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

Application for Individual and Joint Life Insurance - Part 2B

1. Medical History Questionnaire

Proposed Insured First Name | MI | Last Name

Attestation of Truth: The responses that I will provide to the Questions below will be complete, accurate, and truthful to the best of my knowledge and belief. I acknowledge that any inaccurate or misleading statements could result in the denial of benefits or rescission of the policy.

☐ **I AGREE**

1. Do you have a regular physician, doctor, or healthcare provider? ☐ No ☐ Yes

If YES, please complete the following for your regular physician, doctor, or healthcare provider:

First Name | MI | Last Name

City | State | Phone Number

Date of Last Visit | Reason for Last Visit

2. Have you ever received medical advice or has treatment been recommended or received by a licensed member of the medical profession for any cancer, tumor, cyst, or other abnormal growth or lump?
   ☐ No
   ☐ Yes, please complete the **MEDICAL DETAILS PAGE**

3. Have you ever tested positive for exposure to the HIV infection, HIV antibodies in a test taken for the purpose of obtaining insurance, or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?
   ☐ No
   ☐ Yes, please complete the **MEDICAL DETAILS PAGE**

4. Over the last 10 years, please indicate for which of the following you have received advice, treatment, or a diagnosis from a licensed member of the medical profession (check ALL that apply)

a. BRAIN/NERVOUS SYSTEM

- ☐ Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease
- ☐ Aneurysm
- ☐ Anxiety including PTSD, ADD, ADHD, and OCD
- ☐ Cerebral Hemorrhage
- ☐ Confusion
- ☐ Dementia or Memory Loss
- ☐ Depression
- ☐ Dizziness, Numbness, or Weakness
- ☐ Eating Disorder
- ☐ Huntington's Disease
- ☐ Mental Disorder
- ☐ Multiple Sclerosis (MS)
- ☐ Muscular Dystrophy
- ☐ Nervous Disorder
- ☐ Neuromuscular Degeneration
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Psychiatric Disorder
- ☐ Seizure/Epilepsy
- ☐ Stroke or Transient Ischemic Attack (TIA)/Mini-Stroke
- ☐ Other disease or disorder of the brain/nervous system
- ☐ NONE OF THESE

b. HEART/BLOOD SYSTEM

- ☐ Anemia
- ☐ Cardiomyopathy
- ☐ Chest pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Elevated Cholesterol or Triglycerides
- ☐ Heart Arrhythmia
- ☐ Heart Attack
- ☐ Heart Disease or Valvular Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease (excluding varicose veins)
- ☐ Other disease or disorder of the heart/blood system
- ☐ NONE OF THESE

c. LUNGS/RESPIRATORY SYSTEM

- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Sleep apnea
- ☐ Other disease of the lungs/respiratory system
- ☐ NONE OF THESE

d. DIGESTIVE SYSTEM

- ☐ Barrett's Esophagus
- ☐ Biliary Cholangitis
- ☐ Cirrhosis
- ☐ Colitis/Ulcerative Colitis
- ☐ Crohn's/Regional Enteritis
- ☐ Gluten Intolerance/Celiac
- ☐ Hepatitis
- ☐ Other disease or disorder of the liver or an abnormal liver enzyme test
- ☐ Other disease or disorder of the pancreas
- ☐ Other disease or disorder of the rectum or intestines
- ☐ Other disease or disorder of the stomach or esophagus
- ☐ NONE OF THESE

e. EXCRETORY & REPRODUCTIVE SYSTEMS

- ☐ Disease or disorder of the Breasts
- ☐ Disease or disorder of the Genitals
- ☐ Disease or disorder of the Prostate
- ☐ Disease or disorder of the Kidneys or an abnormal urine test or blood kidney function test
- ☐ Disease or disorder of the Reproductive System
- ☐ Disease or disorder of the Urinary System
- ☐ Sexually Transmitted Diseases (excluding HIV, AIDS, and ARC)
- ☐ NONE OF THESE

Complete the MEDICAL DETAILS PAGE for all Checked Boxes above, excluding "None of These"

f. GLANDULAR SYSTEM

- ☐ Diabetes including Borderline Diabetes, Impaired Glucose Intolerance (IGT), and Gestational Diabetes
- ☐ Disease or disorder of the Thyroid or other Endocrine Glands
- ☐ Disease or disorder of Lymph Glands
- ☐ NONE OF THESE

g. SKELETAL SYSTEM

- ☐ Arthritis
- ☐ Back Trouble or Back Surgery
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Joint Replacement
- ☐ Systemic Lupus (SLE)
- ☐ Other disease or disorder of the joints, muscles, or bones
- ☐ NONE OF THESE

h. EYES, EARS, NOSE, THROAT, & SKIN

- ☐ Disease or disorder of the nose
- ☐ Disease or disorder of the skin
- ☐ Disease or disorder of the throat
- ☐ Disease or disorder of the ears
- ☐ Disease or disorder of the eyes (excluding glasses, corrective lens, & Lasik)
- ☐ NONE OF THESE

i. IMMUNE SYSTEM

- ☐ Disease or disorder of the Immune System (excluding HIV, AIDS, and ARC)
- ☐ NONE OF THESE

5. Over the last 5 years, please indicate which of the following you've had completed by a licensed member of the medical profession that was not disclosed in a previous question (check ALL that apply).

- ☐ Consultation or check-up
- ☐ Prescription for medication(s)
- ☐ In-patient or out-patient in a hospital, clinic, medical facility, or similar entity (other than for normal childbirth)
- ☐ Diagnostic test, including EKG, mammogram, colonoscopy, MRI, CT Scan, ultrasound, blood test, or urine test (excluding any disorder related to HIV Antibody, T-Cell, AIDS, or ARC)
- ☐ Surgical operation
- ☐ Treatment or diagnosis for any other medical condition not previously disclosed
- ☐ **Refusal of** or **not yet completed** recommended medical test, medical treatment, surgery or hospitalization, (excluding any disorder related to HIV Antibody, T-Cell, AIDS, or ARC)
- ☐ NONE OF THESE

6. Over the last 5 years, please indicate if you have received benefits from any of the following (check ALL that apply).

- ☐ Disability or long-term care insurance plan
- ☐ Medical assistance/Medicaid
- ☐ State or county assistance program
- ☐ State or federal disability program
- ☐ Worker's compensation
- ☐ NONE OF THESE

Complete the MEDICAL DETAILS PAGE for all Checked Boxes above, excluding "None of These"

7. To the best of your knowledge, please tell us about your family members:

Mother: Current Status: ☐ Living Current Age: _____ ☐ Deceased Age at Death: _____ Cause of Death: _____
☐ Unknown

Father: Current Status: ☐ Living Current Age: _____ ☐ Deceased Age at Death: _____ Cause of Death: _____
☐ Unknown

Siblings: Current Status: ☐ None
Any deceased? ☐ Yes ☐ No
Age at Death: _____ Cause of Death: _____
Age at Death: _____ Cause of Death: _____
Age at Death: _____ Cause of Death: _____
☐ Unknown

8. Have you ever been charged an extra premium, been declined for coverage, or had coverage canceled for a life insurance policy with another company?
☐ No
☐ Yes
If yes, please explain: _____
_____

9. Please provide your height: _____ ft. _____ in.

10. Please provide your weight: _____ lbs.

11. Which of the following describes how your weight has changed in the past 12 months?
☐ Increased by more 10 pounds ☐ Increased by more than 20 pounds
☐ Decreased by more than 10 pounds ☐ Decreased by more than 20 pounds
☐ Did not increase or decrease by more than 10 pounds

If increased or decreased by more than 20 pounds, please provide the following:

a. Amount of increase/decrease: _____
b. Reason for increase/decrease:
☐ Pregnancy ☐ Intentional dieting/exercise
☐ Other: _____
c. Is your doctor aware of your weight change?
☐ No ☐ Yes

MEDICAL DETAILS PAGE - Complete for Questions 2-7

Question Number	**Detail and Date of Each of the Following As Applicable: Medication** (include name, dosage, frequency); **Emergency room visit, hospitalization, biopsy, surgery** (include description of event); **Therapy - physical, counseling, etc.** (include type and frequency); **Tests** (include type and result); **Assistive device - CPAP, etc.** (include type and nature of usage); **Activity restrictions or limitations - work, driving, etc.**(include description); **Other treatment** (include description)	**Medical Source or Facility Name Address Phone Number**

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