



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

Life Pro+SM 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-MA)
Rider specified (face) amount \$ _____
- Children's Level 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-MA
- 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%

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 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
<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				

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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
<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 informationTotal 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 NoIf 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 No2. Life insurance policies? Yes NoWill the life insurance policy being considered replace or change existing contracts or policies? Yes No

Amount of life insurance currently in force? \$ _____

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
<input type="checkbox"/> Applied for <input type="checkbox"/> Inforce If applied for, will both policies be taken? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of company	Face amount	Date issued/applied for
<input type="checkbox"/> Applied for <input type="checkbox"/> Inforce If applied for, will both policies be taken? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of company	Face amount	Date issued/applied for
<input type="checkbox"/> Applied for <input type="checkbox"/> Inforce If applied for, will both policies be taken? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of company	Face amount	Date issued/applied for
<input type="checkbox"/> Applied for <input type="checkbox"/> Inforce If applied for, will both policies be taken? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

- 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.)
- Do you drink alcoholic beverages? Yes No
 (If Yes, please advise frequency, number of drinks per occasion and type of alcohol used.)
- 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.: _____
- Are you a member or do you intend to become a member of the armed forces, including reserves? Yes No
- 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
- Have you ever flown or plan to fly as a pilot or student pilot? (If Yes, complete aviation questionnaire NB2270-01.) Yes No
- 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.)
- 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.)
- 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
- Have you been involved in any discussions regarding selling 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.

- 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 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

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 State of Massachusetts requires applicants to read and acknowledge the below statement.

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.

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.

I have received the Medical Information Bureau disclosure and investigative consumer report notice, form number NB5025.

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 _____

In addition to the above, if the product selected is an equity indexed product, I understand that I am applying for an equity-indexed product, and while the values of the policy may be affected by an external index, the policy does not directly participate in any stock or equity investments. I further understand that any values shown, other than guaranteed minimum values, are not guarantees, promises, or warranties.

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