

SERFF Tracking Number: ALLE-127069806 State: Arkansas
 Filing Company: Allianz Life Insurance Company of North America State Tracking Number: 48227
 Company Tracking Number: LIFE APPLICATION FILING LAPP-01 ETAL MAR 2011
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life
 Adjustable Life
 Product Name: Life Application Filing LAPP-01 etal Mar 2011
 Project Name/Number: Life Application Filing LAPP-01 etal Mar 2011/LAPP-01

Filing at a Glance

Company: Allianz Life Insurance Company of North America

Product Name: Life Application Filing LAPP-01 SERFF Tr Num: ALLE-127069806 State: Arkansas
 etal Mar 2011

TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 48227
 Adjustable Life Closed

Sub-TOI: L09I.101 External Indexed - Single Life Co Tr Num: LIFE APPLICATION State Status: Approved-Closed
 FILING LAPP-01 ETAL MAR 2011

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Tammy Smasal, Jenny Coig

Disposition Date: 03/16/2011

Date Submitted: 03/11/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life Application Filing LAPP-01 etal Mar 2011

Status of Filing in Domicile: Pending

Project Number: LAPP-01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 03/16/2011

State Status Changed: 03/16/2011

Deemer Date:

Created By: Jenny Coig

Submitted By: Jenny Coig

Corresponding Filing Tracking Number:

Filing Description:

March 10, 2011

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

Individual Life Filing AR-UL3-03,et al

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Enclosed for your review are applications and an endorsement 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.

LAPP-01 Life Insurance Policy Application
NB6010-01 Supplemental Application
NB6009-01 Medical Examination-Part II
NB2270-01 Aviation Questionnaire
NB2271-01 Avocation Questionnaire
NB2012B Business Financial Questionnaire
NB2012P Personal Financial Questionnaire
AR-UL3-03 Application for Life Insurance
AR-JSL-03 Application for Life Insurance
PE95132 Aviation Exclusion Endorsement

Form LAPP-01 is a Life Insurance Policy Application intended to replace Form LAPP-AR, previously approved by the Department on 7/30/2007. This form will be completed by the primary insured/first insured (if the product is our joint survivorship product) with an independent agent or broker to apply for our products.

Form NB6010-01 is a Supplemental Application intended to replace Form NB6010-AR, previously approved by the Department on 7/30/2007. This form will be completed by other insureds, if the Other Insured Term Rider is selected, or the second insured, if the joint survivorship product is selected. Also, if the Child Term Rider is selected, the children being covered are indicated on this application. The medical and non-medical questions are the same ones that are asked in form LAPP-01.

Form NB6009-01 is a Medical Examination-Part II will be completed by a health care professional who will ask the insured the questions and indicate their answers. These questions are the same questions that are asked in Section 12 of form LAPP-01.

Form NB2270-01 is an Aviation Questionnaire intended to replace Form NB2270, previously approved by the Department on 7/30/2007. This form will be completed if question #6 under Section 11. in form LAPP-01, and Section 9. in form NB6010-01, is answered "Yes."

Form NB2271-01 is an Avocation Questionnaire intended to replace Form NB2271, previously approved by the Department on 7/30/2007. This form will be completed if question #8 under Section 11. in form LAPP-01, and Section 9. in form NB6010-01, is answered "Yes."

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Form NB2012B is a Business Financial Questionnaire that will be completed as applicable.

Form NB2012P is a Personal Financial Questionnaire that will be completed as applicable.

Form AR-UL3-03 is an Application for Life Insurance intended to replace Form AR-UL3-02, previously approved by the Department on 12/9/2009. This form will be used with Flexible Premium Adjustable Life Insurance policy forms.

Form AR-JSL-03 is an Application for Life Insurance intended to replace Form AR-JSL-02, previously approved by the Department on 12/9/2009. This form will be used with Joint Last Survivor policy forms.

Special Note about bracketing in the UL3 and JSL 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.

Form PE95132 is an Aviation Exclusion Endorsement that will be issued as applicable.

We certify that the forms comply with Regulation 49 and Ark. Code Ann. 23-79-138. In addition, we certify that the forms comply with the Arkansas External-Indexed Contract Guidelines for Disclosure and Advertising and Agent Education.

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 36160, send a fax to me at 763.582.6495, or send a note electronically to me at jenny.coig@allianzlife.com.

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Company and Contact

Filing Contact Information

Tammy Smasal, Senior Compliance Analyst tammy_smasal@allianzlife.com
 5701 Golden Hills Drive 800-328-5601 [Phone] 32804 [Ext]
 Minneapolis, MN 55416-1297 763-582-6495 [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

Filing Fees

Fee Required? Yes
 Fee Amount: \$500.00
 Retaliatory? No
 Fee Explanation: \$50 each form X 10 forms = \$500.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Allianz Life Insurance Company of North America	\$500.00	03/11/2011	45483377

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/16/2011	03/16/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Life Insurance	Jenny Coig	03/15/2011	03/15/2011

SERFF Tracking Number: ALLE-127069806 *State:* Arkansas
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Disposition

Disposition Date: 03/16/2011

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		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Statement of Variability		Yes
Form	Life Insurance Policy Application		Yes
Form	Supplemental Application		Yes
Form	Medical Examination-Part II		Yes
Form	Aviation Questionnaire		Yes
Form	Avocation Questionnaire		Yes
Form	Business Financial Questionnaire		Yes
Form	Personal Financial Questionnaire		Yes
Form	Application for Life Insurance		Yes
Form (revised)	Application for Life Insurance		Yes
Form	Application for Life Insurance	Replaced	Yes
Form	Aviation Exclusion Endorsement		Yes

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Amendment Letter

Submitted Date: 03/15/2011

Comments:

Please find attached revised application AR-JSL-03. The only difference from the attached to the application submitted initially is added question number 21 to the non-medical questions.

Please let me know if you should have any additional questions.

Regards,

Jenny Coig
 (763) 765-6160

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-JSL-03	Application/EApplication nrollment Form	for Life Insurance	Initial				50.000	AR-JSL-03 3.2.11.pdf

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Form Schedule

Lead Form Number: LAPP-01

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LAPP-01	Application/ Enrollment Form	Life Insurance Policy Enrollment Application	Initial		50.000	LAPP-01.pdf
	NB6010-01	Application/ Enrollment Form	Supplemental Enrollment Application	Initial		50.000	NB6010-01.pdf
	NB6009-01	Application/ Enrollment Form	Medical Examination-Initial Enrollment Part II			50.000	NB6009-01.pdf
	NB2270-01	Application/ Enrollment Form	Aviation Enrollment Questionnaire	Initial		50.000	NB2270-01.pdf
	NB2271-01	Application/ Enrollment Form	Avocation Enrollment Questionnaire	Initial		50.000	NB2271-01.pdf
	NB2012B	Application/ Enrollment Form	Business Financial Enrollment Questionnaire	Initial		50.000	NB2012B.pdf
	NB2012P	Application/ Enrollment Form	Personal Financial Enrollment Questionnaire	Initial		50.000	NB2012P.pdf
	AR-UL3-03	Application/ Enrollment Form	Application for Life Insurance	Initial		50.000	AR-UL3-03 3.2.11.pdf
	AR-JSL-03	Application/ Enrollment Form	Application for Life Insurance	Initial		50.000	AR-JSL-03 3.2.11.pdf
	PE95132	Certificate Amendmen	Aviation Exclusion Endorsement	Initial		52.300	Aviation Exclusion

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Page, 3.7.11_2.pdf
Endorseme
nt or Rider

Life Insurance Policy Application

1. Proposed primary/first insured

First name		MI	Last name	
<input type="checkbox"/> Male	Date of birth (mm/dd/yyyy)		Age	Social Security number
<input type="checkbox"/> Female				
Residence address (street required)				
City		State	ZIP code	Email address
Home phone number	Business phone number	Place of birth (state and country)		Driver's license number
State of issue				

Complete Supplemental Application ([NB6010-01]) for other insured/second insured on GenDex Survivor.®

2. Occupational/financial information (proposed primary/first insured)

Employer's name		Occupation/Duties		
Length of employment	If less than two years, provide previous employer, occupation and length of employment:			
If self-employed, include the type of business.		Net worth	Annual income	See Underwriting Guidelines to determine if financial statement NB2012B or P should accompany this application.
		\$	\$	
Are you limited from working full time? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details:				

3. Policy information

Delivery state	Specified amount (face amount)	Rate class
----------------	--------------------------------	------------

4. Product information (Products may not be available in all states)

Generation Planner II™ Life Insurance Policy (issued with Death Benefit Option A only).

Optional riders

Child Term Rider _____ units (\$1,000 per unit. Minimum 5 units/maximum 10 units. Issued to child(ren) ages 15 days to age 20). Available at initial application or policy anniversary after birth of first child, complete Supplemental Application [NB6010-01].

Waiver of Premium Rider

Long Term Care Accelerated Benefit Rider (LTC ABR)¹ Rider specified amount \$ _____
LTC monthly benefit (1-4) _____% of rider specified amount.

¹LTC ABR not available in CA, KY, MA, NJ, OR, UT, VA, and WA.

10 Year Term Life Insurance Policy **20 Year Term Life Insurance Policy** **30 Year Term Life Insurance Policy**

Optional rider Waiver of Premium Rider

4. Product information (continued)

GenDex SurvivorSM Life Insurance Policy

Note: The GenDex Survivor product is a second to die policy. Insured's cannot be listed as each others beneficiaries. A separate person, corporation, or trust has to be named as the beneficiary.

Death Benefit Option (check one). If a box is not selected, Option A will be issued.

- A (specified amount)
- B (specified amount plus accumulation value)
- C (specified amount plus total premium paid)

Definition of life insurance test (check one). If a box is not selected, GPT will be issued.

- Cash value accumulation test (CVAT)
- Guideline premium test (GPT)

Minimum Annual Interest Rate (check one) If a box is not selected, the 0% option will be issued.

- 0%
- 1%

Select the following allocations in increments of "1". The minimum allocation is 1%. Total must equal 100%.

Monthly sum S&P 500 _____%	Monthly sum Nasdaq-100® _____%	Interest earning account _____%
Annual point-to-point S&P 500 _____%	Annual point-to-point Nasdaq-100® _____%	
Monthly sum EURO STOXX 50 _____%	Annual point-to-point blended _____%	
Annual point-to-point EURO STOXX 50 _____%	Monthly average blended _____%	

Optional riders

- Waiver of Specified Premium Rider for proposed first insured Waiver amount \$ _____
(Minimum: \$300/year; Maximum: lesser of \$150,000/year or 2 times the annual planned premium)
- Waiver of Specified Premium Rider for proposed second insured Waiver amount \$ _____
(Minimum: \$300/year; Maximum: lesser of \$150,000/year or 2 times the annual planned premium)
- Waiver of Monthly Deduction Rider for proposed first insured (not available with Waiver of Specified Premium Rider)
- Waiver of Monthly Deduction Rider for proposed second insured (not available with Waiver of Specified Premium Rider)
- Enhanced Liquidity Rider (check one) 50% 100%
- Estate Protection Rider
- First-to-Die Rider Rider specified amount \$ _____

Beneficiary information:

First name		MI	Last name	
Address (street required)			City	State ZIP code
<input type="checkbox"/> Primary	Percentage	Relationship		Social Security number
<input type="checkbox"/> Contingent				
First name		MI	Last name	
Address (street required)			City	State ZIP code
<input type="checkbox"/> Primary	Percentage	Relationship		Social Security number
<input type="checkbox"/> Contingent				

- Loan Protection Rider (not available with Cash value accumulation test (CVAT))

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.

4. Product information (continued)

GenDex FoundationSM Life Insurance Policy

Death Benefit Option (check one). If a box is not selected, Option A will be issued.

- A (specified amount)
- B (specified amount plus accumulation value)
- C (specified amount plus total premium paid)

Definition of life insurance test (check one). If a box is not selected, CVAT will be issued.

- Cash value accumulation test (CVAT)
- Guideline premium test (GPT)

Select the following allocations in increments of "1". The minimum allocation is 1%. Total must equal 100%.

[Monthly sum S&P 500 _____% Monthly sum Nasdaq-100[®] _____% Interest earning account _____%
Annual point-to-point S&P 500 _____% Annual point-to-point Nasdaq-100[®] _____%
Monthly sum EURO STOXX 50 _____% Annual point-to-point blended _____%
Annual point-to-point EURO STOXX 50 _____% Monthly average blended _____%]

Optional riders

- Other Insured Term Rider (Complete Supplemental Application [NB6010-01])
Rider specified (face) amount \$ _____
- Child Term Rider ___ units (\$1,000 per unit. Minimum 5 units/maximum 10 units. Issued to child(ren) ages 15 days to age 20).
Available at initial application or policy anniversary after birth of first child, complete Supplemental Application [NB6010-01]
- Waiver of Specified Premium Rider Waiver amount \$ _____
(Minimum: \$300/year; Maximum: lesser of \$150,000/year or 2 times the annual planned premium)
- Waiver of Monthly Deduction Rider (not available with Waiver of Specified Premium Rider)
- Long Term Care Accelerated Benefit Rider (LTC ABR)¹ Rider specified (face) amount \$ _____
LTC monthly benefit (1-4) _____% of rider specified amount
¹LTC ABR not available in CA, KY, MA, NJ, OR, UT, VA, and WA
- Loan Protection Rider (not available with Cash value accumulation test (CVAT))

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.]

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5. Beneficiary information – proposed primary insured’s/beneficiary/designated survivorships – percentage must equal 100% for primary and 100% for contingent. Note: Distribution will be made equally to the survivor(s) unless otherwise noted.

First name	MI	Last name	
Address (street required)		City	State ZIP code
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage	Relationship	Social Security number
First name	MI	Last name	
Address (street required)		City	State ZIP code
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage	Relationship	Social Security number
First name	MI	Last name	
Address (street required)		City	State ZIP code
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage	Relationship	Social Security number

Proposed primary insured’s beneficiary if not an individual – percentage must equal 100% for primary and 100% for contingent

Primary Contingent Trust Corporation Partnership Sole proprietorship

Trust/Business name (if applicable)	If trust is named, provide trustee’s first and last name	
Percentage	Date of trust (mm/dd/yyyy)	Tax or employer ID number (if available)

6. Proposed owner’s information, if other than proposed insured

Individual

First name	MI	Last name	
Date of birth (mm/dd/yyyy)	Social Security number	Relationship to proposed insured	
Home phone number		Business phone number	
Residence address (street required)			
City		State	ZIP code
Optional mailing address			
City		State	ZIP code

6. Proposed owner's information, if other than proposed insured (continued)

Trust Corporation Partnership Sole proprietorship

Trust/Business name (if applicable)		If trust is named, provide trustee's first and last name	
Date of trust (mm/dd/yyyy)	Tax or employer ID number	Preferred phone number	
Trustee/Business address (street required)			
City		State	ZIP code
Optional mailing address			
City		State	ZIP code

Proposed joint owner (proposed owners are joint tenants with rights of survivorship) or Contingent owner

First name	MI	Last name	
Date of birth (mm/dd/yyyy)	Social Security number		Relationship to proposed insured(s)
Residence address (street required)			
City		State	ZIP code
Optional mailing address			
City		State	ZIP code

7. Premium information

Total amount submitted with Application None, or enter amount \$ _____

Frequency, check one Single premium Annually Semiannually Quarterly Monthly (complete EFT authorization, and provide void check)

Lump-sum amount (Non-1035 exchange)	\$ _____	Billed premium amount	Additional billed amount
1035 exchange amount	+\$ _____		
Total lump sum	=\$ _____	\$ _____	\$ _____

Is lump sum coming from a 1035 exchange of a life insurance policy? Yes No

If from a life insurance policy, was the contract that is being replaced a Modified Endowment Contract (MEC)? Yes No

8. Replacement (proposed primary/first insureds)

Does the proposed primary/first insured have existing:

- Annuity contracts? Yes No
- Life insurance policies? Yes No
 Will the life insurance policy being considered replace or change existing contracts or policies? Yes No
 Amount of life insurance currently in force? \$ _____
- Long term care insurance (LTCi) policies/riders? Yes No
 Will the life insurance policy being considered replace or change existing LTCi contracts or policies/riders? Yes No

9. Insurance activity

Amount of life insurance currently in force \$ _____ or None in force or applied for

Amount of life insurance currently applied for, other than the amount being applied for on this application \$ _____

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for Inforce If applied for, will both policies be taken? Yes No

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for Inforce If applied for, will both policies be taken? Yes No

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for Inforce If applied for, will both policies be taken? Yes No

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for Inforce If applied for, will both policies be taken? Yes No

List any additional insurance in force or applied for in Section 10.

Have you ever been charged an extra premium or been declined coverage with another company? Yes No

If Yes, provide details:

10. Special requests:

11. Nonmedical section (proposed primary/first insured)

Provide details to any No answer for question 3, 5 and 13 and any Yes answer for questions 1, 2, 4 through 9, 12 through 14, and 18.

1. Have you smoked one or more cigarettes or used any other form of tobacco/nicotine within the past 10 years? Yes No
(If Yes, include date of last use, type of tobacco or nicotine, and amount used.)
2. Do you drink alcoholic beverages? Yes No
(If Yes, please advise frequency, number of drinks per occasion and type of alcohol used.)
3. Are you a U.S. Citizen? Yes No
If No, do you hold a green card or Visa? Yes No
Provide green card number or type of Visa: _____
Indicate how long you've been in the U.S.: _____
4. Are you a member or do you intend to become a member of the armed forces, including reserves? Yes No
5. Do you currently drive? Yes No
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? (List date(s) and violation type(s).) Yes No
6. Have you ever flown or plan to fly as a pilot or student pilot? (If Yes, complete aviation questionnaire [NB2270-01].) . Yes No
7. Do you intend to travel outside the US or Canada within the next two years? Yes No
(If yes, please provide reason for travel, anticipated dates of travel, including frequency of travel, where you'll be traveling – name of country and locale, and length of travel.)
8. Have you engaged in, or do you 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
(If Yes, complete avocation questionnaire [NB2271-01].)
9. Have you ever been convicted of a crime or are you currently on probation? Yes No
(If Yes, provide type of conviction(s) and date(s) of probation, name of county and state where convicted, and date(s) of convictions.)
10. 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

11. Nonmedical section (continued)

Provide details to any No answer for question 3, 5 and 13 and any Yes answer for questions 1, 2, 4 through 9, 12 through 14, and 18.

- 11. Have you been involved in any discussions regarding selling this life insurance policy? Yes No
- 12. 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
(If Yes, please explain)
- 13. Will any portion of the premium for this insurance be financed? Yes No
(If No, what source of funds will be used to pay for this policy? (for example, income, savings, investments, or mortgage)
Will any portion of the premium for this insurance be paid for by someone else? If Yes, by whom?)
(If Yes, are you obligated to repay the loan? What is the plan to repay the loan? Will you be able to pay the premiums on the policy if you were not able to renew the loan at some time in the future?)
- 14. Have you discussed changing ownership or beneficiaries once this policy is issued? Yes No
(If Yes, please provide the changes that will be made?)
- 15. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? Yes No
- 16. 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
- 17. 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
- 18. Do you engage in regular exercise?..... Yes No
(If yes, please provide type of exercise, how often you exercise, and how long you exercise.)

Question	Details

12. Medical section (proposed primary/first insured)

Name of your personal physician

Address of your personal physician

Phone number of your personal physician

Date of last visit

Reason consulted

Diagnosis made – treatment prescribed

Provide details to any questions answered Yes at the end of Section 12.

- 1. Your height in feet and inches: _____' _____" 2. Your weight in pounds: _____ lbs.
- 3. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months?..... Yes No
- 4. Do you have any physical deformity or defect? Yes No
- 5. Within the past 10 years, have you received medical advice or has treatment been recommended or received for:

12. Medical section (continued)

- a. Any abnormality or disease of the brain or nervous system, including depression, psychiatric or mental disorder, seizures, stroke or Transient Ischemic Attack (TIA), Parkinson’s disease, Multiple Sclerosis, Amyotrophic Lateral 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 Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (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 joints, muscle, or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? Yes No
- h. Any disease or abnormality of the eyes, ears, nose, throat or skin? Yes No
- i. Any disease or abnormality of the immune system (other than HIV or AIDS)? Yes No
- 6. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? Yes No
- 7. Within the last 12 months, have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body? Yes No
- 8. 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
- 9. 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
- 10. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency? Yes No
(If Yes, include the date(s) of treatment, type of treatment and name of facility, if applicable.)
- 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. 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
- 13. In the past 10 years, have you been treated or diagnosed with any other medical condition(s) not previously disclosed? Yes No
- 14. 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
- 15. Within the past five years, have you refused recommended surgery or treatment? Yes No

12. Medical section (continued)

16. Please fill in the box below regarding your family members (mother, father and siblings). If they have been diagnosed with and/or treated for cancer, stroke or aneurysm, diabetes, heart disease, surgery, or failure, including coronary bypass, or any neurodegenerative disorder, please provide details below:

Relationship to Applicant	Current age, if living	Details to any of the conditions named above including type of cancer, if applicable	Age at diagnosis, if applicable	Age at death if applicable
Mother				
Father				
Brother(s)				
Sister(s)				

Complete questions 17-19 only if age 66 and above, or applying for Long Term Care Accelerated Benefit Rider

17. Within the past 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
18. Within the past 12 months, have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair or any other medical appliance such as catheter, oxygen equipment, respirator or dialysis machine?..... Yes No
19. 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

Provide details here

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

Note: List any additional medical details in Section 12.

13. Acknowledgement and signatures

The following states require applicants to read and acknowledge the statement for your state below.

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

CO, OH, TN, VA: Any person who knowingly intends to defraud an insurance company, submits an application or files a statement of claim containing any false, incomplete, or misleading information, commits the crime of fraud, and may be subject to criminal prosecution and civil penalties. In CO, additional penalties may include imprisonment, fines, or denial of insurance benefits. Also in CO, an insurer or insurance agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of regulatory agencies.

DC, KY, NM: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In DC, penalties may include imprisonment and/or fines, or denial of insurance benefits. In NM, this activity subjects such a person to criminal and civil penalties.

RI: 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.

WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

I understand that the complete application consists of my written answers to the questions in this application and any supplemental applications. I agree, to the best of my knowledge and belief, 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, to the best of my knowledge and belief, my policy may not be valid, subject to the Incontestability provision in the policy. All statements and descriptions made here are considered to be representations and not warranties. 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. Information obtained from this application will be used only for the purpose of obtaining the coverage applied for.

CAUTION: Review your answers carefully; if your answers are incorrect or untrue, Allianz may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the policy.

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.

Signed at: _____
City State

Proposed primary insured's/first insured's signature: X _____ Date _____

Owner's signature: X _____ Date _____

To be answered by licensed agent:

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

To the best of my knowledge, the proposed insured 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 _____

14. Agent information

Printed agent name	Telephone number
Printed agent name	Telephone number

Supplemental Application

Proposed primary/first insured's name

First name	MI	Last name
------------	----	-----------

1. Proposed other insured, or second insured for GenDex Survivor®

First name	MI	Last name
------------	----	-----------

Relationship to insured	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)	Age	Social Security number
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Residence address (street required)

City	State	ZIP code
------	-------	----------

Place of birth (state and country)	Driver's license number	State of issue
------------------------------------	-------------------------	----------------

Specified amount/face amount (N/A for GenDex Survivor)	Rate class quoted
--	-------------------

2. Proposed other/second insured's occupational/financial information

Employer's name	Occupation/Duties
-----------------	-------------------

Length of employment	If less than two years, provide previous employer, occupation and length of employment:
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If self-employed, include the type of business.	Net worth \$	Annual income \$	See Underwriting Guidelines to determine if financial statement NB2012B or NB2012P should accompany this application.
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Are you limited from working full time? Yes No If Yes, provide details:

3. Proposed other insured's beneficiary(s) – percentage must equal 100% for primary and 100% for contingent.

(N/A for GenDex Survivor)

First name	MI	Last name
------------	----	-----------

Address (street required)	City	State	ZIP code
---------------------------	------	-------	----------

<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage	Relationship	Social Security number
---	------------	--------------	------------------------

First name	MI	Last name
------------	----	-----------

Address (street required)	City	State	ZIP code
---------------------------	------	-------	----------

<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage	Relationship	Social Security number
---	------------	--------------	------------------------

First name	MI	Last name
------------	----	-----------

Address (street required)	City	State	ZIP code
---------------------------	------	-------	----------

<input type="checkbox"/> Primary	Percentage	Relationship	Social Security number
----------------------------------	------------	--------------	------------------------

4. Proposed other insured's beneficiary if not an individual – percentage must equal 100% for primary and 100% for contingent

(N/A for GenDex Survivor)

<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Trust <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship
Trust/Business name (if applicable)	If trust is named, provide trustee's first and last name

Percentage	Date of trust (mm/dd/yyyy)	Tax or employer ID number (if available)
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Proposed other insured name _____

5. Child(ren) coverage (list name, date of birth, and gender for each child to be insured under Child Term Rider)

First and last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)
First and last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)
First and last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)
First and last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)

6. Proposed other/second insured's replacement

Does the proposed other/second insured have a(n) existing :

1. Annuity contracts? Yes No

2. Life insurance policies? Yes No

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

Amount of life insurance currently in force \$ _____

3. Long term care (LTC) policies/riders? Yes No

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

7. Proposed other/second insured's insurance activity

Amount of life insurance currently in force? \$ _____, or None in force or applied for

Amount of life insurance currently applied for, other than the amount being applied for on this application? \$ _____

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for In force If applied for, will both policies be taken? Yes No

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for In force If applied for, will both policies be taken? Yes No

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for In force If applied for, will both policies be taken? Yes No

Name of company	Face amount	Date issued/applied for
-----------------	-------------	-------------------------

Applied for In force If applied for, will both policies be taken? Yes No

List any additional insurance in force or applied for in Section 8.

Have you ever been charged an extra premium or been declined coverage with another company? Yes No

If Yes, provide details:

8. Special requests:

Proposed other insured name _____

9. Nonmedical section

Provide details to any No answer for question 3, 5 and 13 and any Yes answer for questions 1, 2, 4 through 9, 12 through 14, and 18.

- 1. Have you smoked one or more cigarettes or used any other form of tobacco/nicotine within the past 10 years? Yes No
(If Yes, include date of last use, type of tobacco or nicotine, and amount used.)
- 2. Do you drink alcoholic beverages? Yes No
(If Yes, please advise frequency, number of drinks per occasion and type of alcohol used.)
If No, do you hold a green card or Visa? Yes No
Provide green card number or type of Visa: _____
Indicate how long you've been in the U.S.: _____
- 4. Are you a member or do you intend to become a member of the armed forces, including reserves?..... Yes No
- 5. Do you currently drive? Yes No
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? (List date(s) and violation type(s).) Yes No
- 6. Have you ever flown or plan to fly as a pilot or student pilot? (If Yes, complete aviation questionnaire [NB2270-01].) . Yes No
- 7. Do you intend to travel outside the US or Canada within the next two years? Yes No
(If yes, please provide reason for travel, anticipated dates of travel, including frequency of travel, where you'll be traveling – name of country and locale, and length of travel.)
- 8. Have you engaged in, or do you 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
(If Yes, complete avocation questionnaire [NB2271-01].)
- 9. Have you ever been convicted of a crime or are you currently on probation? Yes No
(If Yes, provide type of conviction(s) and date(s) of probation, name of county and state where convicted, and date(s) of convictions.)
- 10. 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
- 11. Have you been involved in any discussions regarding selling this life insurance policy? Yes No
- 12. 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
(If Yes, please explain)
- 13. Will any portion of the premium for this insurance be financed? Yes No
(If No, what source of funds will be used to pay for this policy? (for example, income, savings, investments, or mortgage)
Will any portion of the premium for this insurance be paid for by someone else? If Yes, by whom?)
(If Yes, are you obligated to repay the loan? What is the plan to repay the loan? Will you be able to pay the premiums on the policy if you were not able to renew the loan at some time in the future?)
- 14. Have you discussed changing ownership or beneficiaries once this policy is issued? Yes No
(If Yes, please provide the changes that will be made?)
- 15. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? Yes No
- 16. 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
- 17. 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
- 18. Do you engage in regular exercise?..... Yes No
(If yes, please provide type of exercise, how often you exercise, and how long you exercise.)

Question	Details

10. Medical section

Name of your personal physician	Address of your personal physician
Phone number of your personal physician	Date of last visit
Reason consulted	Diagnosis made – treatment prescribed

Provide details for any questions answered Yes at the end of Section 10.

1. Your height in feet and inches: _____' _____" 2. Your weight in pounds: _____ lbs.
3. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months?..... Yes No
4. Do you have any physical deformity or defect? Yes No
5. 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 Transient Ischemic Attack (TIA), Parkinson’s disease, Multiple Sclerosis, Amyotrophic Lateral 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 Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (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 joints, muscle, or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? Yes No
 - h. Any disease or abnormality of the eyes, ears, nose, throat or skin?..... Yes No
 - i. Any disease or abnormality of the immune system (other than HIV or AIDS)?..... Yes No
6. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? Yes No
7. Within the last 12 months, have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body?..... Yes No
8. 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
9. 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
10. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency?..... Yes No
(If Yes, include the date(s) of treatment, type of treatment and name of facility, if applicable.)
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. 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

Proposed other insured name _____

10. Medical section (continued)

- 13. In the past 10 years, have you been treated or diagnosed with any other medical condition(s) not previously disclosed? Yes No
- 14. 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
- 15. Within the past five years, have you refused recommended surgery or treatment? Yes No
- 16. Please fill in the box below regarding your family members (mother, father and siblings). If they have been diagnosed with and/or treated for cancer, stroke or aneurysm, diabetes, heart disease, surgery, or failure, including coronary bypass, or any neurodegenerative disorder, please provide details below:

Relationship to Applicant	Current age, if living	Details to any of the conditions named above including type of cancer, if applicable	Age at diagnosis, if applicable	Age at death if applicable
Mother				
Father				
Brother(s)				
Sister(s)				

Complete questions 17-19 only if age 66 and above

- 17. Within the past 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
- 18. Within the past 12 months, have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair or any other medical appliance such as catheter, oxygen equipment, respirator or dialysis machine?..... Yes No
- 19. 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

Provide details here

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

Note: List any additional medical details in Section 10.

Proposed other insured name _____

11. Acknowledgement and signatures

The following states require applicants to read and acknowledge the statement for your state below.

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

CO, OH, TN, VA: Any person who knowingly intends to defraud an insurance company, submits an application or files a statement of claim containing any false, incomplete, or misleading information, commits the crime of fraud, and may be subject to criminal prosecution and civil penalties. In CO, additional penalties may include imprisonment, fines, or denial of insurance benefits. Also in CO, an insurer or insurance agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of regulatory agencies.

DC, KY, NM: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In DC, penalties may include imprisonment and/or fines, or denial of insurance benefits. In NM, this activity subjects such a person to criminal and civil penalties.

RI: 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.

WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

I understand that the complete application consists of my written answers to the questions in this application and any supplemental applications. I agree, to the best of my knowledge and belief, 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, to the best of my knowledge and belief, my policy may not be valid, subject to the Incontestability provision in the policy. All statements and descriptions made here are considered to be representations and not warranties. 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. Information obtained from this application will be used only for the purpose of obtaining the coverage applied for.

CAUTION: Review your answers carefully; if your answers are incorrect or untrue, Allianz may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the policy.

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.

Signed at: _____
City State Today's date

Proposed other/second insured's signature: X _____

To be answered by licensed agent:

I certify that the statements of the proposed other/second insured have been correctly recorded in this supplemental 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 _____

12. Agent information

Printed agent name	Telephone number
Printed agent name	Telephone number

Medical Examination-Part II

Proposed insured (first name, initial, last name)	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Medical section

Name of your personal physician

Address of your personal physician

Phone of your personal physician

Date of last visit

Reason consulted

Diagnosis made – treatment prescribed

Provide details to any questions answered Yes at the end of this section.

1. Your height in feet and inches: _____ ' _____ " 2. Your weight in pounds: _____ lbs.
3. Has your weight changed 10 pounds or more (weight loss or gain) in the past 12 months? Yes No
4. Do you have any physical deformity or defect? Yes No
5. 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 Transient Ischemic Attack (TIA), Parkinson’s disease, Multiple Sclerosis, Amyotrophic Lateral 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 Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (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 joints, muscle, or bones including arthritis, fibromyalgia, fatigue, systemic lupus (SLE), back trouble, osteoporosis, or joint replacement? Yes No
 - h. Any disease or abnormality of the eyes, ears, nose, throat or skin? Yes No
 - i. Any disease or abnormality of the immune system (other than HIV or AIDS)? Yes No
6. Have you ever received medical advice or has treatment been recommended or received for any cancer, tumor, or other abnormal growth? Yes No
7. Within the last 12 months, have you ever noticed any lump in your breast, lymph nodes, or elsewhere on your body? .. Yes No
8. 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
9. 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
10. Within the past 10 years, have you been advised to seek or had treatment for alcohol use or drug dependency? Yes No
(If Yes, include the date(s) of treatment, type of treatment, and name of facility, if applicable.)
11. Have you been prescribed or are you presently taking medication including prescription, nonprescription, or alternative remedies (i.e. holistic or herbal)? Yes No

Medical section (continued)

12. 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
13. In the past 10 years, have you been treated or diagnosed any other medical condition(s) not previously disclosed? .. Yes No
14. 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
15. Within the past five years, have you refused recommended surgery or treatment? Yes No
16. Please fill in the box below regarding your family members (mother, father and siblings).
If they have been diagnosed with and/or treated for cancer, stroke or aneurysm, diabetes, heart disease, surgery, or failure, including coronary bypass, or any neurodegenerative disorder, please provide details below:

Relationship to applicant	Current age, if living	Details to any of the conditions named above including type of cancer, if applicable	Age at diagnosis, if applicable	Age at death, if applicable
Father				
Mother				
Brother(s)				
Sister(s)				

Complete questions 17 – 19 only if age 66 and above, or applying for Long Term Care Accelerated Benefit Rider

17. Within the past 12 months, have you ever required or do you currently require assistance or supervision, or are you limited in performing daily activities such as bathing, dressing, toileting, managing money, using the telephone, driving, eating, mobility, or managing medication? Yes No
18. Within the past 12 months, have you ever required or do you currently require or use a cane, brace(s), walker, wheelchair or other medical appliances such as catheter, oxygen equipment, respirator or dialysis machine? Yes No
19. 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

Provide details here

Question	Date	Description	Name and address of medical source or facility

Acknowledgement and signatures

I DECLARE that, to the best of my knowledge and belief, the statements and answers in this Part II of the Medical Examination are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

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

CO, OH, TN, VA: Any person who knowingly intends to defraud an insurance company, submits an application or files a statement of claim containing any false, incomplete, or misleading information, commits the crime of fraud, and may be subject to criminal prosecution and civil penalties. In CO, additional penalties may include imprisonment, fines, or denial of insurance benefits. Also in CO, an insurer or insurance agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of regulatory agencies.

DC, KY, NM: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In DC, penalties may include imprisonment and/or fines, or denial of insurance benefits. In NM, this activity subjects such a person to criminal and civil penalties.

RI: 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.

WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

Signed at: (city & state) _____ On _____ 20_____

Signature of examiner

Signature of proposed insured

Aviation Questionnaire

Proposed insured:

First name	MI	Last name
Total number of hours flown as a pilot or a crew member		Total number of hours flown in the last 12 months
Total number of hours anticipated flying in the next 12 months		Date of last flight

Do you plan that your future flying will be of a different nature?

Yes No If yes, explain: _____

Provide the type of certificate held (please check):

- Student Recreational Private Commercial
 Airline transport Instrument Flight Rating (IFR) Other (specify) _____

What is the current status of your certificate:

Provide the purpose of flying (please check all that apply)

- Private/pleasure Commercial Military* Flight instruction Crop spraying
 Aerial photography Airline crew Construction work Helicopter Police work
 Survey work Test pilot Other (specify): _____

Provide the type of airplane flown (include category, class and type of aircraft):

Do you fly outside the U.S.?

Yes No If yes, provide details including frequency, location and reason _____

Have there been any aviation accidents and/or violations?

Yes No If yes, provide details including date, location, any injuries and cause of the accident or type of violation: _____

Has your certificate ever been suspended or revoked?

Yes No If yes, provide details including when and reason for suspension or revocation: _____

Do you engage in aerobatic flight, stunt flying, racing, or have you flown or do you contemplate flying an experimental or amateur built aircraft?

Yes No If yes, provide details: _____

If your aviation activity requires an extra premium or aviation exclusion rider, which would you prefer?

Extra premium Aviation exclusion rider

*For military aviation, please complete military aviation section below.

Aviation – Military

Which branch of the military are you flying for?

- Army – fixed wing Army – helicopter Coast Guard Air Force
 Marines Navy National Guard or Reserves

What is your position when flying?

- Pilot Crew member Student Instructor
 Flight surgeon or nurse Other (specify): _____

What type of aircraft is flown?

- Anti-submarine Attack Attack fighter Bomber Cargo/transport Fighter (interceptor)
 Glider Helicopter Observation Patrol Reconnaissance Tanker
 Utility Prototype or experimental Space project Other (specify): _____

Do you do proficiency flying (defined as <150 hours per year, primary duties administrative)? Yes No

Acknowledgement and signatures

I understand that the answers to the questions in this questionnaire are part of my complete application for life insurance. I agree that the questions have been answered completely and truthfully, to the best of my knowledge and belief. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, the policy may not be valid, subject to the Incontestability provision in the policy.

CAUTION: Review your answers carefully; if your answers are incorrect or untrue, Allianz may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the policy. A copy of this questionnaire will be attached to and made part of any life insurance policy issued.

Signed at _____ this _____ day of _____
City, State

Signed: _____ Witnessed By: _____
Proposed insured's signature Agent's signature

Avocation Questionnaire

Proposed insured:

First name	MI	Last name
------------	----	-----------

Skin or Scuba diving

What is the level of certification? Basic Open water Advanced open water Master Diver Other (specify):

Diving history	Number of dives in past 12 months	Number of dives anticipated in the next 12 months
75 feet or under		
76 – 100 feet		
>100 feet		

What is the average depth of your dives? _____ feet	How many dives have you made in your lifetime?	Date of your last dive?
--	--	-------------------------

Where do you dive? <input type="checkbox"/> Ocean/sea <input type="checkbox"/> Inland waters (lakes/rivers)	Do you ever dive alone? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:
--	--

What is the purpose of your diving?

Recreation Commercial Instruction Photography
 Hunting Wreck/salvage/retrieval Other (specify):

Do you plan that your future diving will be of a different nature?
 Yes No If yes, explain:

Do you engage in any specialty/technical diving? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of specialty diving? <input type="checkbox"/> Cave <input type="checkbox"/> Wreck <input type="checkbox"/> Ice <input type="checkbox"/> Deep <input type="checkbox"/> Nitrox <input type="checkbox"/> Other (specify):
--	--

Have you ever experienced or been treated for Decompression Illness? (includes Decompression Sickness (CDs) or Arterial Gas Embolism (AGE - also known as air embolism))
 Yes No If yes, provide details including date, name of facility where treated, current status: _____

Have you ever had a diving accident?
 Yes No If yes, provide details including date, details of accident, name of facility where treated and current status: _____

Motorized sports (includes automobiles, motorcycles, motor boats, snowmobiles, karts, dirt bikes, and dune buggies)

What type of vehicle is driven?
 Automobile Motorcycle Motor boat Snowmobile Kart Dirt bike Dune buggy Other (specify):

What type of racing do you participate in?
 Crash/demolition Derby Championship/Indy car Drag Dune/sand Buggy Go kart Midget Sprint
 Stock Sports car Solo events Rally/slalom Other (specify):

What type of event do you participate in? (i.e. Sprint Cup, Nationwide Series, , NASCAR, Craftsman Truck Series, World of Outlaws, Baby Grand National, etc):

Are you affiliated with any racing organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of organization:	Number of races in the past 12 months
---	---------------------------------------

Number of races anticipated in the next 12 months	Do you plan that your future participation will be of a different nature? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
---	--

Years of experience _____ years	Date of last race	Vehicle make/model
------------------------------------	-------------------	--------------------

Engine displacement/horsepower	Type of gas/fuel	Maximum speed (MPH)
--------------------------------	------------------	---------------------

Have any modifications been made to the vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	Length of track/course
---	------------------------

Length of race (miles, laps, time)	Class/category/division (i.e. stock, street prepared, modified, street touring, etc.)
------------------------------------	---

Type of course
 Paved track Dirt Drag strip Offroad/desert Ice Other (specify):

Have you attended a competition driver's school or hold a competition driver's license?
 Yes No If yes, explain:

Do you anticipate racing in any other type or class racing?
 Yes No If yes, provide details:

Sky-diving or surfing, ballooning or hang-gliding

Type of sport in which you participate:	Number of times in past 12 months	Number of times contemplated in the next 12 months	Date you last participated in this sport
Sky diving			
Sky surfing			
Ballooning			
Hang-gliding			
Other (specify)			

Any flying over mountains, remote terrain or ocean/sea by history or planned for the future?

Yes No If yes, provide details including dates, location and frequency, include any future plans: _____

What is the maximum height?

Level of experience in the sport

Amateur Student Professional

Any record attempts or stunt/test flying?

Yes No If yes, provide details:

Do you plan that your future participation will be of a different nature?

Yes No If yes, explain:

If ballooning, is it

Tethered Free flight

Do you use

Helium Hot air

How many hours of flying per year?

How many hours of experience?

Any around-the-world flights?

Yes No If yes, provide details:

If hang gliding, are you a member of a club/association?

Yes No

Do you operate a powered hang-glider?

Yes No If yes, provide details:

If sky diving or surfing, are you a member of a club/association?

Yes No

Are you an instructor or trainer?

Yes No If yes, provide details:

Mountaineering/Rock climbing

What type of climbing do you do?

Trail Rock Snow and ice Mountain Other (specify):

How often do you climb?

Date of your last climb?

How long have you been climbing?

What is your average height?

On your average climb, how many hours/days would you be climbing?

What is your level of climbing (using Yosemite Decimal System of climbing)?

What courses have you completed and in what year(s)?

What was the location of your last climb?

Name the geographical location(s) where you climb:

What was your highest climb (include the height, location and date)?

What was your highest level of difficulty (include location and date)?

List the equipment you normally carry:

Do you ever climb alone?

Yes No If yes, provide details:

What are your future climbing goals and climbing locations?

Other

Type of avocation in which you participate:	Number of times in past 12 months	Number of times contemplated in the next 12 months	Date you last participated in this avocation
Rodeos			
Cave exploring/spelunking			
Extreme sports: <input type="checkbox"/> Bungee jumping			
<input type="checkbox"/> Canyoneer			
<input type="checkbox"/> Street luge			
<input type="checkbox"/> Zorbing			
<input type="checkbox"/> White water rafting			
<input type="checkbox"/> BASE jumping			
<input type="checkbox"/> Adventure racing			
<input type="checkbox"/> Other:			
Record events: What record:			

If rodeos, What event(s) do you participate in?

Amateur Professional

If cave exploring/spelunking, where do you go?

Are you a member of a club or rescue team?

Yes No If yes, provide details:

If record events, will you attempt this or other records in the future?

Yes No If yes, provide details:

Do you plan that your future participation will be of a different nature?

Yes No If yes, provide details:

Acknowledgement and signatures

I understand that the answers to the questions in this questionnaire are part of my complete application for life insurance. I agree that the questions have been answered completely and truthfully, to the best of my knowledge and belief. I am aware that Allianz will rely on these answers and that if my answers are not complete and true, the policy may not be valid, subject to the Incontestability provision in the policy.

CAUTION: Review your answers carefully; if your answers are incorrect or untrue, Allianz may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the policy. A copy of this questionnaire will be attached to and made part of any life insurance policy issued.

Signed at _____ this _____ day of _____
City, State

Signed: _____ Witnessed By: _____
Proposed insured's signature Agent's signature

Supplement to the Life Insurance Application

Business Financial Questionnaire

We retain the right to require additional documentation and/or financial and tax statements for verification as needed.

Proposed Insured: _____ Date of Birth: ____/____/____
First Middle Last MM DD YYYY

Please check purpose of insurance: Buy-Sell Deferred Compensation Split Dollar – Provide details in cover letter
 Key Person Executive Bonus REBA Restricted Executive Bonus Arrangement
 Business Loan Protection – Provide a copy of the loan agreement
 Other _____

How was the face amount determined? _____

Has a needs analysis been completed? Yes No If yes, please provide a copy.

Information on the Company (Must complete all of the following section.)

Name of Company: _____

Address of Company: _____ City: _____ State: _____ Zip: _____

Company's Web Site, if available: _____

Description of Business Engaged In: _____

Type of Organization: Corporation Partnership Sole Proprietorship Other _____
 C-Corp S-Corp LLC Start Up

Date Company Established: _____ State of Registration: _____ No of employees: _____

Company's Fair Market Value: \$ _____ How was this value determined: _____

1. Do you expect any significant changes in income or net worth for this company in the next year? Yes No

If "Yes", please explain: _____

2. Have operations of the business changed significantly in the last 3 years or do you anticipate any major changes in the next 24 months? Yes No

If "Yes" please explain: _____

3. Are there any pending lawsuits or liens against the company? Yes No

If "Yes" please provide details: _____

4. Have you or the business declared bankruptcy in the past 5 years or do you anticipate declaring bankruptcy in the foreseeable future? Yes No

If "Yes" check which applies and provide details below: _____

Type of bankruptcy: Chapter 7 (debt forgiveness) Chapter 13 (debt reorganization)

Date Filed: ____/____/____
MM DD YYYY

Current status: Still open Closed If closed, provide date bankruptcy was discharged: ____/____/____
MM DD YYYY

Information on the Company (continued)

Please provide Business Finances for Last 2 Years (If available, attach copy of the income statements and balance sheets for last 2 years)

Year	Assets	Net Worth	Net Worth	Gross Sales	Net Profit

Please complete the following information for each partner, owner, corporation officer or key person:

Name	Title	Ownership Percentage	Amount of Insurance in for Applied for	Purpose of Insurance
		%	\$	
		%	\$	
		%	\$	
		%	\$	
		%	\$	

If other members of the company are not insured or not applying, please explain: _____

Proposed Insured's Information (Must complete all of the following section.)

Title and duties of proposed insured: _____

Years with company: _____ Ownership percentage: _____% Value of Ownership Percentage \$ _____

Years of experience in a similar or the same business, but with a different company? _____

Proposed Life Insured's personal compensation for the year as related to this business:

Source of Earnings	Amount (most recent year)	Amount (two years ago)
Salary	\$	\$
Bonuses or Commissions	\$	\$
Retained Earnings	\$	\$
Undistributed Profits	\$	\$
Stock Options	\$	\$
Other	\$	\$
Total	\$	\$

Third Party Financial Advisor Information

Do you have a third party financial advisor (i.e. attorney, CPA, certified financial planner) or did an advisor help you prepare this Personal Financial Questionnaire? If "Yes" please provide the following details: Yes No

Advisor's Name: _____ Designation: _____ License #: _____

Accounting Firm Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ - _____ - _____ How long have they been representing you? _____

For Key Person insurance only:

How is the proposed insured financially valuable to the company? _____

What unique skills, knowledge or abilities does he/she possess which makes the life insurance necessary? _____

For Buy-Sell – Cross Purchase or Split Dollar insurance only :

Is there a written agreement in effect? Yes No If yes, please provide a copy.

Agreement being currently prepared? Yes No Expected finalization date? _____

Has or is a professional business valuation being done? Yes No If yes, please provide a copy.

For Loan Protection insurance only – attach a copy of the loan agreement:

Did the lender request the insurance? Yes No Name of lender: _____

Amount of coverage required by lender? \$ _____ Amount of the loan \$ _____

Purpose of loan: _____

Origination date of the loan: ____/____/____ Personally Guaranteed? Yes No

I understand that my answers to the questions on this form are part of my complete application for life insurance. I represent that all information and values provided on this form are true and accurate statements to the best of my knowledge and belief. I further agree that I will notify Allianz if any statement or answer given on this Business Financial Questionnaire changes prior to policy delivery. 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, subject to the Incontestability provision in the policy.

CAUTION: Review your answers carefully; if your answers are incorrect or untrue, Allianz may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the policy. A copy of this supplement to the life insurance application will be attached to and made part of any life insurance policy issued.

Proposed insured's signature: _____ Today's Date: ____/____/____

Proposed owner's signature: _____ Today's Date: ____/____/____

Agent's signature: _____ Today's Date: ____/____/____

Supplement to the Life Insurance Application

Personal Financial Questionnaire

We retain the right to require additional documentation and/or financial and tax statements for verification as needed.

Proposed Insured: _____ Date of Birth: ____/____/____
First Middle Last MM DD YYYY

Please provide a breakdown of proposed insured's income and worth below:

Assets	Liabilities	Proposed Insured's Earned Income – Past Year	Proposed Insured's Unearned Income – Past Year
Cash in Bank \$	Unpaid Interest & Taxes \$	Salary (if self employed, provide gross and net) \$	Pension/Social Security \$
Primary Real Estate ¹ \$	Mortgages \$	Bonus \$	Disability Payments, if Applicable \$
Other Real Estate Holdings ¹ \$	Credit Card Debt \$	Commission \$	Dividends/Interest \$
Stocks, Bonds, Securities \$	Secured Loans \$	Spouse's Earned Income \$	Rentals/Royalties \$
Personal Property \$	Personal Notes \$	Other \$	Other \$
Business Equity ² \$	Other Long Term Debt \$	Total Earned Income \$	Total Unearned Income \$
Life Insurance Cash Value \$	Other Liabilities (provide details) \$		
401K, IRA or SEP \$	\$		
Annuities \$	\$		
Other Assets – Provide Details \$	\$		
Total Assets \$	- Total Liabilities \$	= Net Worth \$	

¹ Real estate holdings (If additional space is needed, list on a separate sheet which is signed and dated)

Property Address	Purchase Price	Date Purchased	Current Market Value	How Was Value Determined	Ownership	Outstanding Mortgage Amount
	\$		\$		%	\$
	\$		\$		%	\$
	\$		\$		%	\$
	\$		\$		%	\$
TOTALS			\$			\$

² Business Equity (If additional space is needed, list on a separate sheet which is signed and dated)

Name of Business	Type of business	Year Acquired	Percentage Owned	Fair Market Value	How Was Value Determined

Personal Financial Questionnaire – continued

1. Do you expect any significant changes in income or net worth in the next year? Yes No
If "Yes", explain: _____

2. Have you declared bankruptcy in the past 5 years or do you anticipate declaring bankruptcy in the future?
If "Yes", check which applies and provide details below: Yes No

Type of bankruptcy: Chapter 7 (debt forgiveness) Chapter 13 (debt reorganization)

Date Filed: ____/____/____
MM DD YYYY

Current status: Still open Closed If closed, provide date bankruptcy was discharged: ____/____/____
MM DD YYYY

3. Are there any pending lawsuits or liens against you or any of your business interests? Yes No
If "Yes", please provide details: _____

Please check purpose for death benefit need:

- Income Replacement Retirement Income Estate Preservation Final Expenses
- Charitable Giving – Provide annual donation amount \$ _____
- Mortgage Protection - Provide mortgage amount \$ _____
- Debt repayment/loan protection - Loan amount \$ _____ (Provide a copy of the loan)
- Other: _____

How was the face amount determined? _____

A detailed cover letter is strongly encouraged.

Third Party Financial Advisor Information

Do you have a third party financial advisor (i.e. attorney, CPA, certified financial planner) or did an advisor help you prepare this Personal Financial Questionnaire? If "Yes" please provide the following details: Yes No

Advisor's Name: _____ Designation: _____ License #: _____

Accounting Firm Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ - _____ - _____ How long have they been representing you? _____

In what capacity have they represented you? _____

I understand that my answers to the questions on this form are part of my complete application for life insurance. I represent that all information and values provided on this form are true and accurate statements to the best of my knowledge and belief. I further agree that I will notify Allianz if any statement or answer given on this Personal Financial Questionnaire changes prior to policy delivery. 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, subject to the Incontestability provision in the policy.

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Proposed insured's signature: _____ Today's Date: ____/____/____

Proposed owner's signature: _____ Today's Date: ____/____/____

Agent's signature: _____ Today's Date: ____/____/____

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:]

[Indexed allocations [(standard)] [(select)]:

[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:]

[Fixed 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]

[Inflation Protection 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: \$ Frequency:
Total billed amount: \$
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 life insurance 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Life insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

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

Proposed other insured	# 1	[# 2	[# 3	[# 4
<input type="checkbox"/> Yes <input type="checkbox"/> 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"/> |
| 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
20. Do you drink alcoholic beverages? Yes No Yes No
21. Do you engage in regular exercise? Yes No Yes No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2 through 11, 14 through 16, and 20 through 21 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:

Phone number of your personal physician:

Reason consulted:

Diagnosis made–treatment prescribed:

[Proposed other insured #1

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 other insured #2

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 other insured #3

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 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 (mother father, siblings) been diagnosed with and/or treated for cancer, stroke or aneurysm, diabetes, heart disease, surgery, or failure, including coronary bypass, or any neurodegenerative disorder?..... 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, or any 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
20. Is your father still living? Yes No Yes No
21. Is your mother still living? Yes No Yes No

Details to medical questions 4 - 21

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 and any supplemental applications. I agree, to the best of my knowledge and belief, 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, to the best of my knowledge and belief, my policy may not be valid, subject to the Incontestability provision in the policy. All statements and descriptions made here are considered representations and not warranties. 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. Information obtained from this application will be used only for the purpose of obtaining the coverage applied for.

[Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the 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 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:]

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:]

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 |
| 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 |

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 Yes No
13. Have you been involved in any discussions regarding selling this life insurance policy? Yes No 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 Yes No
15. Will any portion of the premium for this insurance be financed? Yes No Yes No
16. Have you discussed changing ownership or beneficiaries once this policy is issued? Yes No 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 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 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 Yes No
20. Do you drink alcoholic beverages? Yes No Yes No
21. Do you engage in regular exercise? Yes No Yes No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2 through 11, 14 through 16, and 20 through 21 above.

Under Insured - P1 indicates proposed first insured, P2 indicates proposed second insured

Question number Insured Details

X. Medical history

1. Proposed first 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 second 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 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 (mother, father, siblings) been diagnosed with and/or treated for cancer, stroke or aneurysm, diabetes, heart disease, surgery, or failure, including coronary bypass,, or any neurodegenerative disorder?.....	<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, or any 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
- 20. Is your father still living? Yes No Yes No
- 21. Is your mother still living? Yes No Yes No

Details to medical questions 4 - 21

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 and any supplemental applications. I agree, to the best of my knowledge and belief, 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, to the best of my knowledge and belief, my policy may not be valid, subject to the Incontestability provision in the policy. All statements and descriptions made here are considered representations and not warranties. 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. Information obtained from this application will be used only for the purpose of obtaining the coverage applied for.

[Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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, subject to the Incontestability provision in the 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:

Aviation Exclusion Endorsement

The Company has issued this endorsement as a part of the Entire Contract. If there are any conflicts between this endorsement and the policy, the provisions of this endorsement will prevail.

Definitions

The following term is added to the Definitions section.

Crew Member

A Crew Member is a pilot, officer, or any other person having duties aboard an aircraft. This includes any person giving or receiving instructions.

Aviation Exclusion

If the Insured, or the last surviving Insured in the case of a joint last survivor policy, dies as a result of operating or riding in any kind of aircraft while a Crew Member of that aircraft, we are liable only for premium paid, minus any Partial Surrenders, any applicable Partial Surrender Charges, any Policy Loans, and any accelerated benefits. Premium paid does not include any premium that is waived under any attached riders.

This exclusion also applies if the last surviving Insured, in the case of a joint last survivor policy, dies as a result of riding in any kind of aircraft with a Crew Member of that aircraft and the Crew Member is an Insured.

This exclusion does not apply to any rider providing benefits specifically for disability or death by accident.

In all other respects, the provisions, conditions, exceptions, and limitations contained in the policy remain unchanged and apply to this endorsement.

Signed for the Company at its home office.

Allianz Life Insurance Company Of North America

[

Maureen A. Phillips
Secretary

Gary Bhojwani
President

]

SERFF Tracking Number: ALLE-127069806 State: Arkansas
Filing Company: Allianz Life Insurance Company of North America State Tracking Number: 48227
Company Tracking Number: LIFE APPLICATION FILING LAPP-01 ETAL MAR 2011
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life
Adjustable Life
Product Name: Life Application Filing LAPP-01 etal Mar 2011
Project Name/Number: Life Application Filing LAPP-01 etal Mar 2011/LAPP-01

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Certificate of Readability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Please see form schedule tab.		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: SOV Life Applications 3.8.11.pdf		

CERTIFICATE OF READABILITY

Contract Form	Flesch Score
LAPP-01	50 (when scored with contract)
NB6010-01	50 (when scored with contract)
NB6009-01	50 (when scored with contract)
NB2270-01	50 (when scored with contract)
NB2271-01	50 (when scored with contract)
NB2012B	50 (when scored with contract)
NB2012P	50 (when scored with contract)
AR-UL3-03	50 (when scored with contract)
AR-JSL-03	50 (when scored with contract)
PE95132	52.3

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: March 10, 2011

Martin G. Kline, AVP Product Development

Statement of Variability

Allianz Life Insurance Company of North America
Forms LAPP-01, NB6010-01, NB6009-01, NB2270-01, NB2271-01, NB2012B, NB2012P,
AR-UL3-03, AR-JSL-03, PE95132

March 8, 2011

Each item is listed in order of appearance on the applicable form. Variable material is denoted as bracketed [] in the form referenced. Blank boxes for the Minimum, Maximum and Current columns do not require further explanation. Please note that if some of these listed items have not been bracketed on the applicable form(s) submitted to you, please disregard the corresponding explanation.

Application Form LAPP-01

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Company Address and Telephone Number				Variable to indicate current mailing address and telephone number.
1	NB6010				Variable to permit form number changes.
ALL	Page numbers				Bracketed page numbers allow the application to print with correct pagination and without blank areas, based on the plan/benefits/disclosures available or required.
ALL	Revision number in right hand corner				Variable to allow for company printing versions; this date will tie to the rollout date of this application.
1, 2, 3, 4	Section 4 – Product information <u>This includes:</u> Product names, Index/product options, riders options, directives below each set of product names, supplemental application requirements, periods, terms				Based on the products' marketing names/index allocation options for each/product options and/or benefits available at the time of application. New products/affiliated options or riders that have been approved by the Department may be added. Also, any products/affiliated options or riders being discontinued will be removed. Any changes will be made to new applications going forward.
4	Bottom of page – Index disclosures				Variable to allow for additions or deletions of indexes and/or changes in disclosure language based on the individual index. Any changes will be made to new applications going forward.
4	Section 9 – Acknowledgement and signatures				Variable to allow for additions or deletions of state required fraud language. These disclosures will need to be updated as states adopt or change their fraud language. Any changes will be made to new applications going forward.

Application Form NB6010-01

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Company Address and Telephone Number				Variable to indicate current mailing address and telephone number.
ALL	Revision number in right hand corner				Variable to allow for company printing versions; this date will tie to the rollout date of this application.
6	Section 11 – Acknowledgement and signatures				Variable to allow for additions or deletions of state required fraud language. These disclosures will need to be updated as states adopt or change their fraud language. Any changes will be made to new applications going forward.

Application Form NB6009-01

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Company Address and Telephone Number				Variable to indicate current mailing address and telephone number.
ALL	Revision number in right hand corner				Variable to allow for company printing versions; this date will tie to the rollout date of this application.
3	Acknowledgement and signatures				Variable to allow for additions or deletions of state required fraud language. These disclosures will need to be updated as states adopt or change their fraud language. Any changes will be made to new applications going forward.

Application Forms NB2270-01, NB2271-01, NB2012B, and NB2012P

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Company Address and Telephone Number				Variable to indicate current mailing address and telephone number.
ALL	Revision number in right hand corner				Variable to allow for company printing versions; this date will tie to the rollout date of this application.

Application Form AR-UL3-03

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Company Address				Variable to indicate current mailing address.
1	Section I and II – Optional mailing address				Variable due to insured/owner's address.
1	Owner's name/date of birth/social security number/residence address				Variable due to owner.
1 and 2	Sections II and III– Date of trust				If applicable, date of trust will be noted.

1 and 2	Sections II and III – Tax or employer ID number				If applicable, tax or employer ID will be noted.
1	Section II – joint owner name				If applicable, joint owner name will be noted.
1	Section II – contingent owner/date of birth social security number/residence address				If applicable, contingent owner name will be noted.
ALL	Page numbers				Bracketed page numbers allow the application to print with correct pagination and without blank areas, based on the plan/benefits/disclosures available or required.
2	Section III – Contingent beneficiary/percentage/relationship				If applicable, contingent beneficiary will be noted.
2 and 3	Section IV – Coverage information – Plan of Insurance/rider coverage				<p>Based on the products' marketing names and/or benefits/riders/index allocation options available at the time of application. New products/affiliated options that have been approved by the Department may be added. Also, any products/affiliated options being discontinued will be removed. Currently, the products and/or riders shown on the application are as follows:</p> <ul style="list-style-type: none"> • Generation Planner II Life Insurance Policy with riders Child Term Rider, Waiver of Premium Rider and Long Term Care Accelerated Benefit Rider. • 10-20-30 Year Term Life Insurance Policy with Waiver of Premium Rider. • Life Pro+ Life Insurance Policy with riders Enhanced Cash Value Rider, Additional Term Rider, Other Insured Term Rider, Child Term Rider, Waiver of Specified Premium Rider, Waiver of Monthly Deduction Rider, Enhanced Liquidity Rider, Long Term Care Accelerated Benefit Rider and Loan Protection Rider. • GenDex Survivor Life Insurance Policy with riders Waiver of Specified Premium Rider, Waiver of Monthly Deduction Rider, Enhanced Liquidity Rider, Estate Protection Rider, First-To-Die Rider and Loan Protection Rider. • GenDex Foundation with riders Other Insured Term Rider, Child Term Rider, Waiver of Specified Premium Rider, Waiver of Monthly Deduction Rider, Long Term Care Accelerated Benefit Rider and Loan Protection Rider.
2	Bottom of page – Index disclosures				Variable to allow for additions or deletions of indexes and/or changes in disclosure language based on the individual index. Any changes will be made to new applications going forward.

4	Section VI – Replacement				If applicable, amount of life insurance in force/ name of company/ annuity contracts/LTC insurance policies information will populate for primary and other insured(s). Second insured will populate for joint survivor life policy.
4	Section VI – Proposed other insured				Replacement information for proposed other insured(s) will populate if applicable.
5	Section VII – Proposed other insured				Occupational/financial information for proposed other insured(s) will populate if applicable.
6	Section IX – Proposed other insureds				Medical history for proposed other insured(s) will populate if applicable.
8	Agreement and signatures – fraud language				Variable to allow for additions or deletions of state required fraud language. These disclosures will need to be updated as states adopt or change their fraud language. Any changes will be made to new applications going forward.
9	Section X - Agreement and Permission section for proposed other insured(s.)				If applicable will populate with information for proposed other insured, signature line for proposed other insured.

Application Form AR-JSL-03

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Company Address				Variable to indicate current mailing address.
1 and 2	Section I, II and III – Optional mailing address				Variable due to insured/owner's address.
1	Owner's name/date of birth/social security number/residence address				Variable due to owner.
ALL	Page numbers				Bracketed page numbers allow the application to print with correct pagination and without blank areas, based on the plan/benefits/disclosures available or required.
1 and 2	Sections III and IV – Date of trust				If applicable, date of trust will be noted.
1	Section III and IV – Tax or employer ID number				If applicable, tax or employer ID will be noted.
1	Section III – joint owner name/date of birth, social security number residence, address				If applicable, joint owner name will be noted.
2	Section III – contingent owner/date of birth social security number/residence address				If applicable, contingent owner name will be noted.
ALL	Page numbers				Bracketed page numbers allow the application to print with correct pagination and without blank areas, based on the plan/benefits/

					disclosures available or required.
2	Section IV – Contingent beneficiary/percentage/relationship				If applicable, contingent beneficiary will be noted.
2 and 3	Section V – Coverage information – Plan of Insurance/rider coverage				<p>Based on the products' marketing names and/or benefits/riders/index allocation options available at the time of application. New products/affiliated options that have been approved by the Department may be added. Also, any products/affiliated options being discontinued will be removed. Currently, the products and/or riders shown on the application are as follows:</p> <ul style="list-style-type: none"> • Generation Planner II Life Insurance Policy with riders Child Term Rider, Waiver of Premium Rider and Long Term Care Accelerated Benefit Rider. • 10-20-30 Year Term Life Insurance Policy with Waiver of Premium Rider. • Life Pro+ Life Insurance Policy with riders Enhanced Cash Value Rider, Additional Term Rider, Other Insured Term Rider, Child Term Rider, Waiver of Specified Premium Rider, Waiver of Monthly Deduction Rider, Enhanced Liquidity Rider, Long Term Care Accelerated Benefit Rider and Loan Protection Rider. • GenDex Survivor Life Insurance Policy with riders Waiver of Specified Premium Rider, Waiver of Monthly Deduction Rider, Enhanced Liquidity Rider, Estate Protection Rider, First-To-Die Rider and Loan Protection Rider. • GenDex Foundation with riders Other Insured Term Rider, Child Term Rider, Waiver of Specified Premium Rider, Waiver of Monthly Deduction Rider, Long Term Care Accelerated Benefit Rider and Loan Protection Rider.
2	Bottom of page – Index disclosures				Variable to allow for additions or deletions of indexes and/or changes in disclosure language based on the individual index. Any changes will be made to new applications going forward.
4	Section VII – Replacement				If applicable, amount of life insurance in force/ name of company/ annuity contracts information will populate for primary and other insured(s). Second insured will populate for joint survivor life policy.
8	Agreement and signatures – fraud language				Variable to allow for additions or deletions of state required fraud language. These disclosures will need to be updated as states adopt or change their fraud language. Any changes will be made to new applications going forward.

Form PE95132

Page #	Variable	Minimum	Maximum	Current	Rationale
1	Names and signatures of company officers				If an officer changes, these names and signatures will change and we will prepare and submit all required filings at the time of any change.

SERFF Tracking Number: ALLE-127069806 State: Arkansas
 Filing Company: Allianz Life Insurance Company of North America State Tracking Number: 48227
 Company Tracking Number: LIFE APPLICATION FILING LAPP-01 ETAL MAR 2011
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.101 External Indexed - Single Life
 Adjustable Life
 Product Name: Life Application Filing LAPP-01 etal Mar 2011
 Project Name/Number: Life Application Filing LAPP-01 etal Mar 2011/LAPP-01

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)
03/10/2011	Form	Application for Life Insurance	03/15/2011	AR-JSL-03 3.2.11.pdf (Superseded)

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:]

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:]

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 |
| 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 |

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 Yes No
13. Have you been involved in any discussions regarding selling this life insurance policy? Yes No 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 Yes No
15. Will any portion of the premium for this insurance be financed? Yes No Yes No
16. Have you discussed changing ownership or beneficiaries once this policy is issued? Yes No 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 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 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 Yes No
20. Do you drink alcoholic beverages? Yes No Yes No

Details to any no answer for questions 1, 3 and 15 above, and any yes answer for questions 2 through 11, 14 through 16, and 20 through 21 above.

Under Insured - P1 indicates proposed first insured, P2 indicates proposed second insured

Question number Insured Details

X. Medical history

1. Proposed first 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 second 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 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 (mother, father, siblings) been diagnosed with and/or treated for cancer, stroke or aneurysm, diabetes, heart disease, surgery, or failure, including coronary bypass,, or any neurodegenerative disorder?.....	<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, or any 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
- 20. Is your father still living? Yes No Yes No
- 21. Is your mother still living? Yes No Yes No

Details to medical questions 4 - 21

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

Question	Insured	Date seen	Name and address of medical source or facility
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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 and any supplemental applications. I agree, to the best of my knowledge and belief, 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, to the best of my knowledge and belief, my policy may not be valid, subject to the Incontestability provision in the policy. All statements and descriptions made here are considered representations and not warranties. 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. Information obtained from this application will be used only for the purpose of obtaining the coverage applied for.

[Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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, subject to the Incontestability provision in the 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: