# Application Options

Allianz

PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

How would you like to apply for this policy?

[X] Worksheet Process

- Phone History Interview
- May be eligible for Accelerated Underwriting
- Abbreviated Exam (if ineligible for Accelerated Underwriting)

[ ] Traditional Application Process

- Full Paramedical Exam
- Required for High Net Worth Foreign National Program
- Ineligible for Accelerated Underwriting

# Primary/First Insured

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Anajali — First Name
M.I.
Chhabra Nandwani — Last Name

Female — Gender
09/29/1977 — Date of Birth
42 — Age
669-20-5328 — Social Security Number/TIN

1620 Bareback Ranch Rd — Street Address
75036 — ZIP Code
Frisco — City
TX — State

j_nandawani@yahoo.com — Email Address
201 736 9828 — Mobile Phone
201 360 7713 — Other Phone

38227812 — Driver's License Number
TX — State of Issue
09/29/2020 — Expiration Date

Place of Birth (State and Country) ☐ United States _____ ☒ Other India

In which country are you considered a legal citizen/permanent resident? ☒ United States ☐ Other _____

Best time to Call for Client Interview ☐ Morning ☐ Afternoon ☒ Evening

Special Requests ☐ Hearing Impaired ☐ Interpreter Needed, Language _____

☐ Other _____

_____
Parent or Legal Guardian Name

_____
Relationship to Juvenile

# Primary/First Insured

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www.allianzlife.com

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Are you currently employed?

- [X] Yes, full-time (more than 30 hours per week)
- [ ] Yes, part-time (30 hours per week or less)
- [ ] Self-Employed _____
- [ ] No, homemaker, student, or retired
- [ ] Not currently employed

If employed, please provide your current:

Employer's Name: Tech Mahindra Americas

Job Title and Type/Line of Business: Vice President

Length of Employment: 10+ years

Is this a U.S. based company? [ ] Yes [X] No

$ 190,000.00 — Annual Earned Income

$ — Annual Unearned Income

Source of Unearned Income

$ 250,000.00 — Annual Income of Spouse/Domestic Partner/Civil Union Partner

$ 950,000.00 — Household Net Worth

$ 100,000.00 — Household Liquid Assets

$ 150,000.00 — Household Annual Expenses

Have you ever filed for bankruptcy? [ ] Yes [X] No

If yes, provide dates and details for each bankruptcy filing:

# Medical Information

PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Within the past 12 months has the Proposed Primary/First Insured received treatment or advice from a member of the medical profession for heart disease, Type 1 diabetes, stroke or cancer? ☐ Yes ☒ No

Physician/Medical Facility Name for Proposed Primary/First Insured

Phone Number

Street Address

City

State

ZIP Code

# Replacement and Insurance Activity

(PRIMARY/FIRST INSURED)

Allianz

PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

How many Life/Annuity products do you own and/or have applied for? 0

**Policy/Contract 1 Details:**

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

**Policy/Contract 2 Details:**

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

**Policy/Contract 3 Details:**

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

**Policy/Contract 4 Details:**

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

# Replacement and Insurance Summary

Allianz

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Allianz Life Pro + Advantage

**Primary/First Insured**

Do you have existing life insurance/annuity contracts? ☐ Yes ☒ No

Will this insurance replace any existing life insurance/annuity contracts? ☐ Yes ☒ No

Amount of life insurance currently inforce $_____

Amount of life insurance currently applied for $ 0.00

# Owner

Allianz
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Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Is the Owner the same as the Primary/First Insured? [X] Yes [ ] No

Type: [X] Individual [ ] Joint [ ] Trust [ ] Corporation [ ] Partnership [ ] Sole Proprietorship

Anajali | | Chhabra Nandwani
First Name | M.I. | Last Name

Non-Individual Owner Name

Relationship to Proposed Insured | Female
Gender

09/29/1977 | 669-20-5328
Date of Birth/Date of Trust | Social Security Number/TIN

1620 Bareback Ranch Rd | 75036 | Frisco | TX
Street Address | ZIP Code | City | State

201 736 9828 | 201 360 7713 | j_nandawani@yahoo.com
Mobile Phone | Other Phone | Email Address

$ | $ 440,000.00
Amount of Insurance Inforce on Proposed Policy Owner | Household Annual Income

$ 950,000.00 | $ 100,000.00 | $ 150,000.00
Household Net Worth | Household Liquid Assets | Household Annual Expenses

Are there additional proposed owners? [ ] Yes [X] No

Trustee Name

Trustee Name

Trustee Name

# Beneficiary

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

[X] Primary [ ] Contingent

[X] Individual [ ] Trust [ ] Corporation

Spouse
Relationship

100
Percentage

Jitendra
First Name

M.I.

Nandwani
Last Name

Trust/Corporation Name

Trustee Name

Male
Gender

11/19/1976
Date of Birth/Date of Trust

708-61-7173
Social Security Number/TIN

201-360-7713
Telephone Number

1620 Bareback Ranch Rd
Street Address

Frisco
City

TX
State

75036
ZIP Code

United States
Country

[ ] Primary [ ] Contingent

[ ] Individual [ ] Trust [ ] Corporation

Relationship

Percentage

First Name

M.I.

Last Name

Trust/Corporation Name

Trustee Name

Gender

Date of Birth/Date of Trust

Social Security Number/TIN

Telephone Number

Street Address

City

State

ZIP Code

Country

Primary Total _____ Contingent Total _____

FL6407ALZ20072963531

# Premium/Billing

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Frequency: ☐ Single Premium ☒ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

$ 15,000.00
Billed/Planned Premium Amount

$
Total Amount Submitted with the Worksheet Acknowledgement

$
First Year Lump Sum Amount

$
1035 Exchange Amount

How many years will the premium amount be paid? _____

Is lump sum coming from a 1035 Exchange of a life insurance policy? ☐ Yes ☒ No

If this is a replacement of a life insurance policy, was the contract a Modified Endowment Contract (MEC)? ☐ Yes ☒ No

The Payor is: ☒ Proposed Primary Insured ☐ Proposed Owner ☐ Other

Payor Name

Relationship to Proposed Insured | Gender | Date of Birth | Social Security Number/TIN

Street Address | City | State | ZIP Code

Mobile Phone | Other Phone | Email Address

$
Amount of Insurance Inforce on Proposed Payor

$
Household Annual Income

$
Household Net Worth

$
Household Liquid Assets

$
Household Annual Expenses

Reason this Person is the Payor

# Product Information

Allianz

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800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

$ 471,876.00
Specified Face Amount

Preferred Plus Non-Tobacco
Risk Class

Death Benefit Option

- [ ] A - Specified Amount
- [X] B - Specified Amount Plus Accumulation Value
- [ ] C - Specified Amount Plus Total Premium Paid

Definition of Life Insurance Test

- [X] Cash Value Accumulation Test (CVAT)
- [ ] Guideline Premium Test (GPT)

# Product Information

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Allianz Life Pro + Advantage

☐ Child Term Rider Units _____

☐ Enhanced Liquidity Rider ☐ 50% ☐ 100%

☐ Premium Deposit Fund Rider Amount $ _____ Period _____

☐ Supplemental Term Rider Amount $ _____

☐ Waiver of Specified Premium Rider Amount $ _____

**Bonused Indexed Allocations**

34 % Blended Index Annual Point-to-Point

33 % Bloomberg US Dynamic Balance II ER Index Annual Point-to-Point

_____ % NASDAQ 100® Index Monthly Sum

33 % PIMCO Tactical Balanced ER Index Annual Point-to-Point

_____ % S&P 500® Index Annual Point-to-Point

_____ % S&P 500® Index Monthly Sum

_____ % S&P 500® Index Trigger Method

**Select Indexed Allocations**

_____ % Blended Index Annual Point-to-Point

_____ % Bloomberg US Dynamic Balance II ER Index Annual Point-to-Point

_____ % PIMCO Tactical Balanced ER Index Annual Point-to-Point

_____ % S&P 500® Index Annual Point-to-Point

**Standard Indexed Allocations**

_____ % Blended Index Annual Point-to-Point

_____ % NASDAQ 100® Index Monthly Sum

_____ % S&P 500® Index Annual Point-to-Point

_____ % Fixed Allocation

Total 100 %

# Purpose of Insurance

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Allianz Life Pro + Advantage

Personal Insurance:

- [ ] Income Replacement
- [ ] Final Expenses
- [ ] Charitable Giving
- [X] Retirement Planning
- [ ] Estate Conservation
- [ ] College Funding
- [ ] Mortgage Protection

Mortgage Amount $ _____

Business Insurance:

- [ ] Deferred Compensation
- [ ] Buy/Sell
- [ ] Key Person
- [ ] Business Continuation
- [ ] Split Dollar
- [ ] Executive Bonus
- [ ] Other: _____

How was the face amount determined? _____

Minimum Face for Planned Premium

Do both the proposed owner(s) and the proposed insured(s) believe this life insurance policy being applied for will meet the insurance needs and objectives of each person? [X] Yes [ ] No

Did the agent discuss with both the proposed owner(s) and the proposed insured(s) the current life insurance policies and other assets of each person prior to the decision to purchase this life insurance policy? [X] Yes [ ] No

Does the proposed owner(s) feel sufficient liquid assets are available to them for living expenses and emergencies in addition to the money allocated to pay the life insurance premiums? [X] Yes [ ] No

Please indicate which of the following discussions have been had with the proposed owner(s) and the proposed insured(s) of this life insurance policy. Select ALL that apply.

- [ ] Been offered “free insurance”, a cash payment, or some other promised benefit as an incentive
- [ ] Discussed selling this life insurance policy
- [ ] Had an evaluation to determine the insured’s life expectancy (how long the insured will live)
- [ ] Discussed changing ownership or beneficiaries once this policy is issued
- [X] None of these

Provide details for any discussions indicated above: _____

# Source of Funds

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

- [X] Earned Income
- [ ] Annuity Contract
- [ ] Money Market Fund
- [ ] Savings
- [ ] Inheritance
- [ ] Other
- [ ] Qualified Funds
- [ ] Loans
- [ ] Other Life Insurance Policy
- [ ] Mutual Fund/Brokerage Account

Qualified Fund details (ie: IRA, 401k, 403b): _____

Inheritance details: _____

Other details: _____

Will this policy be funded using Premium Financing? [ ] Yes [X] No

_____
Name of the Company who is administering the Premium Finance

_____
Name of Lender

Type of loan? [ ] Recourse [ ] Non-Recourse

Is the client obligated to repay the loan? [ ] Yes [ ] No

Does the financial professional have a signed Premium Finance Addendum on file with Allianz? [ ] Yes [ ] No

# Illustration Certification

Allianz

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Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Has the Proposed Policy Owner seen an Illustration for this policy? [X] Yes [ ] No

Does the Illustration fully match the policy that is being applied for? [ ] Yes [X] No

Proposed Policy Owner Statement:

[ ] I received an illustration conforming to the policy described on this worksheet acknowledgement. I understand that if the policy is approved other than applied for, a revised illustration conforming to the policy as issued will be provided no later than the time the policy is delivered.

[X] I received an illustration for the 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 no later than at the time the policy is delivered.

[ ] 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 no later than at the time the policy is delivered.

Producer's Statement:

[ ] I provided an illustration conforming to the policy described on this worksheet acknowledgement.

[X] I provided an illustration that differs from the policy described on this worksheet acknowledgement.

[ ] I did not provide an illustration.

# Additional Questions

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

**Electronic Transaction Authorization**

By selecting "yes", I am authorizing and directing Allianz Life Company of North America (Allianz) to act on electronic instructions from my financial professional and anyone authorized by him/her to initiate such instructions. Electronic instructions include, but are not limited to, requests received by telephone, fax, email, or the Allianz website. I understand must make the decision or approve the transactions recommended by my financial professional and that my financial professional does not have discretion over my life insurance policy. By selecting no, electronic instructions will only be accepted from me, the Owner. Allianz will use reasonable procedures to confirm these electronic instructions are valid. As long as these procedures are followed, the company and it officers, employees, representatives and producers will be held harmless for any claim, liability, loss, or cost arising from unauthorized or fraudulent instructions. Allianz reserves the right to deny any electronic instruction and to discontinue or modify our electronic instruction privileges at any time and for any reason.

☒ Yes ☐ No

**Certification of Taxpayer Information**

If you are applying for this product and/or requesting payments as a U.S. Person, the IRS requires you to agree to the following statements. If you are not a U.S. Person, you are not eligible to apply for this product.

Under penalties of perjury, I certify that:

- The Taxpayer Identification Number shown on this form is correct or I am waiting for a number to be issued to me.
- I am not subject to backup withholding because:
  a. I am exempt from backup withholding, or
  b. I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or
  c. The IRS has notified me that I am no longer subject to backup withholding.
- I am a U.S. person, and
- The Foreign Account Tax Compliance Act (FATCA) code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Has the IRS notified you that you are currently subject to backup withholding because you failed to report interest and dividends on your tax return?

☐ Yes ☒ No

# ELECTRONIC TRANSMISSION AND SIGNATURES CONSENT AGREEMENT AND DISCLOSURE

This Electronic Transaction Consent Agreement and Disclosure ("Agreement") authorizes Allianz Life Insurance Company of North America ("Allianz") to conduct business electronically, and I consent to electronic transactions and document delivery, as set forth below.

Contract owner's email address: j_nandawani@yahoo.com

Joint contract owner's email address: _____

Annuitant/Insured's email address: j_nandawani@yahoo.com

Trustee's email address: _____

Attorney-in-fact's email address: _____

**Scope of Consent:** I consent to the following electronic transactions and document delivery, if available:

- My signature electronically;
- Electronic submission to Allianz of my completed request for an annuity contract or life insurance policy, including all accompanying forms and required point of sale disclosures; and
- Electronic delivery to me of a copy of my completed request.

**How it Works:** I understand that how it works depends on the electronic order entry system used to submit my completed request and if I sign electronically to complete my request:

- When my completed request has my electronic signature, a valid email address is required. My email address will be used to either send me a confirmation email or a copy of my completed request. If I receive a confirmation email, it will include a link to a secure site, from which, once I verify my identity, I will be able to view and retain a copy of my completed request for a limited time.
- When my completed request has my written signature, I can ask my financial professional for a copy.
- Alternatively, I can always contact Allianz for a copy. See Contact Information below for how to do so.

**Effect of Electronic Signatures and Electronic Delivery:** I acknowledge that my electronic signature on this Agreement and other documents requiring my signature will have the same validity and enforceability as my written signature. I also acknowledge that any documents that are delivered to me by electronic means are equivalent to paper copies. The withdrawal of my consent will not diminish the legal effectiveness or enforcement of any transaction agreed to while I have given consent.

**Hardware and Software Requirements:** I understand the following computer hardware and software requirements are necessary to receive, view, and retain documents delivered electronically: access to a personal computer or electronic device, Internet access, an Internet browser, an active email and Adobe Acrobat Reader. More information on viewing PDFs and free downloads are available at www.adobe.com. If there are any changes in the hardware or software requirements, I understand that Allianz will notify me of the changes and remind me that I may withdraw my consent to receive documents electronically.

**Right to Paper Copies:** By consenting to electronic transactions and document delivery, I understand that I will not receive paper copies of the documents specified in this Agreement. See Scope of Consent above. I further understand that I may, at any time, request and receive paper copies of these documents at no cost. See Contact Information below for how to do so. Although I have consented, Allianz may require paper copies of certain documents to be mailed.

**Email Address:** The email address indicated above is my current email address. I further understand that I need to let Allianz know if my email address changes. Allianz is not responsible for an invalid email address. With an invalid email address, Allianz may be required to mail a paper copy of the document (and all future documents). State law may also require me to consent again once I update my email address.

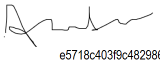
**Withdrawal of Consent:** I understand that my consent to electronic transactions and document delivery is voluntary. I may withdraw my consent to have this transaction completed electronically at any time prior to submitting my request to Allianz by advising the attending financial professional. By withdrawing my consent, I understand that my request for an annuity contract or life insurance policy will not be submitted electronically and instead a paper application and paper copies of all accompanying forms and required point of sale disclosures must be completed to continue the application process.

**Contact Information:**
Website: https://www.allianzlife.com/contact-us
Phone: 800.950.5872 (Monday-Friday from 8:00 a.m. to 5:00 p.m. CT)
Mail: Allianz Life Insurance Company of North America, P.O. Box 1344, Minneapolis, MN 55416-1297

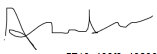
**Agreement and Signature**

I acknowledge and agree that:

- I have read, understand, and accept this Agreement.
- I consent to the electronic transactions and document delivery specified in this Agreement.
- My electronic signature will have the same validity and enforceability as my written signature.
- I confirm that I have ready access to a computer or electronic device with Internet access and a browser, an active email account to receive documents electronically and the ability to read and retain them.

Contract owner's signature: eSigned By FireLight: Anjali c Nandwani 2020-07-31T01:06:00  e5718c403f9c482986e5d93b7eb5cb7b Date: 7/30/2020

Joint contract owner's signature: _____ Date: _____

Annuitant/Insured's signature: eSigned By FireLight: Anjali c Nandwani 2020-07-31T01:06:00  e5718c403f9c482986e5d93b7eb5cb7b Date: 7/30/2020

**Alternate signatures, if applicable**

Trust: _____
TRUSTEE'S SIGNATURE

as trustee of the: _____ Date: _____
TRUST NAME

Power of attorney: _____
CONTRACT OWNER'S NAME

by: _____ Date: _____
ATTORNEY IN FACT'S SIGNATURE

ALLIANZ LIFE INSURANCE COMPANY
OF NORTH AMERICA
5701 Golden Hills Drive
Golden Valley, MN 55416-1297

# Worksheet for Individual and Joint Life Insurance Acknowledgement

Product: Allianz Life Pro + Advantage

Identification eNumber: FL6407ALZ20072963531

## Financial Professional Information

Name(s): JOSEPH COROZZA

## Proposed Primary/First Insured

Name: Anajali Chhabra Nandwani

Address: 1620 Bareback Ranch Rd, Frisco, TX, 75036

Email address: j_nandawani@yahoo.com

Date of birth: 09/29/1977

SSN/TIN: 669-20-5328

Gender: Female

Mobile Phone: 201 736 9828

## Proposed Joint/Other Insured

Name:

Address:

Email address:

Date of birth:

SSN/TIN:

Gender:

Mobile Phone:

## Proposed Policy Owner

Name: Anajali Chhabra Nandwani

Address: 1620 Bareback Ranch Rd, Frisco, TX, 75036

Email address: j_nandawani@yahoo.com

Date of birth: 09/29/1977

SSN/TIN: 669-20-5328

Gender: Female

Mobile Phone: 201 736 9828

## Proposed Joint Policy Owner

Name:

Address:

Email address:

Date of birth:

SSN/TIN:

Gender:

Mobile Phone:

## Allocation Selection(s)

34% Blended Index Annual Point-to-Point (bonus)
33% Bloomberg US Dynamic Balance Index II ER Annual Point
33% PIMCO Tactical Balanced ER Index Annual Point-to-Point

## Product Features

Specified Face Amount: 471,876.00

Risk Class: Preferred Plus Non-Tobacco

Optional Riders:

## Verification of Existing Policies or Contracts

Proposed Primary/First Insured

| | | |
|---|---|---|
| 1. Do you have existing life insurance policies or annuity contracts? | ☐ Yes | ☒ No |
| 2. Will the life policy applied for replace or change existing contracts or policies? | ☐ Yes | ☒ No |

Proposed Joint/Other Insured

| | | |
|---|---|---|
| 1. Do you have existing life insurance policies or annuity contracts? | ☐ Yes | ☐ No |
| 2. Will the life policy applied for replace or change existing contracts or policies? | ☐ Yes | ☐ No |

## Existing Policies and Contracts to be replaced

| Insured Name | Company Name | Life or Annuity | Amount In force |
|---|---|---|---|

## Beneficiary Designation

| Type | Name | Relationship | % |
|---|---|---|---|
| Primary | Jitendra Nandwani | Spouse | 100 |

## Illustration Certification

**A signed illustration conforming to the policy described on this worksheet must be submitted with the completed worksheet. If a conforming illustration has not been submitted, this section must be completed.**

**By signing this worksheet acknowledgment, I confirm that:**

**Applicant Acknowledgement:**

I received an illustration for the 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 no later than at the time the policy is delivered.

## Transaction Authorization

☒ Yes ELECTRONIC TRANSACTION AUTHORIZATION: By selecting "yes", I am authorizing and directing Allianz Life Insurance Company of North America (Allianz) to act on electronic instructions from my financial professional and anyone authorized by him/her to initiate such instructions. Electronic instructions include, but are not limited to, requests received by telephone, fax, email, or the Allianz website. I understand I must make the decision or approve the transactions recommended by my financial professional and that my financial professional does not have discretion over my policy. If the box is not checked, electronic instructions will only be accepted from me, the Owner. Allianz will use reasonable procedures to confirm these electronic instructions are valid. As long as these procedures are followed, the company and it officers, employees, representatives and financial professionals will be held harmless for any claim, liability, loss, or cost arising from unauthorized or fraudulent instructions. Allianz reserves the right to deny any electronic instruction and to discontinue or modify our electronic instruction privileges at any time and for any reason.

## Certification of Taxpayer Identification Number

If you are applying for this product and/or requesting payments as a U.S. Person, the IRS requires you to agree to the following statements. If you are not a U.S. Person, prior approval is required before submitting this application. If approved, the appropriate IRS Form W-8BEN is required to be completed.

Under penalties of perjury, I certify that:

1. The Taxpayer Identification Number shown on this form is correct or I am waiting for a number to be issued to me.
2. I am not subject to backup withholding because:
    a. I am exempt from backup withholding, or
    b. I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or
    c. The IRS has notified me that I am no longer subject to backup withholding.
3. I am a U.S. person, and
4. The Foreign Account Tax Compliance Act (FATCA) code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

☐ Check here **ONLY** if the IRS has notified you that you are currently subject to backup withholding because you failed to report interest and dividends on your tax return.

## Life Insurance Confirmation and Acknowledgement

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued.

You should consult with legal advisors if you have any questions about these matters.

**For all states, each of the undersigned declares, understands and agrees that:**

- Coverage under any policy approved or issued by Allianz a result of the worksheet shall be considered effective and in force only when, during the insured's lifetime and continued insurability
  a. a policy is issued, delivered, received and accepted by the policy owner;
  b. the first full premium has been received by Allianz; and
  c. all answers material to the risk are still true and complete to the best of the owner's and insured's knowledge.
- The MIB, Inc. Disclosure and Investigative Consumer Report Notice has been received by me.

CAUTION: If the answers on the worksheet are incorrect or untrue, Allianz may have the right to deny benefits or rescind the policy.

**The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

TX

Signed at (State)

eSigned By FireLight: Anjali c Nandwani
2020-07-31T01:06:00 e5718c403f9c482986e5d93b7eb5cb7b

Proposed Policy Owner's signature — Date: 7/30/2020

Proposed Joint Policy Owner's signature — Date

eSigned By FireLight: Anjali c Nandwani
2020-07-31T01:06:00 e5718c403f9c482986e5d93b7eb5cb7b

Proposed Primary/First Insured signature — Date: 7/30/2020

Proposed Joint/Other Insured signature — Date

**Alternate signatures, if applicable**

Trust:[1] _____ as trustee of the: _____ _____
Trustee's signature — Trust name (please print) — Date

Trust:[1] _____ as trustee of the: _____ _____
Second trustee's signature (as applicable) — Trust name (please print) — Date

[1] Submit a current copy of the trust certification form if not already on file.

**Statement of Financial Professional**

**By signing below, the Financial Professional certifies to the following:**

- The Owner statement regarding existing policies or annuity contracts is true and accurate to the best of my knowledge and belief.
- The Owner statement as to whether or not an existing life insurance policy or annuity contract is being replaced is true and accurate to the best of my knowledge and belief.
- I only used sales materials that were previously approved by Allianz in my presentation.
- I left a copy of all sales material used during my presentation with the applicant.
- I have provided the Owner with all appropriate disclosure and replacement requirements prior to the completion of this application.
- I understand all instructions I submit to Allianz on behalf of the owner must be approved by the owner prior to submitting to Allianz.
- I understand I do not have discretion over the owner's policy.

**By signing this worksheet:**

**Financial Professional Certification:**

I provided an illustration that differs from the policy described on this worksheet acknowledgement.

eSigned By FireLight: JOSEPH L COROZZA
2020-07-29T15:04:14 JOSEPH L COROZZA d2ebd31f2bbe4e9a81f83d7f671aa03e

Writing Financial Professional's Signature

7/29/2020
Date

JOSEPH COROZZA
Financial Professional's Name (Please Print)

800 325 8907
Phone Number

jcorozza@seemanholtz.com
Financial Professional's Email

For questions, contact Allianz at 800.950.7372

FL6407ALZ20072963531

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

Allianz

# Producer Report

## 1. Proposed Primary/First Insured

| First Name | MI | Last Name |
|---|---|---|
| Anajali | | Chhabra Nandwani |

## 2. Producer Information

| First Name | Last Name | Producer Number | Phone Number | Split % |
|---|---|---|---|---|
| JOSEPH | COROZZA | 795001660 | 800 325 8907 | 100 |
| | | | | |
| | | | | |

## 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? | 0-1 year | |
| 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): | Internet Conference Call | |
| d. The proposed insured is: | ☐ Single ☒ Married ☐ Divorced ☐ Widowed | ☐ Single ☐ Married ☐ Divorced ☐ Widowed |
| e. If married, amount of life insurance in force on spouse: | $ 1,250,000.00 | $ |
| 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? | ☐ 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. 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

## 8. 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:

## 9. 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:

## 10. 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:

## 11. 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:

## 12. Special Requests/Remarks

## 13. 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 |
|---|---|---|
| TX | 38227812 | 09 / 29 / 2020 |

**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 |
|---|---|---|
| | | |

## 14. 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:** eSigned By FireLight: JOSEPH L COROZZA JOSEPH L COROZZA 2020-07-29T15:04:14 d2ebd31f2bbe4e9a81f83d7f671aa03e **Date:** 7/29/2020

| Producer Name (please print) | Phone Number |
|---|---|
| JOSEPH COROZZA | 800 325 8907 |

jcorozza@seemanholtz.com

**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

**Return to Home Office**

Allianz Life Insurance Company
of North America

Allianz

Would you like to add a trusted contact? Yes X No

# Trusted Contact Designation Form

Designating a Trusted Contact is optional.
This form must be completed if you elect to designate a Trusted Contact who may be contacted regarding your contract(s)/policy(ies).

## What is a Trusted Contact?

A Trusted Contact is an individual, such as a family member or close friend at least 18 years old, who you designate as a point of contact for Allianz Life Insurance Company of North America (Allianz) in the event that we suspect fraud or financial exploitation. Although not required, a Trusted Contact provides Allianz with another person to contact if we suspect you may be the victim of financial exploitation. In these situations, an Allianz home office representative may contact your Trusted Contact for information about you, such as to confirm your current contact information if we are unable to reach you, to confirm your health status, or to confirm or verify the identity of any legal guardian, executor, trustee or holder of a power of attorney that may be listed on your contract(s)/policy(ies). Your financial professional cannot be designated as your Trusted Contact. *Designating a Trusted Contact is optional.*

## What is the benefit of a Trusted Contact?

Designating a Trusted Contact can benefit both you and Allianz by providing Allianz with a resource we can reach out to in situations where we have reason to believe financial exploitation against you has occurred, is occurring or is likely to occur. Designating a Trusted Contact will not guarantee the prevention of financial exploitation.

## What is financial exploitation?

Financial exploitation is defined as:

- The wrongful or unauthorized taking, withholding, appropriation, or use of another person's money or assets, or
- Any act or omission by a person, including through the use of a power of attorney, guardianship, or any other authority regarding another person for the purpose of:
  - Obtaining control through deception, intimidation or undue influence over the other person's money, assets or property; or
  - Converting the other person's money, assets or property.

## What access will my Trusted Contact have to my contract(s)/policy(ies)?

When talking to your Trusted Contact, we may need to disclose information about your Allianz contract(s)/policy(ies) to look into a situation where financial exploitation is suspected. This form does not give your Trusted Contact authorization to make changes to or take action on your contract(s)/policy(ies).

## Designation Terms

This Trusted Contact Designation Form will not expire. You may revoke or modify an elected Trusted Contact at any time by contacting Allianz at the address or phone number listed on the last page of this form.

**NOTE:** For MT residents, this Trusted Contact Designation Form will expire 24 months from the last signed date on the next page.

## Acknowledgment and Authorization

By signing on the next page, I (we) authorize Allianz to contact the designated Trusted Contact assigned on the next page and to disclose information about my contract(s)/policy(ies) and obtain information about me for the purposes provided above. I (we) understand that Allianz will maintain a copy of this document in my customer file. I (we) understand that I (we), or a person authorized to act on my (our) behalf, may request a copy of this document at any time by contacting Allianz at the address or phone number provided on the last page of this form. I (we) also understand that I (we) should make a copy of this form for my (our) personal records.

*(continued on next page)*

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 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.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These test are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

## 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.

## Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to be informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

## Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

## Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Further information about HIV testing and AIDS, can be obtained by calling the National AIDS hotline at 800/342-2437.

## Notification of Test Result:

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 that the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician for reporting a positive result: _____

Address _____

_____

| Please check if applicable: | Insured | Other Insured | |
|---|---|---|---|
| | ☐ | ☐ | If you do not wish to know the results of the test. (In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.) |
| | ☐ | ☐ | If you want to know the results of the test but do not at present have a private physician. (The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.) |

## Consent for HIV Testing:

I acknowledge that 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 that blood, and the disclosure of the test results as described below. I have read the information on the 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. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

| Anajali Chhabra Nandwani | 1620 Bareback Ranch R( | Frisco | TX | 75036 |
|---|---|---|---|---|
| Name of Proposed Insured (please print) | Address | City | State | Zip Code |

eSigned By FireLight: Anjali c Nandwani
2020-07-31T01:06:00 e5718c403f9c482986e5d93b7eb5cb7b

7/30/2020

Signature of Proposed Insured — Date

| Name of Proposed Other Insured (please print) | Address | City | State | Zip Code |
|---|---|---|---|---|

Signature of Proposed Other Insured — Date

Allianz Life Insurance Company
of North America

5701 Golden Hills Drive
Minneapolis, MN 55416-1297

FL6407ALZ20072963531

# 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.**

Anajali Chhabra Nandwani
Name of Proposed Insured (please print)

09/29/1977
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.

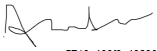
This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Allianz 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.

eSigned By FireLight: Anjali c Nandwani



2020-07-31T01:06:00 e5718c403f9c482986e5d93b7eb5cb7b
Signature of Proposed Insured or Personal Representative

7/30/2020
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
800.950.1962

# Accelerated Benefit
## Disclosure Statement

Thank you for choosing to purchase a Universal Life Insurance Policy with an Accelerated Benefit feature. Please read the following and sign the form to indicate your understanding.

**An accelerated benefit available under the policy is intended to qualify under section 101(g) of the Internal Revenue Code of 1986. If the accelerated benefit qualifies for such favorable tax treatment, it will be excludable from your income and will not be subject to federal taxation. Tax laws relating to the acceleration of life insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which an accelerated benefit is excludable from income under federal law.**

**Receipt of an accelerated benefit from a life insurance policy may affect your, your spouse's, or your family's eligibility for public assistance programs, such as Medicare, Medicaid, Social Security, and Supplemental Security Income (SSI). You are advised to consult with a qualified tax advisor and with social services agencies concerning how receipt of an accelerated benefit payment will affect your, your spouse's, and your family's eligibility for public assistance.**

**Receipt of an accelerated benefit from a life insurance policy may be taxable. You may wish to obtain advice from a tax professional before you decide to take an accelerated benefit from a life insurance policy.**

The Terminal Illness Accelerated Death Benefit provides a one-time benefit up to the Death Benefit. You may not request more than $1,000,000 or less than $10,000. This benefit may be taken in the event that the Insured is diagnosed with a Terminal Illness. A Terminal Illness is defined as a diagnosis by a physician of a medical condition that is expected to result in death of the Insured within 12 months, or less. The payment to you will equal the accelerated benefit amount discounted for one half year's interest using the Fixed Charge Rate shown on the policy schedule minus any Automatic Loan Repayment.

If applicable, the Chronic Illness Accelerated Benefit provides a benefit up to 25% of the Death Benefit. You may not request more than $250,000 or less than $75,000. If $75,000 is more than 5% of the Death Benefit, you may request 5% of the Death Benefit. This benefit may be taken in the event that the Insured is diagnosed with a Chronic Illness. A Chronic Illness is defined as a diagnosis by a physician that the Insured (1) is unable to perform without Substantial Assistance at least two ADLs for at least 90 continuous days, or (2) requires Substantial Supervision due to Cognitive Impairment. The payment to you is equal to the Discounted Accelerated Benefit minus any Automatic Loan Repayment and any Accelerated Benefit Charge. We calculate the Discounted Accelerated Benefit based on the following factors:

- The accelerated benefit amount you request.
- The life expectancy of the Insured at the time of the acceleration. The life expectancy we use will never be more than the applicable life expectancy published in the Minimum Mortality Table shown on the Policy Schedule.
- The discount rate we use, which will never exceed the maximum adjustable policy loan interest rate in the state where your policy is issued.

The Automatic Loan Repayment is equal to the Policy Loan multiplied by the accelerated benefit amount, divided by the Death Benefit immediately before the acceleration. The Accelerated Benefit Charge will never be greater than $200.00.

**Submit to Home Office. Leave copy with owner. Keep copy in agent file.**

The following is an example of how these values are reduced.

| Assumptions | |
|---|---|
| Accelerated Benefit Amount | $100,000 |
| Accelerated Benefit Payment | $93,717 |

| Policy Value | Before Accelerated Benefit | After Accelerated Benefit |
|---|---|---|
| Specified Amount | $1,000,000 | $900,000 |
| Death Benefit Base (Option A) | $1,000,000 | $900,000 |
| Total Premium Paid | $100,000 | $90,000 |
| Minimum Monthly Premium | $1,000 | $900 |
| Current Value | $300,000 | $270,000 |
| Guaranteed Accumulation Value | $90,000 | $81,000 |
| Full Surrender Charge | $10,000 | $9,000 |
| Policy Loan | $5,000 | $4,500 |
| Cash Value | $285,000 | $256,500 |

Receipt of an accelerated benefit will reduce the Specified Amount, Total Premium Paid, Minimum Monthly Premium, Current Value, Guaranteed Accumulation Value, and Full Surrender Charges. It will also reduce, if applicable, the Rider Specified Amount of the Supplemental Term Rider. Additionally, the Terminal Illness Benefit and Chronic Illness Accelerated Benefit will reduce any Policy Loans.

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.

eSigned By FireLight: Anjali c Nandwani

Owner 2020-07-31T01:06:00 e5718c403f9c482986e5d93b7eb5cb7b _____ Date 7/30/2020

Joint 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.

eSigned By FireLight: JOSEPH L COROZZA JOSEPH L COROZZA

Producer 2020-07-29T15:04:14 d2ebd31f2bbe4e9a81f83d7f671aa03e _____ Date 7/29/2020

**Submit to Home Office. Leave copy with owner. Keep copy in agent file.**

Allianz Life Insurance Company
of North America

PO Box 59060
Minneapolis, MN 55459-0060

# Notice of Disclosure

**Notice of Disclosure**

One of the prime objectives of the Company is to provide insurance at a fair cost. The underwriting process (evaluation of risks) is necessary not only to assure this fair cost, but also to assure that each policyholder contributes his fair share of the cost. In considering your application, information from various sources, therefore, must be considered. These include the results of your physical examination, if required, and any reports received from doctors and hospitals who have attended you.

**Notice of Insurance Information Practices**

To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. Although the information we obtain about you is confidential, in some cases we may disclose information to others without your specific authorization. We will furnish a more detailed summary of our information practices upon request.

**Fair Credit Reporting Act**

As a part of our evaluation of your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health and mode of living.

You may request to be interviewed in connection with the preparation of any investigative reports. Upon your written request and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense. We will advise you of the name and address of the consumer reporting agency from whom you may receive a copy of the report to inspect the report itself.

**Medical Information Bureau Notice**

Information regarding your insurability will be treated as confidential. Allianz Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc. a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Allianz Life, or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.