Allianz Life Insurance Company
of North America

5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Allianz

Authorization for Release of Information
To Allianz Life Insurance Company of North America ("Company")

(This authorization complies with the HIPAA Privacy Rule)

The applicant must read and sign this form and it must be submitted with every insurance application.

Name of Proposed Insured (please print) ____________________ Date of birth ____________________

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, and reinsurers. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

I also authorize any insurance company, my insurance agent, employers, consumer reporting agencies, health plan administrators, Pharmacy Benefit Managers, government agencies, relatives, friends, neighbors, and others with whom I am acquainted ("Other Persons"), that have any records or knowledge of me relating to my health/medical history, character, general reputation, personal characteristics, or mode of living, to give to the Company, its agents, its employees, its representatives, and its reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

I authorize MIB, Inc, and any MIB member insurer, to provide any medical or personal information that it has about me to the Company, its reinsurers or any MIB authorized third party administrator performing underwriting services for the Company.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and other information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

This protected health information and other information is to be disclosed under this Authorization so that the Company, its agents, employees, representatives, and reinsurers may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

The Company, its agents, employees, representatives, and reinsurers may release information obtained by this Authorization to reinsurers, and other persons and entities performing business or legal services in connection with my application. Further, I authorize the Company, its reinsurers or authorized third party administrators to make a brief report of my protected health information to MIB, Inc.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Allianz Life Insurance Company of North America at 5701 Golden Hills Drive, Minneapolis, MN 55416-1297.

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my entire medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I also understand that if I refuse to sign this Authorization, the Company may not be able to process my application. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured or Personal Representative ____________________ Date ____________________

Description of Personal Representative's authority or relationship to Proposed Insured ____________________

Submit original to Home Office with application. Leave copy with owner. Keep copy in financial professional file.

Allianz Life Insurance Company
of North America

PO Box 59060
Minneapolis, MN 55459-0060

Allianz

Notice and Consent for AIDS - Related Blood Testing

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood or other bodily fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure. Test results will be reported only to the person or persons designated by the consent form and to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. An insurer may also make a report of a nonspecific blood disorder to the Medical Information Bureau.

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during intravenous drug use.) Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs and sexual contacts of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

THE HIV ANTIBODY TEST

Before you consent to testing, please read the following important information:

1. **Purpose**. The test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-through with your personal physician because you may be infected with HIV.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Positive errors include:
   (a) False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   (b) False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
4. **Possible Adverse Effects of Test.** A positive test may cause you significant anxiety. A positive test may result in uninsurability for life, health or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your tests were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you or the physician that you designate.
6. **Confidentiality**. Like all medical information, HIV test results are confidential. An insurer, insurance agent or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a report of a nonspecific blood disorder may be made to the Medical Insurance Bureau, a national insurance data bank.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Further information about HIV testing and AIDS can be obtained by contacting one of the counseling resources attached to this form.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list a private physician so that he or she can tell you the test result and explain its meaning.

Name of physician reporting a positive test result: ______________________________

Address: ______________________________

____

If you want the test results to be given directly to you, initial here: ____________.

You should consult a physician or one of the resources listed to discuss the results.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of the blood, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive. (This Consent is valid for six months from the date it is signed.)

I acknowledge that I have received a copy of this authorization. A photocopy of this form will be as valid as the original.

______________________________ ____________

Signature of Proposed Insured Date

____

Address

California AIDS Community Resources

San Francisco AIDS Foundation
414/864-5855

Sacramento AIDS Foundation
916/448-2437

Central Valley AIDS Team
209/264-2436

AIDS Services Foundation of Orange County
714/646-0411

San Diego AIDS Project
619/543-0300

AIDS Project – East Bay
415/420-8181

AIDS Project Los Angeles
213/876-8951

AIDS Hotline
800/922-AIDS
213/876-AIDS

Spanish AIDS Hotline
800/222-SIDA

Hemophilia AIDS Project
818/793-6192

TTY Information
213/464-0029

AIDS Hotline – U.S. Public Health Service
800/342-AIDS

California Department of Health Services Office of AIDS
916/323-7415

Kern County AIDS Team
805/861-3631

Inland AIDS Project
714/820-2437 (San Bernardino)
714/784-2437 (Riverside)

Santa Barbara County AIDS Counseling and Assistance Program
805/963-3636

AIDS Information Hotline
805/965-2925

Santa Clara County ARIS Project
408/370-3272

Shasta County AIDS Helpline
916/225-5252

Sonoma County AIDS Information Hotline
707/579-AIDS

Stanislaus County Community AIDS Project
209/571-5341

Allianz Life Insurance Company
of North America
PO Box 59060
Minneapolis, MN 55459-0060

Producer Report

1. Proposed Primary/First Insured

First Name	MI	Last Name

2. Producer Information

First Name	Last Name	Producer Number	Phone Number	Split %

3. Commission Choice (Select one option)

☐ Option A (Level)	☐ Option B (Spread)

4. Proposed Insured(s) Information

Question	Proposed Primary/First Insured	Proposed Other/Second Insured
a. How long have you known the insured?	______________	______________
b. Did you meet with the proposed insured(s)?	☐ Yes ☐ No	☐ Yes ☐ No
c. If you did not meet with the proposed insured(s), give reason (e.g. previous relationship, application via mail, etc):	______________	______________
d. The proposed insured is:	☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Widowed
e. If married, amount of life insurance in force on spouse:	$______________	$______________
f. Is the proposed insured related to you or your spouse?	☐ Yes ☐ No	☐ Yes ☐ No
g. If related, state relationship:	______________	______________
h. Is the proposed insured(s) an employee of Allianz Life Insurance Company of North America (Allianz)?	☐ Yes ☐ No	☐ Yes ☐ No

5. Companion File Information

Is there another person or persons applying for coverage with Allianz that is in connection with this client?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide name(s):	______________	______________

Return to Home Office

6. Requirement Ordering

If you prefer that the Home Office schedule and follow-up on all requirements, check 'Home Office' below

Who will be ordering the medical requirements? ☐ Home Office ☐ Producer/Field Office

If exam has been scheduled, provide name of vendor and phone number:

Paramedical Company ____________________ Phone Number ____________________

If an APS is required, who should order? ☐ Home Office ☐ Producer/Field Office

If an APS has already been ordered, provide doctor/facility name: ____________________

7. California Elder Disclosures

If the applicant(s) is age 65 or older, please complete the following questions:

a. I have provided the applicant(s) with a copy of the Disclosure to California Residents (form # NB5002-CA) and have retained proof of delivery in my client's file ☐ Yes ☐ No

b. The sale is based on the product's treatment under the California Medi-Cal Program ☐ Yes ☐ No

c. If yes, I have provided the applicant(s) the Notice Regarding Standards for Medi-Cal Eligibility and Recovery (form # NB5003-CA) and submitted the signed copy with the completed Worksheet ☐ Yes ☐ No

d. Did you meet with the applicant(s) in their home? ☐ Yes ☐ No

e. If yes, I have provided the applicant(s) with a copy of the In-Home Senior Visit Disclosure (form # NB4019-CF) and have retained proof of delivery in my client's file ☐ Yes ☐ No

8. Military Sales Disclosure

a. Is the applicant(s) a member of the armed services, on active duty or a dependent of such a person? ☐ Yes ☐ No

b. If yes, I have provided the applicant(s) with a copy of the **Military Sales Disclosure Statement** ☐ Yes ☐ No

9. Replacement

a. Is a replacement involved? ☐ Yes ☐ No

b. If yes, the existing life insurance policy is being replaced and cannot meet the client(s) objectives because:

____

____

10. Suitability

a. Did you discuss with the client their current life insurance policies and other assets prior to their decision to purchase this life insurance policy? ☐ Yes ☐ No

b. In discussing this sale with the client, the client has indicated to you that they have sufficient liquid assets available for living expenses and emergencies other than the money allocated to pay the life insurance premiums? ☐ Yes ☐ No

c. In reviewing the purchase of this insurance policy as to the suitability of such purchase for the client, you have reasonable grounds for believing this purchase is suitable in meeting their insurance needs and financial objectives? ☐ Yes ☐ No

Provide details to any **'No'** answers: ____________________

____

11. Life Settlement

a. To the best of your knowledge, has this client(s) sold, viaticated or settled any previous life insurance policies? ☐ Yes ☐ No

b. To the best of your knowledge, does this client(s) have any intention to sell or settle this policy, if issued? ☐ Yes ☐ No

Provide details to any **'Yes'** answers: ____________________

____

Return to Home Office

12. Insurability

a. Do you know if any information not given on the worksheet/application which might affect the insurability of any person to be insured ☐ Yes ☐ No

Provide details to any **'Yes'** answers:____

____

13. Special Requests/Remarks

____

____

____

____

____

____

14. Anti Money Laundering (AML) Requirement

- The following customer verification is required for AML
- Please indicate the document that was used to verify identification, the state of issue, number and expiration date

I have verified the proposed insured(s)/owner(s) identity by reviewing the government issued photo ID selected below:

Proposed Primary/First Insured

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue ____________ Number ____________ Expiration Date ____________

Proposed Other/Second Insured

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue ____________ Number ____________ Expiration Date ____________

Policy Owner (if other than Insured)

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue ____________ Number ____________ Expiration Date ____________

Joint Policy Owner (if other than Insured)

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue ____________ Number ____________ Expiration Date ____________

15. Producer Attestation and Signature - To be Answered by a Licensed Producer

- To the best of my knowledge the information contained in the producer report is accurate.

► **Producer's Signature:**________________________ **Date:**____________

Producer Name (please print) ________________________ Phone Number ____________

Return to Home Office

Please submit the form using one of the options below:

Email completed forms to:

lifeinsurance@send.allianzlife.com

OR

Web Upload:
You can upload your signed and completed form(s) by logging into your account at Allianzlife.com

OR

Mail:

Regular Mail
Allianz Life Insurance Company of North America
PO Box 59060
Minneapolis, MN 55459-0060

Overnight Mail
Allianz Life Insurance Company of North America
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

OR

Fax: 763.582.6002

Any questions? Call us at 800.950.7372

Allianz Life Insurance Company
of North America
PO Box 59060
Minneapolis, MN 55459-0060
800.950.1962
www.allianzlife.com

Accelerated Benefit
Disclosure Statement

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

I have read the information above. It has been explained to me by the agent, and the agent has not made any statements that differ from this disclosure.

Owner____ Date____________________

I have presented and provided a signed copy of this disclosure to the owner. I have not made statements that differ from this disclosure.

Agent____ Date____________________

ALLIANZ LIFE INSURANCE COMPANY
OF NORTH AMERICA
PO Box 59060
Minneapolis, MN 55459-0060
800.950.7372

Allianz

Application for Additional Coverage: Chronic Illness Accelerated Benefit

1. Policy Information

Policy Number

Policy's Primary Insured First Name | MI | Last Name

Policy's Owner's First Name | MI | Last Name

2. Medical History Questionnaire

1. Over the past 5 years, please indicate for which of the following you have received treatment or a diagnosis from a licensed member of the medical profession.

   Please check yes or no for each of the following:

   a. Alzheimer's Disease ☐ Yes ☐ No
   b. Confusion ☐ Yes ☐ No
   c. Dementia or Memory Loss ☐ Yes ☐ No
   d. Imbalance, gait disturbance, or falling ☐ Yes ☐ No
   e. Incontinence or bowel function abnormality ☐ Yes ☐ No
   f. Tremor ☐ Yes ☐ No
   g. Trouble swallowing ☐ Yes ☐ No

2. Over the last 12 months, please indicate for which of the following you have required or currently require assistance or supervision or for which of the following a licensed member of the medical profession identified that your performance was limited?

   Please check yes or no for each activity:

   a. Bathing ☐ Yes ☐ No
   b. Eating ☐ Yes ☐ No
   c. Mobility ☐ Yes ☐ No
   d. Dressing ☐ Yes ☐ No
   e. Managing Medication ☐ Yes ☐ No
   f. Toileting ☐ Yes ☐ No
   g. Driving ☐ Yes ☐ No
   h. Managing Money ☐ Yes ☐ No
   i. Using the Telephone ☐ Yes ☐ No

Return to Home Office

2. Medical History Questionnaire *(continued)*

3. Over the last 12 months, please indicate which of the following you have required or currently require the use of other than short term use (defined as 6 weeks or less during recovery from a surgery or acute illness/injury).

Please check yes or no for each device:

a. Brace ☐ Yes ☐ No
b. Dialysis machine ☐ Yes ☐ No
c. Walker ☐ Yes ☐ No
d. Quad Cane ☐ Yes ☐ No
e. Oxygen equipment ☐ Yes ☐ No
f. Wheelchair ☐ Yes ☐ No
g. Catheter ☐ Yes ☐ No
h. Respirator ☐ Yes ☐ No
i. Stairlift ☐ Yes ☐ No
j. Handicap Sticker ☐ Yes ☐ No
k. Other medical equipment or appliance ☐ Yes ☐ No

4. Has a member of the medical profession ever treated you for or diagnosed you with the following?

Please check yes or no for each condition:

a. Osteoporosis with fracture ☐ Yes ☐ No
b. Stroke ☐ Yes ☐ No
c. Autoimmune disease including, for example, Type 1 Diabetes, Rheumatoid Arthritis, Systemic Lupus Erythematosus, and Inflammatory Bowel Disease (excluding HIV) ☐ Yes ☐ No
d. Motor neuron disease including, for example, Amyotrophic Lateral Sclerosis (ALS), Primary Lateral Sclerosis, Progressive Bulbar Palsy, and Progressive Muscular Atrophy ☐ Yes ☐ No
e. Neurodegenerative disease including, for example, Parkinson's Disease, Prion's Disease, Huntington's Disease, and Alzheimer's Disease and other dementias ☐ Yes ☐ No
f. Neuromuscular disease including, for example, Charcot-Marie-Tooth Disease, Multiple Sclerosis, Muscular Dystrophy, and Myasthenia Gravis ☐ Yes ☐ No
g. Transient Ischemic Attack (TIA) within last 5 years or more than one by history ☐ Yes ☐ No

Return to Home Office

Allianz Life Insurance Company
of North America

PO Box 59060
Minneapolis, MN 55459-0060

800.950.1962

Allianz

Illustration certification

Agent's statement

I certify that: (check the following that apply)

_______ I did not provide an illustration for____.

_______ The policy applied for differs from the policy illustrated for ___________________________.

_______________________ _______________ _______________________
Agent | Date | Agent license number (where required)

Applicant's statement

I acknowledge that: (check the following that apply)

_______ I did not receive an illustration conforming to the policy I applied for. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

_______ I received an illustration for a policy. However, the illustration differs from the policy I applied for. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

_______________________ _______________
Applicant | Date

Allianz Life Insurance Company
of North America
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Allianz

Allianz Authorization to Transfer Funds Tip Sheet

Please make sure to complete all applicable sections to expedite your transfer request to Allianz Life Insurance Company of North America (Allianz). Incomplete responses may delay processing of the request. For more information please see www.allianzlife.com.

Instructions

- If possible, attach a copy of the contract, policy or account statement for the funds being transferred.
- To avoid delays, complete this form carefully and obtain all necessary signatures.
- Return the original forms to the home office when completed (see mailing addresses below).
- Call the financial institution currently holding the assets to see what they require to transfer the funds. Many financial institutions have different requirements on what is needed to process an outgoing transfer request (e.g., a call to liquidate the account at the existing financial institution or their own transfer form may be required).
- Transfers can involve tax consequences. Customers may want to consult a tax professional before requesting a transfer.

Mailing Transfer Form/Check to Allianz

Allianz Fixed Annuity and Life Addresses:

If shipping **overnight**, please send checks to:
Allianz
ATTN: 360348
500 Ross Street 154-0455
Pittsburgh, PA 15250

If sending regular mail please send **checks** to:
Allianz
PO Box 360348
Pittsburgh, PA 15250-6348

If shipping **transfer form** overnight (not including checks), please send to:
Allianz
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Please send **transfer form** (not including checks) to:
Allianz
PO Box 59060
Minneapolis, MN 55459-0060

Allianz Variable Annuity Addresses:

If shipping **overnight**, please send checks to:
Allianz
NW 5989
1801 Parkview Drive
Shoreview, MN 55126

If sending regular mail please send **checks** to:
Allianz
NW 5989
PO Box 1450
Minneapolis, MN 55485-5989

If shipping **transfer form** overnight (not including checks), please send to:
Allianz
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Please send **transfer form** (not including checks) to:
Allianz
PO Box 561
Minneapolis, MN 55440-0561

Fax numbers

Fixed Annuities New Business fax number: 763-582-6603
Variable Annuities New Business fax number: 800-721-2672 or 763-765-7917
Life fax number: 763-582-6002

Questions

For assistance with completion of the Authorization to Transfer Funds form please call:
Fixed Annuity phone line: 800-950-7372
Variable Annuity phone line: 800-624-0197
Life phone line: 800-950-1962

Allianz Life Insurance Company
of North America

Allianz

Authorization to Transfer Funds

Funds to be applied to Allianz Life Insurance Company of North America (Allianz)

☐ Fixed Annuity/Fixed Indexed Annuity ☐ Variable Annuity ☐ Life Policy (new policy only)
Submitted through ☐ FMO ☐ Broker Dealer

☐ New Allianz contract/policy number (if known):__________________ ☐ Existing Allianz contract/policy number:________________

Original paperwork will need to be mailed to Allianz as many financial institutions will require originals.

Complete for existing contracts/policies only: ☐ Solicited ☐ Not Solicited

Select "Solicited" if your financial professional brought a specific product to your attention through any means including, but not limited to: phone, promotional material, mail or email. This also includes recommending you take a particular course of action in addition to purchasing a product such as transferring, surrendering, adding premium or partially surrendering.

Select "Not Solicited" if you made this decision independently, without input from your financial professional and your financial professional is not providing a recommendation in support of a buy, hold, sell, transfer or add premium transaction.

1. Financial institution holding assets

Company Name ________________ Contract/Policy/Account Number ________________

Company Address (No PO Boxes) ________________

City ________________ State ________ ZIP Code ________ Telephone Number ________________

2. Existing owner information at financial institution shown in section 1

Owner First Name ________________ MI ________ Last Name ________________

Trust/Corporation Name ________________ Social Security Number/TIN ________________

Address ________________

City ________________ State ________ ZIP Code ________

Joint Owner First Name (if applicable) ________________ MI ________ Last Name ________________ Social Security Number ________________

Insured/Annuitant First name (if other than owner) ________________ MI ________ Last Name ________________ Social Security Number ________________

The undersigned ***requests*** and directs the following action be taken to transfer the contract, policy, or account funds identified below.

3. Existing plan type for assets described in section 1 and 2

☐ Nonqualified or after tax ☐ Traditional IRA ☐ Roth IRA ☐ SEP IRA ☐ SIMPLE IRA[1]

☐ Governmental 457(b) ☐ Qualified retirement plan (specify type: 401, Pension, PSP, 403(b))[1,2] ______________________

☐ Beneficial ______________________ IRA (specify type: Traditional, Roth, SIMPLE)[1]

☐ Qualified Plan Beneficiary ☐ Other______________________

[1] SIMPLE IRAs are not available for variable annuities at Allianz. 403(b) contracts are not available at Allianz for fixed or variable business. However, SIMPLE IRA and 403(b) assets can be rolled over to an IRA at Allianz if the assets are eligible for rollover.

[2] Qualified plans (401(k)/pension plans) generally require their own withdrawal paperwork. Clients should contact their former employer to initiate the transfer. If a tax plan is not specified above, and an IRA is being established at Allianz, the transaction will be reported in the Rollover contributions box of IRS Form 5498.

4. Transaction Type (see page 3 of 3 for disclosures on the transaction being requested)

Nonqualified Exchange (as indicated in section 3):

☐ 1035 Exchange (registration of owner must be "like to like" with the same ownership)

Cost basis requested: In accordance with the Tax Equity and Fiscal Responsibility Act of 1982, furnish a statement to the Assignee and to the former contract, policy or account holder of the cost basis in the contract, policy or account if available.

☐ Non-1035 Exchange/other nonqualified assets

Qualified Exchange (as indicated in section 3):

☐ Direct Rollover (e.g., 401(k) to IRA) ☐ Direct Transfer (e.g., IRA to IRA)

☐ Roth IRA Conversion (IRA to Roth IRA) (see disclosure on acceptance letter provided by Allianz)

5. Type of investment held at financial institution described in section 1 and 2 (this section must be fully completed)

If the assets being transferred are currently or were held in an annuity contract or life insurance policy within the last 12 months, state replacement forms may be required in order to be compliant with your state's replacement regulations.

☐ **Annuity**

☐ **Variable Annuity** ☐ **Fixed Annuity/Fixed Indexed Annuity**

☐ **Life Policy**

☐ **Certificate of deposit** (see section 6 for maturity date instructions)

☐ **Brokerage account**[1] ☐ **Mutual fund(s)**[1]

☐ **Money market(s)**

[1] Contact financial institution to liquidate the account prior to submitting transfer paperwork for securities.

6. Transfer instructions for assets described in section 1 and 2 (this section must be fully completed)

This is to request liquidation and/or transfer from the contract/policy/account listed in section 1:

☐ Full liquidation (estimated $ amount) ______________________

☐ Partial liquidation[2] ($ amount) ______________________

[2] Partial 1035 exchange(s) is (are) not permitted on life policies. In order to be considered a 1035 exchange by the IRS, the amount being requested must be transferred and retained in the receiving contract/policy/account.

Transfer and/or liquidation effective:

☐ Immediately- I am aware of penalties that may occur from an early withdrawal.

☐ On maturity/liquidation date[3] ________/________/________

[3] Submit all transfer paperwork at least 10 business days prior to maturity date. Do not submit transfer paperwork requesting to hold for a maturity date any later then 15 business days. If outside of the time frame, requested processing can not be guaranteed. (Does not apply for life policies being established at Allianz.)

If neither box is checked, transfer/liquidation will occur immediately.

☐ **Please waive any conservation period that may apply and process transfer request.**

Optional at the request of writing producer/registered representative: Overnight funds to Allianz (address on acceptance letter provided by Allianz)

Overnight Carrier (e.g., UPS, FedEx): ______________________

Overnight Account Number: ______________________

Return to Home Office

7. Lost contract statement

☐ Contract is attached

☐ Certificate of lost contract – I/We certify that the above referenced contract has been lost or destroyed, and to the best of my/our knowledge and belief is not in anyone's possession.

8. Disclosures

I am aware of any surrender/withdrawal penalties which may apply, and I authorize the transaction described above. This transfer request also authorizes Allianz to receive information on the status of this transfer or exchange by phone or in writing.

The undersigned represents and agrees that Allianz is participating in this transfer at the undersigned's specific request. It is further agreed that Allianz has made no representations and that it has no responsibility nor liability concerning the tax treatment of this transaction under the Internal Revenue Code.

Transaction Disclosure Information
Tax Qualified Transactions:
Transfers: This Certificate of Deposit, brokerage account, mutual fund, money market, and/or annuity contract is held in the IRA type marked above and is to be transferred to the same type of IRA.

Direct Rollover: This amount represents all or part of my eligible rollover distribution. I understand there will be no mandatory 20% withholding from this distribution because it is a direct rollover to an eligible retirement plan as defined under applicable tax law.

Required Minimum Distributions:
Important note to existing financial institution: If I must receive a required minimum distribution (RMD) for any reason (I am age 70 1/2 or older, this is a beneficial IRA, etc.), do not transfer or roll over my current year's RMD calculated for this account.

Important note to owner: The existing financial institution has the most accurate information to ensure that you receive the correct RMD from this account. If you do not receive the full amount of your RMD, you may be subject to an IRS penalty of up to 50% of the underpayment. If necessary, instruct your existing financial institution before effecting this transfer to either: (1) pay your RMD to you now, or (2) retain that amount for distribution to you later.

Nonqualified Transactions
Annuity/Life 1035: Surrender a nonqualified annuity contract(s) or life insurance policy for the purchase of another nonqualified annuity contract under Sec 1035 of the Internal Revenue Code. Annuities only: For partial 1035 exchanges, any surrender or withdrawal from the existing or new annuity contract within 180 days of the exchange may subject you to adverse tax consequences unless you receive amounts as an annuity for the period of 10 or more years (or over your life expectancy). Please see your tax professional for further details.

Surrender (Annuity/Life): The undersigned as owner of this contract or policy specified in this transaction, elects to surrender the assets for its net cash value and directs the transferring company to make payment(s) to the name Assignee. This does not qualify as a 1035 exchange.

Absolute Assignment for 1035 Exchanges of Life or Annuity Contracts
The owner of the above contract(s) hereby assigns ownership and beneficial rights under the contract(s) to the following assignee, Allianz Life Insurance Company of North America, Assignee ID Number: 41-1366075.

All previous designations of beneficiary and payee, and all previous elections of payment options under the contract(s) as to the partial or total amounts shown above, are revoked. The sole beneficiary and payee of the partial or total amounts shown above, shall be the named assignee.

IRA Rollover
Please note that, effective January 1, 2015, if you make a tax-free IRA to IRA rollover, you cannot, within a one-year period, make another tax-free rollover of a distribution from any of your IRAs to another IRA. Please consult your tax advisor for any questions.

9. Transaction authorization

_______________________________ ____________
Owner/Plan Administrator Date

_______________________________ ____________
Joint Owner (if applicable) Date

_______________________________ ____________
Annuitant/Insured (life policy/different than owner) Date

_______________________________ ____________
Spouse[1] (Only in AK, AZ, CA, ID, LA, NM, NV, TX, WA, WI) Date

Medallion Stamp Guarantee
For requesting securities at the transferring company, if required.

Trust:_______________________________ as trustee of the:_______________________________ Date____________
Trustee's Signature Trust Name (Printed)

[1] If you reside in one of the above listed community property states, the spouse must also sign.

If you have additional questions, please call Allianz at 800.950.5872.

Return to Home Office

Allianz Life Insurance Company of North America
PO Box 59060
Minneapolis, MN 55459-0060

Allianz

Automatic Payment Plan-EFT Authorization

I hereby authorize Allianz Life Insurance Company of North America (Allianz) and the financial institution named below to process entries to my account in accordance with my instructions. This authority will remain in effect until I give notification, satisfactory to Allianz, to terminate this authorization.

Account holder (name at financial institution)

First name ______ M.I. ______ Last name ______

Name of applicant/owner (if other than account holder)

First name ______ M.I. ______ Last name ______

Trust/Corporation name ______

Payment information

☐ Life insurance premium (choose one)

☐ EFT including initial premium ☐ EFT only

☐ Loan repayment

Process entries: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Withdrawal day ______ $______ In the amount of ______ Add to policy/contract number ______

NOTE: Withdrawal day can be selected between the 1st through the 28th. Drafts for loan payments can **ONLY** occur monthly on the 1st or 20th.

Payment source for annuity contracts: ☐ Qualified ☐ Non-qualified

If any part of the payment being submitted is an indirect rollover from a qualified plan and was received by the contract owner within the last 60 days, this payment is considered qualified for annuity contracts. These assets must comply with the requirement that only one rollover is permitted within a one year period from all of the contract owner's IRAs.

Complete for existing contracts: ☐ Solicited ☐ Not Solicited

Select "Solicited" if your financial professional brought a specific product to your attention through any means including, but not limited to: phone, promotional material, mail or email. This also includes recommending you take a particular course of action in addition to purchasing a product such as, transferring, surrendering, adding premium or partially surrendering.

Select "Not Solicited" if you made this decision independently, without input from your financial professional and your financial professional is not providing a recommendation in support of a buy, hold, sell, transfer or add premium transaction.

Account type ☐ Checking ☐ Savings

Routing number ______ Account number ______ Confirm account number ______

Name of financial institution ______

Address of financial institution ______

City ______ State ______ Zip Code ______ Phone number ______

(continued on next page)

The following statement is applicable on life insurance policies only:
I understand and agree that the receipt by Allianz of this Automatic Payment Plan-EFT Authorization will not be considered my actual payment of the initial premium for the above Allianz life insurance policy (the policy number of this policy is shown above). I further understand and agree that this Allianz policy will not go into effect until such time as Allianz receives the actual initial premium from the financial institution or bank shown above, and the policy is delivered and accepted during the lifetime of the applicant/owner. Based on the effective date, I understand Allianz will draft the monthly premiums required to pay my policy to the current date.

Signatures

Account holder signature ______________________ Date of authorization ______________________

Contract owner's signature: ______________________ Date: ______________ (MM/DD/YYYY)

Joint contract owner's signature: ______________________ Date: ______________ (MM/DD/YYYY)

Alternate signature, if applicable

Trust: ______________ (TRUSTEE'S SIGNATURE) as trustee of the: ______________ (TRUST NAME (PRINTED)) Date: ______________ (MM/DD/YYYY)

Power of attorney: ______________ (CONTRACT OWNER'S NAME (PRINTED)) by: ______________ (ATTORNEY-IN-FACT'S SIGNATURE(S)) Date: ______________ (MM/DD/YYYY)

Please submit your form through one of the options below:

Email completed forms to the appropriate product area:
fixedannuity@send.allianzlife.com
variableannuity@send.allianzlife.com
lifeinsurance@send.allianzlife.com

OR

Web Upload:
You can scan and upload your signed and completed form by logging in to your account at allianzlife.com.

OR

Mail – for Fixed Annuities and Life Insurance:

Regular mail
Allianz Life Insurance Company of North America
PO Box 59060
Minneapolis, MN 55459-0060

Overnight mail
Allianz Life Insurance Company of North America
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Mail – for Variable Annuities:

Regular mail
Allianz Life Insurance Company of North America
PO Box 561
Minneapolis, MN 55440-0561

Overnight mail
Allianz Life Insurance Company of North America
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

OR

Fax:
763.582.6002 for Fixed Annuities and Life Insurance
763.765.7912 for Variable Annuities

Any questions? Call us at 800.950.5872