\_\_

[#2 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income:]

[#3 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income:]

[#4 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income:]]

**VIII. Non-medical**

- |   | Proposed primary insured     |                             | [Proposed other insured [1-4]] |                             |
|---|------------------------------|-----------------------------|--------------------------------|-----------------------------|
|   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| 1. Are you a U.S. citizen? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 2. Are you a member or do you intend to become a member of the armed forces including reserves? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 3. Do you currently drive? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| a. If Yes, have you had any moving violations, including driving under the influence, or your driver's license suspended or revoked in the past 10 years? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 4. Have you ever flown or plan to fly as a pilot or student pilot? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 5. Do you intend to travel outside the U.S. or Canada within the next two years?....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 6. Have you engaged in, or intend to engage in any sports, such as powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving, mountain climbing, cave exploring, rodeos, bungee jumping or any record events?..... | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 7. Have you smoked one or more cigarettes or used another form of tobacco/nicotine within the past 10 years?.....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 8. Within the past 10 years, have you used marijuana, cocaine, heroin, amphetamines, barbiturates, morphine, LSD, PCP, or any other hallucinogenic or narcotic drug or controlled substance?.....                                   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 9. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency?.....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 10. Have you ever been convicted of a crime?.....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 11. Are you currently on probation?.....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 12. Has anyone offered you "free Insurance," a cash payment or some other promised benefit as an incentive to apply for this life insurance policy?.....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 13. Have you been involved in any discussions regarding selling this life insurance policy? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 14. Have you had or have you discussed having an evaluation to determine your life expectancy by any person or entity, other than Allianz or its representative, in the last one year period or the next one year period?.....      | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 15. Will any portion of the premium for this insurance be financed? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 16. Have you discussed changing ownership or beneficiaries once this policy is issued?.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 17. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 18. Did the agent discuss with you your current life insurance policies and other assets prior to your decision to purchase this life insurance policy? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |

19. Do you feel you have sufficient liquid assets available for living expenses and emergencies in addition to the money allocated to pay the life insurance premiums?  Yes  No  Yes  No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2, 3a, 4-11, 14, 15 and 16 above.  
Under Insured - PI indicates proposed primary insured, the numbers 1, 2, 3, or 4 indicate proposed other insured #1, 2, 3, or 4

Question number   Insured   Details

## IX. Medical history

### 1. Proposed primary insured

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:

---

### [Proposed other insured #1

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:]

---

### [Proposed other insured #2

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:]

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### [Proposed other insured #3

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:]

**[Proposed other insured #4**

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Phone number of your personal physician:

Reason consulted:

Diagnosis made–treatment prescribed:]]

**Proposed primary insured**

2. Your height in feet and inches:

3. Your weight in pounds:

[Proposed other Insured [1-4]

2. Your height in feet and inches:

3. Your weight in pounds: ]

Proposed primary insured [Proposed other insured [1-4]]

- 4. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months? .....  Yes  No  Yes  No
- 5. Within the past five years, other than above, have you consulted or had any checkup or physical consultation by a medical professional, had any diagnostic testing, been a patient in a hospital, or clinic, or have you had or been advised to have surgery? .....  Yes  No  Yes  No
- 6. Within the past five years, have you refused recommended surgery or treatment?  Yes  No  Yes  No
- 7. Do you have any physical deformity or defect?.....  Yes  No  Yes  No
- 8. Within the past 10 years have you received medical advice or has treatment been recommended or received for:
  - a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or TIA, Parkinson’s disease, Multiple Sclerosis, ALS, Muscular Dystrophy, dizziness, numbness or weakness? .....  Yes  No  Yes  No
  - b. Any disease or abnormality of the heart or blood and blood vessels including high blood pressure, heart attack or coronary artery disease, congestive heart failure, irregular heartbeat, peripheral vascular disease, anemia or other blood disorder? .....  Yes  No  Yes  No
  - c. Any disease or abnormality of the lungs or respiratory system including asthma, emphysema, or chronic obstructive pulmonary disease (COPD), or sleep apnea? .....  Yes  No  Yes  No
  - d. Any disease or abnormality of the liver, pancreas, rectum or intestines, stomach or esophagus including hepatitis or cirrhosis, Barrett’s esophagus, Crohn’s or Ulcerative Colitis? .....  Yes  No  Yes  No
  - e. Any disease or abnormality of the kidneys or urinary system, breasts, prostate, genitals or reproductive system including sexually transmitted diseases other than HIV or AIDS? .....  Yes  No  Yes  No
  - f. Diabetes or any other disease or abnormality of the thyroid or other glands? ..  Yes  No  Yes  No
  - g. Any disease or abnormality of the immune system (other than HIV or AIDS)? ..  Yes  No  Yes  No
  - h. Any disease or abnormality of the joints, muscle or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? .....  Yes  No  Yes  No
  - i. Any disease or abnormality of the eyes, ears, nose, throat, or skin? .....  Yes  No  Yes  No
- 9. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? .....  Yes  No  Yes  No
- 10. Have you ever received treatment for or been diagnosed by a member of the medical profession for positive HIV status, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  Yes  No  Yes  No

11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)? .....  Yes  No  Yes  No
12. In the past 10 years, have you been treated for or diagnosed with any other medical conditions not previously disclosed?.....  Yes  No  Yes  No
13. Has any family member been diagnosed or treated for heart disease, stroke, diabetes, cancer, or kidney disease? .....  Yes  No  Yes  No
14. Within the last 12 months have you ever required or do you currently require assistance or supervision, or are you limited in performing any daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication? .....  Yes  No  Yes  No
15. Within the last 12 months have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair, other medical appliance such as catheter, oxygen equipment, respirator, or dialysis machine? .....  Yes  No  Yes  No
16. Within the past five years have you had symptoms of, been diagnosed with, or been treated by a member of the medical profession for incontinence, imbalance or gait disturbance, confusion, dementia, Alzheimer's disease or memory loss?....  Yes  No  Yes  No
17. Within the last 12 months have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body?.....  Yes  No  Yes  No
18. Have you ever been charged an extra premium or been declined insurance coverage with another company?.....  Yes  No  Yes  No
19. Within the last five years have you ever or are you currently receiving benefits from a disability or long term care insurance plan, state or county assistance program, Medicaid, state or federal disability program, or Worker's Compensation?  Yes  No  Yes  No

Details to medical questions 4 - 19

Under insured - PI indicates proposed primary insured, the numbers 1, 2, 3, and 4 indicate proposed other insured #1, 2, 3, or 4

Question	Insured	Date seen	Name and address of medical source or facility
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Details or reason seen

**X. Allianz Life Insurance Company of North America (Allianz®) agreement and permission**

I understand that the complete application consists of my written answers to the questions in this application. I agree that the questions have been answered completely and truthfully. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, my policy may not be valid. I agree that any insurance approved by Allianz for issuance as a result of this application shall be considered in force only when, during my lifetime and continued insurability, a policy is issued by Allianz, said policy is received and accepted by me, and the first premium has been paid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CAUTION:** Review your answers carefully, if your answers are incorrect or untrue, Allianz has the right to deny benefits or rescind your policy.

Since the date Allianz generated an application from the phone interview [ ], the proposed primary insured and any family members proposed for insurance in the application: (a) have not applied for insurance which was declined, postponed, or modified; and (b) have no application for insurance pending with another company; (c) have not suffered an illness or injury; and (d) have not consulted or been examined by a physician or practitioner and (e) have not changed occupations EXCEPT AS FOLLOWS:

[Since the date Allianz generated an application from the phone interview [ ], proposed other insured [1-4] proposed for insurance in the application: (a) has not applied for insurance which was declined, postponed, or modified; and (b) has no application for insurance pending with another company; and (c) has not suffered an illness or injury; and (d) has not consulted or been examined by a physician or practitioner and (e) has not changed occupations EXCEPT AS FOLLOWS:]

Make all checks payable to Allianz Life Insurance Company of North America. Do not make checks payable to an agency, broker, agent or leave payee blank.

The owner acknowledges delivery and receipt of the above Allianz life insurance policy. The owner also attests that two copies of the Allianz life insurance application have been signed. One copy of the signed application is located in the policy. The other signed copy of the application will be returned to the Allianz home office.

Signed at: \_\_\_\_\_  
City, State

Proposed primary insured's signature: X \_\_\_\_\_  
Date

[Proposed other insured's [1-4] signature: X \_\_\_\_\_ ]  
Date

Owner's signature: X \_\_\_\_\_  
Date

**To be answered by licensed resident agent:**

I certify that the statements of the proposed insured(s) and owner (if different than the primary insured) have been correctly recorded in this application.

To the best of my knowledge, the proposed insured(s)  does not  does have existing life insurance policies or annuity contracts.

To the best of my knowledge, the insurance applied for in this application  will not  will replace existing insurance.

Agent's signature: X \_\_\_\_\_  
Date

**XI. Agent information**

Agent's name:

Phone number:

## Application for Life Insurance

Policy number:

### I. Proposed primary insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### II. Owner (if other than proposed primary insured)

[Same as proposed primary insured]

[Owner's name:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Joint owner's name:

Date of birth:

*(Owners are joint tenants with rights of survivorship)*

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Contingent owner (if applicable):

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

**III. Beneficiary (Percentage must equal 100% for primary and 100% for contingent. If applicable, mode of distribution will be equally or to the survivor(s), unless otherwise noted.)**

Primary beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]

[Contingent beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]]

**IV. Coverage information**

{Plan of insurance:

Specified amount (face amount): \$

Risk class:

**Rider coverage:**

[No rider selected]

[Waiver of Premium Rider]

[Return of Premium Rider]}

**V. Payment of premium**

Planned premium amount: \$  
Billed excess amount: \$  
Total billed amount: \$

Total amount submitted: \$  
Frequency:

**VI. Replacement**

Does the proposed primary insured have existing:

Annuity contracts?  Yes  No  
Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [            ]

[Name of company: ]

**VII. Occupational/financial information**

Employer's name:  
Occupation/duties:  
Net worth:

Annual income:

**VIII. Non-medical**

**Proposed primary insured**

- 1. Are you a U.S. citizen?.....  Yes  No
- 2. Are you a member or do you intend to become a member of the armed forces including reserves? .....  Yes  No
- 3. Do you currently drive? .....  Yes  No
  - a. If Yes, have you had any moving violations, including driving under the influence, or your driver's license suspended or revoked in the past 10 years? .....  Yes  No
- 4. Have you ever flown or plan to fly as a pilot or student pilot? .....  Yes  No
- 5. Do you intend to travel outside the U.S. or Canada within the next two years?.....  Yes  No
- 6. Have you engaged in, or intend to engage in any sports, such as powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving, mountain climbing, cave exploring, rodeos, bungee jumping or any record events?.....  Yes  No
- 7. Have you smoked one or more cigarettes or used another form of tobacco/nicotine within the past 10 years?.....  Yes  No
- 8. Within the past 10 years, have you used marijuana, cocaine, heroin, amphetamines, barbiturates, morphine, LSD, PCP, or any other hallucinogenic or narcotic drug or controlled substance?.....  Yes  No
- 9. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency? .....  Yes  No
- 10. Have you ever been convicted of a crime?.....  Yes  No
- 11. Are you currently on probation?.....  Yes  No
- 12. Has anyone offered you "free Insurance," a cash payment or some other promised benefit as an incentive to apply for this life insurance policy?.....  Yes  No
- 13. Have you been involved in any discussions regarding selling this life insurance policy? .....  Yes  No
- 14. Have you had or have you discussed having an evaluation to determine your life expectancy by any person or entity, other than Allianz or its representative, in the last one year period or the next one year period?.....  Yes  No
- 15. Will any portion of the premium for this insurance be financed? .....  Yes  No
- 16. Have you discussed changing ownership or beneficiaries once this policy is issued? .....  Yes  No
- 17. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? .....  Yes  No
- 18. Did the agent discuss with you your current life insurance policies and other assets prior to your decision to purchase this life insurance policy? .....  Yes  No

19. Do you feel you have sufficient liquid assets available for living expenses and emergencies in addition to the money allocated to pay the life insurance premiums?.....  Yes  No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2, 3a, 4-11, 14, 15 and 16 above.

Question number    Insured    Details

**IX. Medical history**

**1. Proposed primary insured**

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Phone number of your personal physician:

Reason consulted:

Diagnosis made–treatment prescribed:

**Proposed primary insured**

2. Your height in feet and inches:

3. Your weight in pounds:

**Proposed primary insured**

- 4. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months?.....  Yes  No
- 5. Within the past five years, other than above, have you consulted or had any checkup or physical consultation by a medical professional, had any diagnostic testing, been a patient in a hospital, or clinic, or have you had or been advised to have surgery? .....  Yes  No
- 6. Within the past five years, have you refused recommended surgery or treatment?.....  Yes  No
- 7. Do you have any physical deformity or defect?.....  Yes  No
- 8. Within the past 10 years have you received medical advice or has treatment been recommended or received for:
  - a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or TIA, Parkinson’s disease, Multiple Sclerosis, ALS, Muscular Dystrophy, dizziness, numbness or weakness? .....  Yes  No
  - b. Any disease or abnormality of the heart or blood and blood vessels including high blood pressure, heart attack or coronary artery disease, congestive heart failure, irregular heartbeat, peripheral vascular disease, anemia or other blood disorder? .....  Yes  No
  - c. Any disease or abnormality of the lungs or respiratory system including asthma, emphysema, or chronic obstructive pulmonary disease (COPD), or sleep apnea? .....  Yes  No
  - d. Any disease or abnormality of the liver, pancreas, rectum or intestines, stomach or esophagus including hepatitis or cirrhosis, Barrett’s esophagus, Crohn’s or Ulcerative Colitis? .....  Yes  No
  - e. Any disease or abnormality of the kidneys or urinary system, breasts, prostate, genitals or reproductive system including sexually transmitted diseases other than HIV or AIDS? .....  Yes  No
  - f. Diabetes or any other disease or abnormality of the thyroid or other glands? .....  Yes  No
  - g. Any disease or abnormality of the immune system (other than HIV or AIDS)? .....  Yes  No
  - h. Any disease or abnormality of the joints, muscle or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? .....  Yes  No
  - i. Any disease or abnormality of the eyes, ears, nose, throat, or skin? .....  Yes  No

9. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? .....  Yes  No
10. Have you ever received treatment for or been diagnosed by a member of the medical profession for positive HIV status, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....  Yes  No
11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)?.....  Yes  No
12. In the past 10 years, have you been treated for or diagnosed with any other medical conditions not previously disclosed? .....  Yes  No
13. Has any family member been diagnosed or treated for heart disease, stroke, diabetes, cancer, or kidney disease?.....  Yes  No
14. Within the last 12 months have you ever required or do you currently require assistance or supervision, or are you limited in performing any daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication?  Yes  No
15. Within the last 12 months have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair, other medical appliance such as catheter, oxygen equipment, respirator, or dialysis machine?.....  Yes  No
16. Within the past five years have you had symptoms of, been diagnosed with, or been treated by a member of the medical profession for incontinence, imbalance or gait disturbance, confusion, dementia, Alzheimer's disease or memory loss? .....  Yes  No
17. Within the last 12 months have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body? .....  Yes  No
18. Have you ever been charged an extra premium or been declined insurance coverage with another company?.....  Yes  No
19. Within the last five years have you ever or are you currently receiving benefits from a disability or long term care insurance plan, state or county assistance program, Medicaid, state or federal disability program, or Worker's Compensation?.....  Yes  No

Details to medical questions 4 - 19

Question	Insured	Date seen	Name and address of medical source or facility
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Details or reason seen

**X. Allianz Life Insurance Company of North America (Allianz®) agreement and permission**

I understand that the complete application consists of my written answers to the questions in this application. I agree that the questions have been answered completely and truthfully. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, my policy may not be valid. I agree that any insurance approved by Allianz for issuance as a result of this application shall be considered in force only when, during my lifetime and continued insurability, a policy is issued by Allianz, said policy is received and accepted by me, and the first premium has been paid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CAUTION:** Review your answers carefully, if your answers are incorrect or untrue, Allianz has the right to deny benefits or rescind your policy.

Since the date Allianz generated an application from the phone interview [ ], the proposed primary insured and any family members proposed for insurance in the application: (a) have not applied for insurance which was declined, postponed, or modified; and (b) have no application for insurance pending with another company; (c) have not suffered an illness or injury; and (d) have not consulted or been examined by a physician or practitioner and (e) have not changed occupations EXCEPT AS FOLLOWS:

Make all checks payable to Allianz Life Insurance Company of North America. Do not make checks payable to an agency, broker, agent or leave payee bank.

The owner acknowledges delivery and receipt of the above Allianz life insurance policy. The owner also attests that two copies of the Allianz life insurance application have been signed. One copy of the signed application is located in the policy. The other signed copy of the application will be returned to the Allianz home office.

Signed at: \_\_\_\_\_  
City, State

Proposed primary insured's signature: X \_\_\_\_\_  
Date

Owner's signature: X \_\_\_\_\_  
Date

**To be answered by licensed resident agent:**

I certify that the statements of the proposed insured(s) and owner (if different than the primary insured) have been correctly recorded in this application.

To the best of my knowledge, the proposed insured(s)  does not  does have existing life insurance policies or annuity contracts.

To the best of my knowledge, the insurance applied for in this application  will not  will replace existing insurance.

Agent's signature: X \_\_\_\_\_  
Date

**XI. Agent information**

Agent's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

## Application for Life Insurance

Policy number:

### I. Proposed first insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### II. Proposed second insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### III. Owner (if other than proposed insureds)

[Same as proposed insureds]

[Owner's name:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed insureds:

[[If applicable, date of trust:]

Tax or employer ID number: ]]

[Joint owner's name:

Date of birth:

*(Owners are joint tenants with rights of survivorship)*

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed insureds:

[[If applicable, date of trust:]

Tax or employer ID number: ]]



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**Rider coverage:**

[No rider selected]

[Estate Protection Rider]

[First-to-Die Rider]

[Waiver of Monthly Deduction Rider or Waiver of Specified Premium Rider]

Waiver Amount: \$]

[Insured: John Doe]

[Enhanced Liquidity Rider]

Liquidity Percentage: [ ]%

[Loan Protection Rider]

This policy may be purchased with the intention of accumulating cash value on a tax-free basis for some period (such as, until retirement) and then periodically borrowing from the policy without allowing the policy to lapse. The aim of this strategy is to continue borrowing from the policy until its contract value is just enough to pay off the policy loans that have been taken out and then relying on the Loan Protection Rider to keep the policy in force until the death of the insured. Anyone contemplating taking advantage of this strategy should be aware that it involves significant risk. This strategy has not been ruled on by the Internal Revenue Service (the "IRS") or the courts and it may be subject to challenge by the IRS on the grounds the policy has effectively lapsed or been exchanged. It is thus possible that loans under this policy may be treated as taxable distributions when the rider is exercised. In that event, assuming policy loans have not already been subject to tax as distributions, a significant tax liability could arise. Anyone considering using the policy as a source of tax-free income by taking out policy loans should, before purchasing the policy, consult with and rely on a competent tax advisor about the tax risks inherent in such a strategy.]

[Other]}

**VI. Payment of premium**

Planned premium amount: \$

Total amount submitted: \$

Billed excess amount: \$

Total billed amount: \$

Frequency:

Total lump sum amount: \$

**VII. Replacement**

Does the proposed first insured have existing:

Annuity contracts?  Yes  No

Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [            ]

[Name of company: ]

[Long term care insurance (LTCi) policies?  Yes  No

Will the LTCi being considered replace or change existing LTCi contracts or policies?  Yes  No]

Does the proposed second insured have existing:

Annuity contracts?  Yes  No

Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [            ]

[Name of company: ]

[Long term care insurance (LTCi) policies?  Yes  No

Will the LTCi being considered replace or change existing LTCi contracts or policies?  Yes  No]

**VIII. Occupational/financial information**

Proposed first insured's employer's name:

Occupation/duties:

Net worth:

Annual income:

Proposed second insured's employer's name:

Occupation/duties:

Net worth:

Annual income:

**IX. Non-medical**

- |   | Proposed first insured                                   | Proposed second insured                                  |
|---|--|--|
| 1. Are you a U.S. citizen? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you a member or do you intend to become a member of the armed forces including reserves? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you currently drive? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. If Yes, have you had any moving violations, including driving under the influence, or your driver's license suspended or revoked in the past 10 years? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever flown or plan to fly as a pilot or student pilot? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you intend to travel outside the U.S. or Canada within the next two years?...   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you engaged in, or intend to engage in any sports, such as powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving, mountain climbing, cave exploring, rodeos, bungee jumping or any record events?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you smoked one or more cigarettes or used another form of tobacco/nicotine within the past 10 years?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 10 years, have you used marijuana, cocaine, heroin, amphetamines, barbiturates, morphine, LSD, PCP, or any other hallucinogenic or narcotic drug or controlled substance?.....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have you ever been convicted of a crime?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Are you currently on probation?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**Proposed first insured**

2. Your height in feet and inches:

3. Your weight in pounds:

**Proposed second insured**

2. Your height in feet and inches:

3. Your weight in pounds:

	Proposed first insured	Proposed second insured
4. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past five years, other than above, have you consulted or had any checkup or physical consultation by a medical professional, had any diagnostic testing, been a patient in a hospital, or clinic, or have you had or been advised to have surgery? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past five years, have you refused recommended surgery or treatment? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have any physical deformity or defect?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 10 years have you received medical advice or has treatment been recommended or received for:		
a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or TIA, Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, dizziness, numbness or weakness? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Any disease or abnormality of the heart or blood and blood vessels including high blood pressure, heart attack or coronary artery disease, congestive heart failure, irregular heartbeat, peripheral vascular disease, anemia or other blood disorder? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Any disease or abnormality of the lungs or respiratory system including asthma, emphysema, or chronic obstructive pulmonary disease (COPD), or sleep apnea? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Any disease or abnormality of the liver, pancreas, rectum or intestines, stomach or esophagus including hepatitis or cirrhosis, Barrett's esophagus, Crohn's or Ulcerative Colitis?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Any disease or abnormality of the kidneys or urinary system, breasts, prostate, genitals or reproductive system including sexually transmitted diseases other than HIV or AIDS? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes or any other disease or abnormality of the thyroid or other glands? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Any disease or abnormality of the immune system (other than HIV or AIDS)? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Any disease or abnormality of the joints, muscle or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Any disease or abnormality of the eyes, ears, nose, throat, or skin? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever received treatment for or been diagnosed by a member of the medical profession for positive HIV status, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. In the past 10 years, have you been treated for or diagnosed with any other medical conditions not previously disclosed?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Has any family member been diagnosed or treated for heart disease, stroke, diabetes, cancer, or kidney disease? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- 14. Within the last 12 months have you ever required or do you currently require assistance or supervision, or are you limited in performing any daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication? .....  Yes  No  Yes  No
- 15. Within the last 12 months have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair, other medical appliance such as catheter, oxygen equipment, respirator, or dialysis machine? .....  Yes  No  Yes  No
- 16. Within the past five years have you had symptoms of, been diagnosed with, or been treated by a member of the medical profession for incontinence, imbalance or gait disturbance, confusion, dementia, Alzheimer's disease or memory loss?....  Yes  No  Yes  No
- 17. Within the last 12 months have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body?.....  Yes  No  Yes  No
- 18. Have you ever been charged an extra premium or been declined insurance coverage with another company?.....  Yes  No  Yes  No
- 19. Within the last five years have you ever or are you currently receiving benefits from a disability or long term care insurance plan, state or county assistance program, Medicaid, state or federal disability program, or Worker's Compensation?  Yes  No  Yes  No

Details to medical questions 4 - 19

Under insured – P1 indicates proposed first insured, P2 indicates proposed second insured

Question	Insured	Date seen	Name and address of medical source or facility
----------	---------	-----------	--

Details or reason seen

**XI. Allianz Life Insurance Company of North America (Allianz®) agreement and permission**

I understand that the complete application consists of my written answers to the questions in this application. I agree that the questions have been answered completely and truthfully. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, my policy may not be valid. I agree that any insurance approved by Allianz for issuance as a result of this application shall be considered in force only when, during my lifetime and continued insurability, a policy is issued by Allianz, said policy is received and accepted by me, and the first premium has been paid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CAUTION:** Review your answers carefully, if your answers are incorrect or untrue, Allianz has the right to deny benefits or rescind your policy.

Since the date Allianz generated an application from the phone interview [ ], the proposed first insured and any family members proposed for insurance in the application: (a) have not applied for insurance which was declined, postponed, or modified; and (b) have no application for insurance pending with another company; (c) have not suffered an illness or injury; and (d) have not consulted or been examined by a physician or practitioner and (e) have not changed occupations EXCEPT AS FOLLOWS:

Since the date Allianz generated an application from the phone interview [ ], the proposed second insured proposed for insurance in the application: (a) has not applied for insurance which was declined, postponed, or modified; and (b) has no application for insurance pending with another company; and (c) has not suffered an illness or injury; and (d) has not consulted or been examined by a physician or practitioner and (e) has not changed occupations EXCEPT AS FOLLOWS:

Make all checks payable to Allianz Life Insurance Company of North America. Do not make checks payable to an agency, broker, agent or leave payee blank.

The owner acknowledges delivery and receipt of the above Allianz life insurance policy. The owner also attests that two copies of the Allianz life insurance application have been signed. One copy of the signed application is located in the policy. The other signed copy of the application will be returned to the Allianz home office.

Signed at: \_\_\_\_\_  
City, State

Proposed first insured's signature: X \_\_\_\_\_  
Date

Proposed second insured's signature: X \_\_\_\_\_  
Date

Owner's signature: X \_\_\_\_\_  
Date

**To be answered by licensed resident agent:**

I certify that the statements of the proposed insured(s) and owner (if different than the primary insured) have been correctly recorded in this application.

To the best of my knowledge, the proposed insured(s)  does not  does have existing life insurance policies or annuity contracts.

To the best of my knowledge, the insurance applied for in this application  will not  will replace existing insurance.

Agent's signature: X \_\_\_\_\_  
Date

**XII. Agent information**

Agent's name:

Phone number:

SERFF Tracking Number: ALLE-126409366 State: Arkansas  
Filing Company: Allianz Life Insurance Company of North America State Tracking Number: 44275  
Company Tracking Number: LIFE APPLICATION UL3-02  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application UL3-02  
Project Name/Number: Life Application UL3-02/Life Application UL3-02

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Certificate of Readability.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> The applications are located under the Form Schedule tab.		
<b>Comments:</b>		

**CERTIFICATE OF READABILITY**

<b>Contract Form</b>	<b>Flesch Score</b>
AR-UL3-02	50 (when scored with policy)
AR-TL-02	50 (when scored with policy)
AR-JSL-02	50 (when scored with policy)

It is hereby certified that each policy form listed above meets the minimum reading ease score required in your state.

The Flesch score was calculated using the text of the entire form. ("Text" is as defined by state regulations).

Each form is readable and complies with all applicable state rules and regulations as to size of print, format and arrangement.



Date: December 2, 2009

Martin G. Kline, Senior Director Actuary

SERFF Tracking Number: ALLE-126409366 State: Arkansas  
 Filing Company: Allianz Life Insurance Company of North America State Tracking Number: 44275  
 Company Tracking Number: LIFE APPLICATION UL3-02  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life Application UL3-02  
 Project Name/Number: Life Application UL3-02/Life Application UL3-02

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/07/2009	Form	Application	12/08/2009	AR-UL3-02.pdf (Superseded)
12/07/2009	Form	Application	12/08/2009	AR-TL-02.pdf (Superseded)
12/07/2009	Form	Application	12/08/2009	AR-JSL-02.pdf (Superseded)

## Application for Life Insurance

Policy number:

### I. Proposed primary insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### II. Owner (if other than proposed primary insured)

[Same as proposed primary insured]

[Owner's name:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Joint owner's name:

Date of birth:

*(Owners are joint tenants with rights of survivorship)*

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Contingent owner (if applicable):

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

**III. Beneficiary (Percentage must equal 100% for primary and 100% for contingent. If applicable, mode of distribution will be equally or to the survivor(s), unless otherwise noted.)**

Primary beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]

[Contingent beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]]

**IV. Coverage information**

{Plan of insurance:

Specified amount (face amount): \$

Risk class:

[Death benefit option:]

[Minimum Annual Interest Rate:]

[Index crediting method:

[Monthly sum S&P 500 allocation percentage:]

[Monthly sum Nasdaq 100 allocation percentage:]

[Annual point-to-point S&P 500 allocation percentage:]

[Annual point-to-point Nasdaq 100 allocation percentage:]

[Monthly sum EURO STOXX 50 allocation percentage:]

[Monthly average blended allocation percentage:]

[Annual point-to-point EURO STOXX 50 allocation percentage:]

[Annual point-to-point blended allocation percentage:]

[Interest allocation percentage:]

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[“Dow Jones” and “Dow Jones Industrial Average<sup>SM</sup>” are service marks of Dow Jones & Company, Inc. and have been licensed for use for certain purposes by Allianz Life Insurance Company of North America. The product, based on the Dow Jones Industrial Average<sup>SM</sup>, is not sponsored, endorsed, sold or promoted by Dow Jones, and Dow Jones makes no representation regarding the advisability of investing in such product(s).]

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**Rider coverage:**

[No rider selected]

[Waiver of Monthly Deduction Rider or Waiver of Specified Premium Rider or Waiver of Premium Rider

Waiver Amount: \$]

[Additional Term Rider –

Rider specified (face) amount: \$]

[Other Insured Term Rider –

Proposed other insured 1

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

-----  
[Proposed other insured 2

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

-----  
[Proposed other insured 3

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

-----  
[Proposed other insured 4

Date of birth:

Rider specified amount (face amount) : \$

Gender:

Social Security number:

Primary beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Contingent beneficiary:

Percentage: %

[[Date of trust, if applicable:]]

Relationship:

Tax or employer ID number:]]

[Long Term Care Accelerated Benefit Rider (LTC ABR)

Rider specified amount: \$

LTC monthly benefit: [ ] % of rider specified amount]

[Child Term Rider

Units:

Children coverage (list name, date of birth, and gender of each child being insured under this rider):

Name:

Gender:

Date of birth:]]

[Enhanced Liquidity Rider  
Liquidity Percentage: [ ] %]

[Enhanced Cash Value Rider]

[No Lapse Guarantee Rider]

[Loan Protection Rider]

This policy may be purchased with the intention of accumulating cash value on a tax-free basis for some period (such as, until retirement) and then periodically borrowing from the policy without allowing the policy to lapse. The aim of this strategy is to continue borrowing from the policy until its contract value is just enough to pay off the policy loans that have been taken out and then relying on the Loan Protection Rider to keep the policy in force until the death of the insured. Anyone contemplating taking advantage of this strategy should be aware that it involves significant risk. This strategy has not been ruled on by the Internal Revenue Service (the "IRS") or the courts and it may be subject to challenge by the IRS on the grounds the policy has effectively lapsed or been exchanged. It is thus possible that loans under this policy may be treated as taxable distributions when the rider is exercised. In that event, assuming policy loans have not already been subject to tax as distributions, a significant tax liability could arise. Anyone considering using the policy as a source of tax-free income by taking out policy loans should, before purchasing the policy, consult with and rely on a competent tax advisor about the tax risks inherent in such a strategy.}}

## V. Payment of premium

Planned premium amount: \$

Total amount submitted: \$

Billed excess amount: \$

Total billed amount: \$

Frequency:

Total lump sum amount: \$

## VI. Replacement

Does the proposed primary insured have existing:

Annuity contracts?  Yes  No

Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [ ]

[Name of company: ]

Long term care insurance (LTCi) policies?  Yes  No

Will the LTCi being considered replace or change existing LTCi contracts or policies?  Yes  No

[Does the proposed other insured(s) have existing:

Proposed other insured

# 1

[# 2

[# 3

[# 4

Annuity contracts?  Yes  No

Yes  No

Yes  No

Yes  No

Life insurance?  Yes  No

Yes  No

Yes  No

Yes  No

Will the life insurance being considered replace or change existing contracts or policies?

Proposed other insured

# 1

[# 2

[# 3

[# 4

Yes  No

Yes  No

Yes  No

Yes  No

Amount of life insurance in force:

Name of company:

Amount of life insurance in force:

Name of company:

Amount of life insurance in force:

Name of company:]

**VII. Occupational/financial information**

Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income: \_\_\_\_\_

[Proposed other insured(s)]

#1 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income: \_\_\_\_\_

[#2 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income:]

[#3 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income:]

[#4 Employer's name:  
 Occupation/duties:  
 Net worth: \_\_\_\_\_ Annual income:]

**VIII. Non-medical**

- |   | Proposed primary insured     |                             | [Proposed other insured [1-4]] |                             |
|---|------------------------------|-----------------------------|--------------------------------|-----------------------------|
|   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes   | <input type="checkbox"/> No |
| 1. Are you a U.S. citizen? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 2. Are you a member or do you intend to become a member of the armed forces including reserves? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 3. Do you currently drive? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| a. If Yes, have you had any moving violations, including driving under the influence, or your driver's license suspended or revoked in the past 10 years? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 4. Have you ever flown or plan to fly as a pilot or student pilot? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 5. Do you intend to travel outside the U.S. or Canada within the next two years?....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 6. Have you engaged in, or intend to engage in any sports, such as powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving, mountain climbing, cave exploring, rodeos, bungee jumping or any record events?..... | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 7. Have you smoked one or more cigarettes or used another form of tobacco/nicotine within the past 10 years?.....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 8. Within the past 10 years, have you used marijuana, cocaine, heroin, amphetamines, barbiturates, morphine, LSD, PCP, or any other hallucinogenic or narcotic drug or controlled substance?.....                                   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 9. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency?.....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 10. Have you ever been convicted of a crime?.....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 11. Are you currently on probation?.....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 12. Has anyone offered you "free Insurance," a cash payment or some other promised benefit as an incentive to apply for this life insurance policy?.....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 13. Have you been involved in any discussions regarding selling this life insurance policy? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 14. Have you had or have you discussed having an evaluation to determine your life expectancy by any person or entity, other than Allianz or its representative, in the last one year period or the next one year period?.....      | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 15. Will any portion of the premium for this insurance be financed? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 16. Have you discussed changing ownership or beneficiaries once this policy is issued?.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 17. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |
| 18. Did the agent discuss with you your current life insurance policies and other assets prior to your decision to purchase this life insurance policy? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/>       | <input type="checkbox"/>    |

19. Do you feel you have sufficient liquid assets available for living expenses and emergencies in addition to the money allocated to pay the life insurance premiums?  Yes  No  Yes  No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2, 3a, 4-11, 14, 15 and 16 above.  
Under Insured - PI indicates proposed primary insured, the numbers 1, 2, 3, or 4 indicate proposed other insured #1, 2, 3, or 4

Question number   Insured   Details

## IX. Medical history

### 1. Proposed primary insured

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:

---

### [Proposed other insured #1

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:]

---

### [Proposed other insured #2

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:]

---

### [Proposed other insured #3

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Reason consulted:

Phone number of your personal physician:

Diagnosis made–treatment prescribed:]

**[Proposed other insured #4**

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Phone number of your personal physician:

Reason consulted:

Diagnosis made–treatment prescribed:]]

**Proposed primary insured**

2. Your height in feet and inches:

3. Your weight in pounds:

[Proposed other Insured [1-4]

2. Your height in feet and inches:

3. Your weight in pounds: ]

Proposed primary insured [Proposed other insured [1-4]]

- 4. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months? .....  Yes  No  Yes  No
- 5. Within the past five years, other than above, have you consulted or had any checkup or physical consultation by a medical professional, had any diagnostic testing, been a patient in a hospital, or clinic, or have you had or been advised to have surgery? .....  Yes  No  Yes  No
- 6. Within the past five years, have you refused recommended surgery or treatment?  Yes  No  Yes  No
- 7. Do you have any physical deformity or defect?.....  Yes  No  Yes  No
- 8. Within the past 10 years have you received medical advice or has treatment been recommended or received for:
  - a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or TIA, Parkinson’s disease, Multiple Sclerosis, ALS, Muscular Dystrophy, dizziness, numbness or weakness? .....  Yes  No  Yes  No
  - b. Any disease or abnormality of the heart or blood and blood vessels including high blood pressure, heart attack or coronary artery disease, congestive heart failure, irregular heartbeat, peripheral vascular disease, anemia or other blood disorder? .....  Yes  No  Yes  No
  - c. Any disease or abnormality of the lungs or respiratory system including asthma, emphysema, or chronic obstructive pulmonary disease (COPD), or sleep apnea? .....  Yes  No  Yes  No
  - d. Any disease or abnormality of the liver, pancreas, rectum or intestines, stomach or esophagus including hepatitis or cirrhosis, Barrett’s esophagus, Crohn’s or Ulcerative Colitis? .....  Yes  No  Yes  No
  - e. Any disease or abnormality of the kidneys or urinary system, breasts, prostate, genitals or reproductive system including sexually transmitted diseases other than HIV or AIDS? .....  Yes  No  Yes  No
  - f. Diabetes or any other disease or abnormality of the thyroid or other glands? ..  Yes  No  Yes  No
  - g. Any disease or abnormality of the immune system (other than HIV or AIDS)? ..  Yes  No  Yes  No
  - h. Any disease or abnormality of the joints, muscle or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? .....  Yes  No  Yes  No
  - i. Any disease or abnormality of the eyes, ears, nose, throat, or skin? .....  Yes  No  Yes  No
- 9. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? .....  Yes  No  Yes  No
- 10. Have you ever received treatment for or been diagnosed by a member of the medical profession for positive HIV status, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  Yes  No  Yes  No

11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)? .....  Yes  No  Yes  No
12. In the past 10 years, have you been treated for or diagnosed with any other medical conditions not previously disclosed? .....  Yes  No  Yes  No
13. Has any family member been diagnosed or treated for heart disease, stroke, diabetes, cancer, or kidney disease? .....  Yes  No  Yes  No
14. Within the last 12 months have you ever required or do you currently require assistance or supervision, or are you limited in performing any daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication? .....  Yes  No  Yes  No
15. Within the last 12 months have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair, other medical appliance such as catheter, oxygen equipment, respirator, or dialysis machine? .....  Yes  No  Yes  No
16. Within the past five years have you had symptoms of, been diagnosed with, or been treated by a member of the medical profession for incontinence, imbalance or gait disturbance, confusion, dementia, Alzheimer's disease or memory loss?....  Yes  No  Yes  No
17. Within the last 12 months have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body? .....  Yes  No  Yes  No
18. Have you ever been charged an extra premium or been declined insurance coverage with another company? .....  Yes  No  Yes  No
19. Within the last five years have you ever or are you currently receiving benefits from a disability or long term care insurance plan, state or county assistance program, Medicaid, state or federal disability program, or Worker's Compensation?  Yes  No  Yes  No

Details to medical questions 4 - 19

Under insured - PI indicates proposed primary insured, the numbers 1, 2, 3, and 4 indicate proposed other insured #1, 2, 3, or 4

Question	Insured	Date seen	Name and address of medical source or facility
----------	---------	-----------	--

Details or reason seen

**X. Allianz Life Insurance Company of North America (Allianz®) agreement and permission**

I understand that the complete application consists of my written answers to the questions in this application. I agree that the questions have been answered completely and truthfully. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, my policy may not be valid. I agree that any insurance approved by Allianz for issuance as a result of this application shall be considered in force only when, during my lifetime and continued insurability, a policy is issued by Allianz, said policy is received and accepted by me, and the first premium has been paid.

Any person who knowingly presents a false or fraudulent claim for payment on a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CAUTION:** Review your answers carefully, if your answers are incorrect or untrue, Allianz has the right to deny benefits or rescind your policy.

Since the date Allianz generated an application from the phone interview [ ], the proposed primary insured and any family members proposed for insurance in the application: (a) have not applied for insurance which was declined, postponed, or modified; and (b) have no application for insurance pending with another company; (c) have not suffered an illness or injury; and (d) have not consulted or been examined by a physician or practitioner and (e) have not changed occupations EXCEPT AS FOLLOWS:

[Since the date Allianz generated an application from the phone interview [ ], proposed other insured [1-4] proposed for insurance in the application: (a) has not applied for insurance which was declined, postponed, or modified; and (b) has no application for insurance pending with another company; and (c) has not suffered an illness or injury; and (d) has not consulted or been examined by a physician or practitioner and (e) has not changed occupations EXCEPT AS FOLLOWS:]

Make all checks payable to Allianz Life Insurance Company of North America. Do not make checks payable to an agency, broker, agent or leave payee blank.

The owner acknowledges delivery and receipt of the above Allianz life insurance policy. The owner also attests that two copies of the Allianz life insurance application have been signed. One copy of the signed application is located in the policy. The other signed copy of the application will be returned to the Allianz home office.

Signed at: \_\_\_\_\_  
City, State

Proposed primary insured's signature: X \_\_\_\_\_  
Date

[Proposed other insured's [1-4] signature: X \_\_\_\_\_ ]  
Date

Owner's signature: X \_\_\_\_\_  
Date

**To be answered by licensed resident agent:**

I certify that the statements of the proposed insured(s) and owner (if different than the primary insured) have been correctly recorded in this application.

To the best of my knowledge, the proposed insured(s)  does not  does have existing life insurance policies or annuity contracts.

To the best of my knowledge, the insurance applied for in this application  will not  will replace existing insurance.

Agent's signature: X \_\_\_\_\_  
Date

**XI. Agent information**

Agent's name:

Phone number:

## Application for Life Insurance

Policy number:

### I. Proposed primary insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### II. Owner (if other than proposed primary insured)

[Same as proposed primary insured]

[Owner's name:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Joint owner's name:

Date of birth:

*(Owners are joint tenants with rights of survivorship)*

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

[Contingent owner (if applicable):

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed primary insured:

[[If applicable, date of trust:]

Tax or employer ID number:     ]]

**III. Beneficiary (Percentage must equal 100% for primary and 100% for contingent. If applicable, mode of distribution will be equally or to the survivor(s), unless otherwise noted.)**

Primary beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]

[Contingent beneficiary:

Percentage: %

Relationship:

[[Date of trust (if applicable):]

Tax or employer ID number: ]]

**IV. Coverage information**

{Plan of insurance:

Specified amount (face amount): \$

Risk class:

**Rider coverage:**

[No rider selected]

[Waiver of Premium Rider]

[Return of Premium Rider]}

**V. Payment of premium**

Planned premium amount: \$  
Billed excess amount: \$  
Total billed amount: \$

Total amount submitted: \$  
Frequency:

**VI. Replacement**

Does the proposed primary insured have existing:

Annuity contracts?  Yes  No  
Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [            ]

[Name of company: ]

**VII. Occupational/financial information**

Employer's name:  
Occupation/duties:  
Net worth:

Annual income:

**VIII. Non-medical**

**Proposed primary insured**

- 1. Are you a U.S. citizen?.....  Yes  No
- 2. Are you a member or do you intend to become a member of the armed forces including reserves? .....  Yes  No
- 3. Do you currently drive? .....  Yes  No
  - a. If Yes, have you had any moving violations, including driving under the influence, or your driver's license suspended or revoked in the past 10 years? .....  Yes  No
- 4. Have you ever flown or plan to fly as a pilot or student pilot? .....  Yes  No
- 5. Do you intend to travel outside the U.S. or Canada within the next two years?.....  Yes  No
- 6. Have you engaged in, or intend to engage in any sports, such as powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving, mountain climbing, cave exploring, rodeos, bungee jumping or any record events?.....  Yes  No
- 7. Have you smoked one or more cigarettes or used another form of tobacco/nicotine within the past 10 years?.....  Yes  No
- 8. Within the past 10 years, have you used marijuana, cocaine, heroin, amphetamines, barbiturates, morphine, LSD, PCP, or any other hallucinogenic or narcotic drug or controlled substance?.....  Yes  No
- 9. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency? .....  Yes  No
- 10. Have you ever been convicted of a crime?.....  Yes  No
- 11. Are you currently on probation?.....  Yes  No
- 12. Has anyone offered you "free Insurance," a cash payment or some other promised benefit as an incentive to apply for this life insurance policy?.....  Yes  No
- 13. Have you been involved in any discussions regarding selling this life insurance policy? .....  Yes  No
- 14. Have you had or have you discussed having an evaluation to determine your life expectancy by any person or entity, other than Allianz or its representative, in the last one year period or the next one year period?.....  Yes  No
- 15. Will any portion of the premium for this insurance be financed? .....  Yes  No
- 16. Have you discussed changing ownership or beneficiaries once this policy is issued? .....  Yes  No
- 17. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? .....  Yes  No
- 18. Did the agent discuss with you your current life insurance policies and other assets prior to your decision to purchase this life insurance policy? .....  Yes  No

19. Do you feel you have sufficient liquid assets available for living expenses and emergencies in addition to the money allocated to pay the life insurance premiums?.....  Yes  No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2, 3a, 4-11, 14, 15 and 16 above.

Question number Insured Details

**IX. Medical history**

**1. Proposed primary insured**

Name of your personal physician:

Address of your personal physician:

Date of last visit:

Phone number of your personal physician:

Reason consulted:

Diagnosis made–treatment prescribed:

**Proposed primary insured**

2. Your height in feet and inches:

3. Your weight in pounds:

**Proposed primary insured**

- 4. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months?.....  Yes  No
- 5. Within the past five years, other than above, have you consulted or had any checkup or physical consultation by a medical professional, had any diagnostic testing, been a patient in a hospital, or clinic, or have you had or been advised to have surgery? .....  Yes  No
- 6. Within the past five years, have you refused recommended surgery or treatment?.....  Yes  No
- 7. Do you have any physical deformity or defect?.....  Yes  No
- 8. Within the past 10 years have you received medical advice or has treatment been recommended or received for:
  - a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or TIA, Parkinson’s disease, Multiple Sclerosis, ALS, Muscular Dystrophy, dizziness, numbness or weakness? .....  Yes  No
  - b. Any disease or abnormality of the heart or blood and blood vessels including high blood pressure, heart attack or coronary artery disease, congestive heart failure, irregular heartbeat, peripheral vascular disease, anemia or other blood disorder? .....  Yes  No
  - c. Any disease or abnormality of the lungs or respiratory system including asthma, emphysema, or chronic obstructive pulmonary disease (COPD), or sleep apnea? .....  Yes  No
  - d. Any disease or abnormality of the liver, pancreas, rectum or intestines, stomach or esophagus including hepatitis or cirrhosis, Barrett’s esophagus, Crohn’s or Ulcerative Colitis? .....  Yes  No
  - e. Any disease or abnormality of the kidneys or urinary system, breasts, prostate, genitals or reproductive system including sexually transmitted diseases other than HIV or AIDS? .....  Yes  No
  - f. Diabetes or any other disease or abnormality of the thyroid or other glands? .....  Yes  No
  - g. Any disease or abnormality of the immune system (other than HIV or AIDS)? .....  Yes  No
  - h. Any disease or abnormality of the joints, muscle or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? .....  Yes  No
  - i. Any disease or abnormality of the eyes, ears, nose, throat, or skin? .....  Yes  No

9. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? .....  Yes  No
10. Have you ever received treatment for or been diagnosed by a member of the medical profession for positive HIV status, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?.....  Yes  No
11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)?.....  Yes  No
12. In the past 10 years, have you been treated for or diagnosed with any other medical conditions not previously disclosed? .....  Yes  No
13. Has any family member been diagnosed or treated for heart disease, stroke, diabetes, cancer, or kidney disease?.....  Yes  No
14. Within the last 12 months have you ever required or do you currently require assistance or supervision, or are you limited in performing any daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication?  Yes  No
15. Within the last 12 months have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair, other medical appliance such as catheter, oxygen equipment, respirator, or dialysis machine?.....  Yes  No
16. Within the past five years have you had symptoms of, been diagnosed with, or been treated by a member of the medical profession for incontinence, imbalance or gait disturbance, confusion, dementia, Alzheimer's disease or memory loss? .....  Yes  No
17. Within the last 12 months have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body? .....  Yes  No
18. Have you ever been charged an extra premium or been declined insurance coverage with another company?.....  Yes  No
19. Within the last five years have you ever or are you currently receiving benefits from a disability or long term care insurance plan, state or county assistance program, Medicaid, state or federal disability program, or Worker's Compensation?.....  Yes  No

Details to medical questions 4 - 19

Question	Insured	Date seen	Name and address of medical source or facility
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Details or reason seen

**X. Allianz Life Insurance Company of North America (Allianz®) agreement and permission**

I understand that the complete application consists of my written answers to the questions in this application. I agree that the questions have been answered completely and truthfully. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, my policy may not be valid. I agree that any insurance approved by Allianz for issuance as a result of this application shall be considered in force only when, during my lifetime and continued insurability, a policy is issued by Allianz, said policy is received and accepted by me, and the first premium has been paid.

Any person who knowingly presents a false or fraudulent claim for payment on a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CAUTION:** Review your answers carefully, if your answers are incorrect or untrue, Allianz has the right to deny benefits or rescind your policy.

Since the date Allianz generated an application from the phone interview [ ], the proposed primary insured and any family members proposed for insurance in the application: (a) have not applied for insurance which was declined, postponed, or modified; and (b) have no application for insurance pending with another company; (c) have not suffered an illness or injury; and (d) have not consulted or been examined by a physician or practitioner and (e) have not changed occupations EXCEPT AS FOLLOWS:

Make all checks payable to Allianz Life Insurance Company of North America. Do not make checks payable to an agency, broker, agent or leave payee bank.

The owner acknowledges delivery and receipt of the above Allianz life insurance policy. The owner also attests that two copies of the Allianz life insurance application have been signed. One copy of the signed application is located in the policy. The other signed copy of the application will be returned to the Allianz home office.

Signed at: \_\_\_\_\_  
City, State

Proposed primary insured's signature: X \_\_\_\_\_  
Date

Owner's signature: X \_\_\_\_\_  
Date

**To be answered by licensed resident agent:**

I certify that the statements of the proposed insured(s) and owner (if different than the primary insured) have been correctly recorded in this application.

To the best of my knowledge, the proposed insured(s)  does not  does have existing life insurance policies or annuity contracts.

To the best of my knowledge, the insurance applied for in this application  will not  will replace existing insurance.

Agent's signature: X \_\_\_\_\_  
Date

**XI. Agent information**

Agent's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

## Application for Life Insurance

Policy number:

### I. Proposed first insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### II. Proposed second insured

Name:

Gender:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

### III. Owner (if other than proposed insureds)

[Same as proposed insureds]

[Owner's name:

Date of birth:

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed insureds:

[[If applicable, date of trust:]

Tax or employer ID number: ]]

[Joint owner's name:

Date of birth:

*(Owners are joint tenants with rights of survivorship)*

Social Security number:

Residence address:

[Optional mailing address:]

Relationship to proposed insureds:

[[If applicable, date of trust:]

Tax or employer ID number: ]]



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**Rider coverage:**

[No rider selected]

[Estate Protection Rider]

[First-to-Die Rider]

[Waiver of Monthly Deduction Rider or Waiver of Specified Premium Rider]

Waiver Amount: \$]

[Insured: John Doe]

[Enhanced Liquidity Rider]

Liquidity Percentage: [ ]%

[Loan Protection Rider]

This policy may be purchased with the intention of accumulating cash value on a tax-free basis for some period (such as, until retirement) and then periodically borrowing from the policy without allowing the policy to lapse. The aim of this strategy is to continue borrowing from the policy until its contract value is just enough to pay off the policy loans that have been taken out and then relying on the Loan Protection Rider to keep the policy in force until the death of the insured. Anyone contemplating taking advantage of this strategy should be aware that it involves significant risk. This strategy has not been ruled on by the Internal Revenue Service (the "IRS") or the courts and it may be subject to challenge by the IRS on the grounds the policy has effectively lapsed or been exchanged. It is thus possible that loans under this policy may be treated as taxable distributions when the rider is exercised. In that event, assuming policy loans have not already been subject to tax as distributions, a significant tax liability could arise. Anyone considering using the policy as a source of tax-free income by taking out policy loans should, before purchasing the policy, consult with and rely on a competent tax advisor about the tax risks inherent in such a strategy.]

[Other]}

**VI. Payment of premium**

Planned premium amount: \$

Total amount submitted: \$

Billed excess amount: \$

Total billed amount: \$

Frequency:

Total lump sum amount: \$

**VII. Replacement**

Does the proposed first insured have existing:

Annuity contracts?  Yes  No

Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [            ]

[Name of company: ]

[Long term care insurance (LTCi) policies?  Yes  No

Will the LTCi being considered replace or change existing LTCi contracts or policies?  Yes  No]

Does the proposed second insured have existing:

Annuity contracts?  Yes  No

Life insurance?  Yes  No

Will the life insurance being considered replace or change existing contracts or policies?  Yes  No

Amount of life insurance in force: [            ]

[Name of company: ]

[Long term care insurance (LTCi) policies?  Yes  No

Will the LTCi being considered replace or change existing LTCi contracts or policies?  Yes  No]

**VIII. Occupational/financial information**

Proposed first insured's employer's name:

Occupation/duties:

Net worth:

Annual income:

Proposed second insured's employer's name:

Occupation/duties:

Net worth:

Annual income:

**IX. Non-medical**

- |   | Proposed first insured                                   | Proposed second insured                                  |
|---|--|--|
| 1. Are you a U.S. citizen? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you a member or do you intend to become a member of the armed forces including reserves? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you currently drive? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. If Yes, have you had any moving violations, including driving under the influence, or your driver's license suspended or revoked in the past 10 years?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever flown or plan to fly as a pilot or student pilot? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you intend to travel outside the U.S. or Canada within the next two years?...   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you engaged in, or intend to engage in any sports, such as powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving, mountain climbing, cave exploring, rodeos, bungee jumping or any record events?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you smoked one or more cigarettes or used another form of tobacco/nicotine within the past 10 years?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 10 years, have you used marijuana, cocaine, heroin, amphetamines, barbiturates, morphine, LSD, PCP, or any other hallucinogenic or narcotic drug or controlled substance?.....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have you ever been convicted of a crime?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Are you currently on probation?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**Proposed first insured**

2. Your height in feet and inches:

3. Your weight in pounds:

**Proposed second insured**

2. Your height in feet and inches:

3. Your weight in pounds:

	Proposed first insured	Proposed second insured
4. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past five years, other than above, have you consulted or had any checkup or physical consultation by a medical professional, had any diagnostic testing, been a patient in a hospital, or clinic, or have you had or been advised to have surgery? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past five years, have you refused recommended surgery or treatment? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have any physical deformity or defect? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 10 years have you received medical advice or has treatment been recommended or received for:		
a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or TIA, Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, dizziness, numbness or weakness? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Any disease or abnormality of the heart or blood and blood vessels including high blood pressure, heart attack or coronary artery disease, congestive heart failure, irregular heartbeat, peripheral vascular disease, anemia or other blood disorder? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Any disease or abnormality of the lungs or respiratory system including asthma, emphysema, or chronic obstructive pulmonary disease (COPD), or sleep apnea? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Any disease or abnormality of the liver, pancreas, rectum or intestines, stomach or esophagus including hepatitis or cirrhosis, Barrett's esophagus, Crohn's or Ulcerative Colitis? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Any disease or abnormality of the kidneys or urinary system, breasts, prostate, genitals or reproductive system including sexually transmitted diseases other than HIV or AIDS? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes or any other disease or abnormality of the thyroid or other glands? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Any disease or abnormality of the immune system (other than HIV or AIDS)? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Any disease or abnormality of the joints, muscle or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Any disease or abnormality of the eyes, ears, nose, throat, or skin? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever received treatment for or been diagnosed by a member of the medical profession for positive HIV status, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. In the past 10 years, have you been treated for or diagnosed with any other medical conditions not previously disclosed? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Has any family member been diagnosed or treated for heart disease, stroke, diabetes, cancer, or kidney disease? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- 14. Within the last 12 months have you ever required or do you currently require assistance or supervision, or are you limited in performing any daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication? .....  Yes  No  Yes  No
- 15. Within the last 12 months have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair, other medical appliance such as catheter, oxygen equipment, respirator, or dialysis machine? .....  Yes  No  Yes  No
- 16. Within the past five years have you had symptoms of, been diagnosed with, or been treated by a member of the medical profession for incontinence, imbalance or gait disturbance, confusion, dementia, Alzheimer's disease or memory loss?....  Yes  No  Yes  No
- 17. Within the last 12 months have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body? .....  Yes  No  Yes  No
- 18. Have you ever been charged an extra premium or been declined insurance coverage with another company? .....  Yes  No  Yes  No
- 19. Within the last five years have you ever or are you currently receiving benefits from a disability or long term care insurance plan, state or county assistance program, Medicaid, state or federal disability program, or Worker's Compensation?  Yes  No  Yes  No

Details to medical questions 4 - 19

Under insured – P1 indicates proposed first insured, P2 indicates proposed second insured

Question	Insured	Date seen	Name and address of medical source or facility
----------	---------	-----------	--

Details or reason seen

**XI. Allianz Life Insurance Company of North America (Allianz®) agreement and permission**

I understand that the complete application consists of my written answers to the questions in this application. I agree that the questions have been answered completely and truthfully. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, my policy may not be valid. I agree that any insurance approved by Allianz for issuance as a result of this application shall be considered in force only when, during my lifetime and continued insurability, a policy is issued by Allianz, said policy is received and accepted by me, and the first premium has been paid.

Any person who knowingly presents a false or fraudulent claim for payment on a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CAUTION:** Review your answers carefully, if your answers are incorrect or untrue, Allianz has the right to deny benefits or rescind your policy.

Since the date Allianz generated an application from the phone interview [ ], the proposed first insured and any family members proposed for insurance in the application: (a) have not applied for insurance which was declined, postponed, or modified; and (b) have no application for insurance pending with another company; (c) have not suffered an illness or injury; and (d) have not consulted or been examined by a physician or practitioner and (e) have not changed occupations EXCEPT AS FOLLOWS:

Since the date Allianz generated an application from the phone interview [ ], the proposed second insured proposed for insurance in the application: (a) has not applied for insurance which was declined, postponed, or modified; and (b) has no application for insurance pending with another company; and (c) has not suffered an illness or injury; and (d) has not consulted or been examined by a physician or practitioner and (e) has not changed occupations EXCEPT AS FOLLOWS:

Make all checks payable to Allianz Life Insurance Company of North America. Do not make checks payable to an agency, broker, agent or leave payee blank.

The owner acknowledges delivery and receipt of the above Allianz life insurance policy. The owner also attests that two copies of the Allianz life insurance application have been signed. One copy of the signed application is located in the policy. The other signed copy of the application will be returned to the Allianz home office.

Signed at: \_\_\_\_\_  
City, State

Proposed first insured's signature: X \_\_\_\_\_  
Date

Proposed second insured's signature: X \_\_\_\_\_  
Date

Owner's signature: X \_\_\_\_\_  
Date

**To be answered by licensed resident agent:**

I certify that the statements of the proposed insured(s) and owner (if different than the primary insured) have been correctly recorded in this application.

To the best of my knowledge, the proposed insured(s)  does not  does have existing life insurance policies or annuity contracts.

To the best of my knowledge, the insurance applied for in this application  will not  will replace existing insurance.

Agent's signature: X \_\_\_\_\_  
Date

**XII. Agent information**

Agent's name:

Phone number: