Allianz Life Insurance Company
of North America
PO Box 59060
Minneapolis, MN 55459-0060
800.950.7372

Life Insurance Policy Application

1. Proposed primary/first insured

First name	MI	Last name

☐ Male ☐ Female	Date of birth (mm/dd/yyyy)	Age	Social Security number

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-FL) 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-FL or NB2012P-FL should accompany this application.

Are you limited from working full time? ☐ Yes ☐ 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)

☐ **Life Pro+℠ 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, GPT 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%.

Interest earning account _____%

Standard allocations (You cannot allocate to Standard allocations and Select allocations at the same time):

Monthly sum S&P 500 _____%	Annual point-to-point blended _____%
Annual point-to-point S&P 500 _____%	Annual point-to-point blended w/Annual Floor _____%
Monthly sum Nasdaq-100® _____%	Monthly average blended _____%
Annual point-to-point Nasdaq-100® _____%	Trigger S&P 500 _____%

Select allocations (You cannot allocate to Standard allocations and Select allocations at the same time):

Monthly sum S&P 500 _____%	Annual point-to-point blended _____%
Annual point-to-point S&P 500 _____%	Monthly average blended _____%
Monthly sum Nasdaq-100® _____%	
Annual point-to-point Nasdaq-100® _____%	

Optional riders

☐ Premium Deposit Fund Rider Initial Deposit amount $ _____

Premium Deposit Fund Period: ☐ 3 years ☐ 4 years ☐ 5 years ☐ 6 years ☐ 7 years ☐ 8 years ☐ 9 years ☐ 10 years

☐ Enhanced Cash Value Rider (not available with any other riders)

☐ Additional Term Rider Rider specified (face) amount $_____

☐ Other Insured Term Rider (Complete Supplemental Application NB6010-01-FL)
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-FL

☐ Waiver of Specified Premium Rider Waiver amount $_____
(Minimum: $300/year; Maximum: lesser of $150,000/year or 2 times the minimum annual premium)

☐ Enhanced Liquidity Rider (check one) ☐ 50% ☐ 100%

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

4. Product information (continued)

☐ **GenDex Survivor℠ 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 minimum annual 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 minimum annual 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
☐ Primary ☐ Contingent	Percentage	Relationship	Social Security number	
First name	MI	Last name		
Address (street required)		City	State	ZIP code
☐ Primary ☐ Contingent	Percentage	Relationship	Social Security number	

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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 or to the survivor(s) unless otherwise noted.

First name	MI	Last name		
Address (street required)		City	State	ZIP code
☐ Primary ☐ Contingent	Percentage	Relationship	Social Security number	

First name	MI	Last name		
Address (street required)		City	State	ZIP code
☐ Primary ☐ Contingent	Percentage	Relationship	Social Security number	

First name	MI	Last name		
Address (street required)		City	State	ZIP code
☐ Primary ☐ 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:

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 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 12 and any Yes answer for questions 1, 2, 4 through 8, 11 through 13, and 17.

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, within the next two years, 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. Within the past five years, have you ever flown or do you, within the next two years, plan to fly as a pilot or student pilot? (If Yes, complete aviation questionanaire NB2270-01-FL.) .... ☐ Yes ☐ No
7. Within the past two years, have you engaged in, or do you intend to engage in, within the next 12 months, powered vehicle racing, ballooning, hang gliding, scuba diving, sky diving mountain climbing, cave exploring, rodeos, bungee jumping, or where the purpose is to beat a previously set record? .... ☐ Yes ☐ No
   (If Yes, complete avocation questionnaire NB2271-01-FL.)
8. 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.)
9. 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 12 and any Yes answer for questions 1, 2, 4 through 8, 11 through 13, and 17.

10. Have you been involved in any discussions regarding selling this life insurance policy? ..... ☐ Yes ☐ No
11. 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)
12. 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?)
13. Have you discussed changing ownership or beneficiaries once this policy is issued? ..... ☐ Yes ☐ No
    (If Yes, please provide the changes that will be made?)
14. Do you believe this life insurance policy that you are applying for will meet your insurance needs and financial objectives? ..... ☐ Yes ☐ No
15. 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
16. 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
17. Do you engage in 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. Have you received medical advice or diagnosis, or has treatment been recommended or received by a licensed member of the medical professional for any physical deformity or defect? ..... ☐ Yes ☐ No

12. Medical section *(continued)*

5. Within the past 10 years, have you received medical advice or diagnosis or has treatment been recommended or received by a licensed member of the medical profession 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 by a licensed member of the medical profession for any cancer, tumor, or other abnormal growth? ☐ Yes ☐ No

7. Within the last 12 months, have you received medical advice or has treatment been recommended by a licensed member of the medical profession for a lump in your breast, lymph nodes, or elsewhere on your body? ☐ Yes ☐ No

8. Have you been tested positive for exposure to the HIV infection, or been diagnosed as having AIDS or ARC caused by the HIV infection, or other sickness or condition derived from such infection? ☐ 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 other than as prescribed by a physician? ☐ Yes ☐ No

10. Within the past 10 years, have you been advised to seek treatment for alcohol use or drug dependency by a licensed member of the medical profession or received treatment by a licensed member of the medical profession 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 by a licensed member of the medical profession? ☐ Yes ☐ No

13. In the past 10 years, have you been treated by a licensed member of the medical profession for 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 by a licensed member of the medical profession ? ☐ Yes ☐ No

12. Medical section *(continued)*

16. Please fill in the box below regarding your family members (mother, father and siblings). To the best of your knowledge, if they have been diagnosed with and/or treated by a licensed member of the medical profession 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 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 State of Florida requires applicants to read and acknowledge the below statement.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 _____

I understand that I have the right to designate at least one person, other than myself, to receive notice of possible lapse of this life insurance policy for nonpayment of premium. I understand that this notice to my designee will not be given until 30 days after a premium is due and unpaid.

Must select one:

☐ I elect **NOT** to designate any person to receive such notice.

☐ I elect to designate this person to receive such notice (name and home address):

_____

_____

_____

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

Florida license identification number(s)