Generation Protector Select™

Application for the state of:

Texas

Product requirements:

The following forms must be signed and returned to the Home Office:

- ☐ 11-A-SEL-FULL-TX – Completed application (return signed form to Home Office)
  - If the applicant does not inform the Company that they currently own an Allianz fixed, universal, term, or variable life insurance policy or annuity contract (section 1), they will not receive the existing policyholder discount. If the applicant informs the Company at a later date, they will receive the discount from that date forward.
  - Include physician information for each applicant (section 9)
  - If replacement is involved, applicant must acknowledge receiving replacement notice (section 10)
- ☐ NB5078 – Complete the Agent's Report (return signed form to the Home Office with application)
- ☐ WS2 – LTCi Personal Worksheet, one for each applicant (refer to the Suitability Standards on our Web site)
- ☐ X-0143-TX – Acknowledgement of Nonduplication
- ☐ NB3046-WS – HIPAA Health Information (Must complete for Authorization of Release of Medical Records)

The following forms must be left with the applicant(s):

- ☐ PRD-TX – LTCi Potential Rate Increase Disclosure Form
- ☐ 11-OC-Q-SEL-FULL-TX – Outline of Coverage
- ☐ 0-C4 – Notice of Disclosure
- ☐ 0-C5-TX – Things You Should Know Before You Buy Long Term Care Insurance
- ☐ 0-C6 – Important Notice to Persons on Medicare
- ☐ RPL – Notice to Applicant Regarding Replacement

Required forms not available in application packet:

- ☐ TX-specific Long Term Care Shopper's Guide (must be left with applicant)

Additional information:

- If you have completed an illustration/proposal, please include a copy with the application
- If paying monthly, include the EFT form and voided check
- Conditional Premium Receipt (CPR) must be left with applicant
- Refer to Underwriting Guide 11-UG
- For questions contact the FASTeam at 800.950.7372 (press 1 for Sales Support, then 3 for LTCi)
- All forms are available on the Web site at www.allianzlife.com or call the Supply Department at 800.358.8585

Long Term Care Application

IMPORTANT: Remove all carbonless forms from back of packet before completing application.

Allianz Life Insurance Company
of North America

PO Box 1292
Minneapolis, MN 55440-1292

Overnight Address:
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

www.allianzlife.com

For agent use only

Allianz

Allianz Life Insurance Company
of North America

PO Box 1292
Minneapolis, MN 55440-1292

Guidelines for Long Term Care Insurance Applicants

Dear Insurance Applicant:

The application you are submitting for long term care insurance is often supplemented by additional information. This packet explains the nature of this information.

Allianz is continuing to develop ways that assist you in understanding how information is gathered and used. We place the highest priority on privacy, accuracy, and responsiveness.

Information asked for and obtained by us is used in order to make proper underwriting decisions. Information obtained can often speed up the approval of your policy and enable you to get the coverage you want. In other cases, this information might be a factor in our decision to rate or decline a policy.

What type of reports does Allianz gather?

Depending on your age and the type of coverage you are requesting, Allianz may need one or more of the following requirements:

- **Medical History Interview** – Someone from our office will call you and ask you a series of questions. A cognitive test may be included in this interview.
- **Attending Physician Statements** – We will be obtaining your medical records from your physician or clinic covering your doctor visits for the last five years. It is extremely important that you furnish us with correct doctor information and addresses. Include information in which you saw a doctor under a different name. (i.e. maiden name, Kaiser Medical Facility patient number, etc.)
- **Face-to-Face Assessment** – A trained assessor may come to your home or business and ask you a series of questions. Some of this information may have already been gathered by your agent. A cognitive test may be included in this interview.

What you should know:

The Attending Physician Statement is obtained by going directly to the doctor or clinic you disclosed on the application. By signing the application, you are giving us your consent to obtain your medical records. It is very important that you are able to supply on the application the full name of your doctor or medical facility along with a complete address.

For the Face-to-Face Assessment and the Phone History Interview, we will be asking you general questions about your health and lifestyle. We may need the names, dates and addresses or phone numbers of physicians you have seen. We may also need the names, dates and addresses or phone numbers of any hospitals you have been confined to. In addition, information on your medications and dosages will be obtained.

Although some of this information may be repetitive to what you disclosed on the application, we generally get more detail on the phone histories and Face-to-Face Assessments.

Leave with Applicant

Allianz Life Insurance Company
of North America

Home Office: Minneapolis, MN 55416-1297

PO Box 1292
Minneapolis, MN 55440-1292

Home Office use only

Allianz assigned policy number(s)

Primary:

Second:

Application for Generation Protector Select™ Long Term Care Insurance

☐ New application
☐ Existing policy change/reinstatement

1. Tell us about yourself

Proposed primary insured

First | Middle | Last

Occupation | Social Security number

Residence address

City | State | ZIP code

Day phone number | Evening phone number | Best time to call ☐ a.m. ☐ p.m.

Date of birth (mm/dd/yyyy) | Age | Gender ☐ Male ☐ Female | Height ′ ″ | Weight lbs.

Tobacco use: ☐ Nonsmoker of cigarettes in past 24 months ☐ Smoker of cigarettes in past 24 months ☐ Other tobacco use _____

Marital status
☐ Married ☐ Single
☐ Widowed ☐ Divorced

With whom do you currently live?
☐ Spouse ☐ Alone ☐ Other _____

Is this person currently covered by an Allianz long term care insurance policy? ☐ Yes ☐ No

Do you currently own an Allianz fixed, universal, term, or variable life insurance policy or annuity contract? ☐ Yes ☐ No

Policy or contract number

Type of coverage _____

Proposed second insured

First | Middle | Last

Occupation | Social Security number

Residence address

City | State | ZIP code

Day phone number | Evening phone number | Best time to call ☐ a.m. ☐ p.m.

Date of birth (mm/dd/yyyy) | Age | Gender ☐ Male ☐ Female | Height ′ ″ | Weight lbs.

Tobacco use: ☐ Nonsmoker of cigarettes in past 24 months ☐ Smoker of cigarettes in past 24 months ☐ Other tobacco use _____

Do you currently own an Allianz fixed, universal, term, or variable life insurance policy or annuity contract? ☐ Yes ☐ No

Policy or contract number

Type of coverage _____

(10/2007)

2. Agent information

First	Middle initial	Last
Phone number ( )– –	**% Split**	**Agent number**
First	**Middle initial**	**Last**
Phone number ( )– –	**% Split**	**Agent number**

3. Other insurance information

	Primary Insured Yes	Primary Insured No	Insured Second Yes	Insured Second No
1. Do you have, or, in the past 12 MONTHS did you have, another long term care insurance policy or certificate in force (including a healthcare service contract or health maintenance organization contract)? If "Yes,"list details below.	☐	☐	☐	☐
2. Are you currently receiving benefits from a state assistance program (Medicaid)?	☐	☐	☐	☐
3. Do you intend to replace any of your long term care, medical, or health insurance coverage with this policy? If "Yes," you MUST complete Section 10 (Replacement).	☐	☐	☐	☐
4. In the past 12 MONTHS, have you been declined by another company for a policy providing nursing home care, long term care, or home health care?	☐	☐	☐	☐

Agent must list all health insurance including long term care policies they have sold to the applicant(s) which: are still in force; and were sold in the last five years but are no longer in force. Agent must also list any other health insurance, including long term care policies, the applicant has in force.

☐ **Proposed primary insured** ☐ **Proposed second insured**

Status of policy	When (mm/dd/yyyy)	Type of benefit
☐ Lapsed ☐ Applied for ☐ In force	/ /	
Name of company		Policy number
To be replaced by this coverage ☐ Yes ☐ No	Amount of benefit $,	Other ______

☐ **Proposed primary insured** ☐ **Proposed second insured**

Status of policy	When (mm/dd/yyyy)	Type of benefit
☐ Lapsed ☐ Applied for ☐ In force	/ /	
Name of company		Policy number
To be replaced by this coverage ☐ Yes ☐ No	Amount of benefit $,	Other ______

☐ **Proposed primary insured** ☐ **Proposed second insured**

Status of policy	When (mm/dd/yyyy)	Type of benefit
☐ Lapsed ☐ Applied for ☐ In force	/ /	
Name of company		Policy number
To be replaced by this coverage ☐ Yes ☐ No	Amount of benefit $,	Other ______

4. Choose a benefit package

Proposed primary insured coverage

Risk class ☐ Preferred Plus ☐ Preferred ☐ Standard ☐ Select I ☐ Select II

Benefit Period ☐ 3 years ☐ 4 years ☐ 5 years

Facility Care Daily Benefit ***(choose from $50–$500 in increments of $10)*** $ ☐☐☐

Inflation protection riders

☐ 3% Lifetime Compound Benefit Increase Rider ☐ 4% Lifetime Compound Benefit Increase Rider ☐ 5% Lifetime Compound Benefit Increase Rider
☐ Two Times Compound Benefit Increase Rider ☐ Simple Benefit Increase Rider

Rejection of inflation protection rider ***(PLEASE READ. You MUST check the box below if you did NOT select an inflation protection rider above.)***

☐ By signing this application, I acknowledge by checking this box that I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without inflation protection. I realize that based on current heath care cost trends, the benefits provided by a long term care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible to use them. Specifically, I have reviewed the 3%, 4%, and 5% Lifetime Compound Benefit Increase Riders, the Two Times Compound Benefit Increase Rider, and the Simple Benefit Increase Rider, and I acknowledge that I reject inflation protection.

Nonforfeiture rider benefit ☐ Shortened Benefit Rider

Rejection of nonforfeiture rider benefit ***(PLEASE READ. You MUST check the box below if you did not select the Shortened Benefit Rider above.)***

☐ By signing this application, I acknowledge by checking this box that I have reviewed the outline of coverage and the nonforfeiture benefit as described therein. Specifically, I have reviewed the Shortened Benefit Rider, and I acknowledge that I reject such nonforfeiture benefit.

Benefit packages ***(Must select one)***

☐ Package A
70% Home and Community Care Daily Benefit
90-calendar day Elimination Period

☐ Package B
100% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit

☐ Package C
130% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit
25% Monthly Indemnity Benefit

Name of beneficiary **Relationship**

Proposed second insured coverage

Spousal rider benefits

☐ Spousal Shared Care Rider (the two insureds' plans must be identical)

Risk class ☐ Preferred Plus ☐ Preferred ☐ Standard ☐ Select I ☐ Select II

Benefit Period ☐ 3 years ☐ 4 years ☐ 5 years

Facility Care Daily Benefit ***(choose from $50–$500 in increments of $10)*** $ ☐☐☐

Inflation protection riders

☐ 3% Lifetime Compound Benefit Increase Rider ☐ 4% Lifetime Compound Benefit Increase Rider ☐ 5% Lifetime Compound Benefit Increase Rider
☐ Two Times Compound Benefit Increase Rider ☐ Simple Benefit Increase Rider

Rejection of inflation protection rider ***(PLEASE READ. You MUST check the box below if you did NOT select an inflation protection rider above.)***

☐ By signing this application, I acknowledge by checking this box that I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without inflation protection. I realize that based on current heath care cost trends, the benefits provided by a long term care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible to use them. Specifically, I have reviewed the 3%, 4%, and 5% Lifetime Compound Benefit Increase Riders, the Two Times Compound Benefit Increase Rider, and the Simple Benefit Increase Rider, and I acknowledge that I reject inflation protection.

Nonforfeiture rider benefit ☐ Shortened Benefit Rider

Rejection of nonforfeiture rider benefit ***(PLEASE READ. You MUST check the box below if you did not select the Shortened Benefit Rider above.)***

☐ By signing this application, I acknowledge by checking this box that I have reviewed the outline of coverage and the nonforfeiture benefit as described therein. Specifically, I have reviewed the Shortened Benefit Rider, and I acknowledge that I reject such nonforfeiture benefit.

Benefit packages ***(Must select one)***

☐ Package A
70% Home and Community Care Daily Benefit
90-calendar day Elimination Period

☐ Package B
100% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit

☐ Package C
130% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit
25% Monthly Indemnity Benefit

Name of beneficiary **Relationship**

5. Your premium payment amount

Proposed primary insured

Planned modal premium	Frequency *(Must select one)*
$,.	☐ Monthly PAC/EFT *(submit authorization form and 2 months premium)* ☐ Monthly List Bill ☐ Quarterly ☐ Semiannually ☐ Annually
Total amount submitted with application	If endorsed group:
$,.	Group name

Proposed second insured

Planned modal premium	Frequency *(Must select one)*
$,.	☐ Monthly PAC/EFT *(submit authorization form and 2 months premium)* ☐ Monthly List Bill ☐ Quarterly ☐ Semiannually ☐ Annually
Total amount submitted with application	
$,.	

6. Special requests

Proposed primary insured

Date to save age	Special effective date	Other
/ /	/ /	

Proposed second insured

Date to save age	Special effective date	Other
/ /	/ /	

7. Payor if other than proposed insured(s)

Full name

Relationship to you

Billing address

City	State	ZIP code
		–

8. Designation of third party for protection against unintended lapse

I understand that I have the right to designate at least one person, other than myself, to receive notice of possible lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that this notice 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:

Proposed primary insured

Full name of third party designee

Phone number

( )– –

Mailing address

City	State	ZIP code
		–

8. Designation of third party for protection against unintended lapse (continued)

I understand that I have the right to designate at least one person, other than myself, to receive notice of possible lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that this notice 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 the same person as the primary insured

☐ I elect to designate this person to receive such notice:

Proposed second insured

Full name of third party designee

Phone number

( ) –

Mailing address

City | State | ZIP code

9. Medical history - Part I

If any questions in Part I of the Medical history are answered "Yes," please provide details on page 7.

	Primary Insured YES	Primary Insured NO	Second Insured YES	Second Insured NO
1. In the past 6 MONTHS, or are you currently:				
a. Receiving disability, long term care, or workers compensation benefits?	☐	☐	☐	☐
b. Using a cane, walker or wheelchair, or confined to bed or home?	☐	☐	☐	☐
c. Using any medical appliance such as a catheter, oxygen equipment, respirator, or dialysis machine?	☐	☐	☐	☐
d. Requiring any assistance or supervision with, or limited in any capacity from performing any of the following daily activities: eating, bathing, dressing, toileting, bladder control, bowel control, or mobility?	☐	☐	☐	☐
2. Due to any physical or mental conditions, has any person or institution ever or currently been authorized to act on your behalf?	☐	☐	☐	☐
3. Have you ever been diagnosed or treated by a member of the medical profession or a health care professional for any of the following conditions:				
a. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	☐	☐
b. Diabetes treated with insulin or arthritis treated with chronic steroid use or gold therapy?	☐	☐	☐	☐
c. Alzheimer's Disease, Organic Brain Syndrome, senility, confusion, disorientation, memory loss, or dementia?	☐	☐	☐	☐
d. Parkinson's Disease, Multiple Sclerosis, ALS (Lou Gehrig's Disease), or Muscular Dystrophy?	☐	☐	☐	☐
e. Stroke, congestive heart failure, COPD/emphysema with continued smoking, cirrhosis of the liver, or unoperated aneurysm?	☐	☐	☐	☐
4. In the past 10 YEARS, have you received medical advice or treatment for any of the conditions listed below? (If "YES," check all that apply. PI = Proposed Primary Insured. SI = Proposed Second Insured.)	☐	☐	☐	☐

PI	SI		PI	SI		PI	SI		PI	SI	
☐	☐	Alcoholism	☐	☐	Cancer	☐	☐	Epilepsy/seizures	☐	☐	Neurological disorder
☐	☐	Angina/Chest pain	☐	☐	Carotid artery disease	☐	☐	Fibromyalgia	☐	☐	Osteoporosis
☐	☐	Anxiety disorder	☐	☐	Chronic bronchitis	☐	☐	Fractures	☐	☐	Pacemaker
☐	☐	Arrhythmia	☐	☐	Circulatory disorder	☐	☐	Heart attack	☐	☐	Peripheral vascular disease
☐	☐	Arteriosclerosis	☐	☐	COPD/emphysema	☐	☐	Heart disease			
☐	☐	Arthritis	☐	☐	Coronary artery disease	☐	☐	Hepatitis	☐	☐	Respiratory/Lung disorders
☐	☐	Asthma	☐	☐	Crohn's disease or ulcerative colitis	☐	☐	High blood pressure	☐	☐	Skin ulcers
☐	☐	Auto-Immune Disorder				☐	☐	Joint replacement	☐	☐	Spine/Back disorders
☐	☐	Back disorder/surgery	☐	☐	Depression	☐	☐	Lupus	☐	☐	Stroke/CVA
☐	☐	Blindness	☐	☐	Diabetes	☐	☐	Melanoma	☐	☐	Transcient Ischemic Attack
☐	☐	Blood disorders	☐	☐	Drug or substance abuse	☐	☐	Mental/nervous disorder	☐	☐	Urinary incontinence

9. Medical history - Part I (Continued)

If any questions in Part I of the Medical history are answered "Yes," please provide details on page 7.

	Primary Insured YES	Primary Insured NO	Second Insured YES	Second Insured NO
5. In the past 10 YEARS, have you been treated by a member of the medical profession or health care professional for any condition not listed previously?	☐	☐	☐	☐
6. In the past 10 YEARS, have you had any episodes of falling, or used a cane, walker, or wheelchair, or been confined to a bed or home?	☐	☐	☐	☐
7. In the past 12 MONTHS, have you:				
a. Been confined to a hospital, nursing home, or sanitarium?	☐	☐	☐	☐
b. Received home care services, physical therapy, or rehabilitative therapy?	☐	☐	☐	☐
c. Sought medical advice or treatment for loss of appetite, falling, fainting, problems with balance, dizziness, or deterioration of vision?	☐	☐	☐	☐
d. Had any surgical procedure or had any surgical procedure recommended or scheduled?	☐	☐	☐	☐

9. Medical history - Part II

Physician of proposed primary insured

Physician name

Phone number

( ) –

Mailing address

City | State | ZIP code

Medical specialist name

Phone number

( ) –

Mailing address

City | State | ZIP code

Physician of proposed second insured

Physician name

Phone number

( ) –

Mailing address

City | State | ZIP code

Medical specialist name

Phone number

( ) –

Mailing address

City | State | ZIP code

9. Medical history - Part III

What medications, prescription and non-prescription, are you currently taking?

Name of medication	Dose	Frequency	Condition(s) for which you are taking it	PI	SI
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

9. Medical history - Part IV *(provide details to any questions answered "Yes" in Medical history – Part I)*

Home Office changes to this application

10. Replacement (complete only if replacement is involved)

By signing this application, I acknowledge that I have received and read a copy of the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. The "Notice to applicant" was delivered to (printed name of proposed insured):

First	Middle	Last

on (date) ☐☐/☐☐/☐☐☐☐

Agent first	Middle	Last

Agent address

City	State	ZIP code
		☐☐☐☐☐–☐☐☐☐

11. Your agreement and acknowledgement

AGREEMENT – The answers given are complete and true. I understand that the Company will rely on my written answers to the questions in this application and that if my answers are not complete and true, my policy may not be valid, subject to the Incontestability provision in the policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I understand that a 5% discount on my long term care insurance policy premiums is available if I have an existing in force life insurance policy or annuity contract with the Company.

ACKNOWLEDGEMENT – By signing below, I acknowledge receipt of an Outline of Coverage, Texas-specific Shopper's Guide titled "Long Term Care Insurance," Medicare Notice, Potential Rate Increase Disclosure, and Disclosure Statement, which includes the Medical Information Bureau Notice and the Notice of Insurance
Information Practices.

CAUTION – If your responses on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy, subject to the Incontestability provision in the policy. 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, may be guilty of a crime and may be subject to fines and confinement in prison.

Signed at city	State

Day	Month	Year

X _____
Proposed primary insured's signature

X _____
Proposed second insured's signature

To be answered by licensed resident agent: I certify that the statements of the proposed insured(s) have been correctly recorded in this application. To the best of my knowledge, if the above Section 10 (Replacement) is completed, the insurance applied for in this application will replace existing insurance.

Writing agent's signature _____

Writing agent's phone number (☐☐☐)–☐☐☐–☐☐☐☐

Agent's statement

		YES	NO
1.	Did you personally interview the proposed insured(s), ask all the questions and witness the signatures?	☐	☐
2.	a. Did the proposed insured(s) (or their representative) initiate the contact that resulted in this application?	☐	☐
	b. How long have you known the proposed insured(s)? _____		
	c. Are you or your spouse related to the proposed insured(s)? If yes, relationship? _____	☐	☐
3.	Did you notice any impairments with regard to walking, talking or any type of tremor or signs of disorientation? (Please explain in "REMARKS.")	☐	☐
4.	Do you have reason to believe that any information on this application (whether favorable or unfavorable) might be inaccurate or misleading or do you have any information not disclosed in this application regarding the health, habits, or home surroundings of the proposed insured(s) (whether favorable or unfavorable) which might assist in the underwriting decision on this application? (Please explain in "REMARKS.")	☐	☐
5.	Does a Power of Attorney document exist for the proposed insured(s)? ..... If "Yes," please explain why this agreement has been established in "REMARKS."	☐	☐

6. Proposed Insured(s) type of dwelling:
   ☐ Private Home ☐ Apartment ☐ Assisted Living Facility
   ☐ Nursing Facility ☐ Retirement Home ☐ Other _____

7. Indicate the best time of day to contact the proposed insured(s) by telephone: _____

REMARKS:

Agent's Report (Must be completed)

1. What commission choice are you selecting? *(Please check only one option. Refer to the Product Information section of www.allianzlife.com, or call the FASTeam at 800.950.7372 should you have any questions on these options.)*

   ☐ Option A

   ☐ Option B

   ☐ Option C*

   *Option not available in DE, IN, MI, and WI

2. Complete agent information

First	MI	Last
Signature		**Agent number**

Return to Home Office

Allianz Life Insurance Company
of North America

PO Box 1292
Minneapolis, MN 55440-1292

Allianz

Long Term Care Insurance Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

The insurance company will fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information
(to be filled out by agent)

Policy Form Number(s) _____

The premium for the coverage you are considering will be $ _____ per month, or $ _____ per year.

Type of Policy: Guaranteed Renewable.

The Company's Right to Increase Premiums: The company has a right to increase premiums on this policy form in the future, provided we base the premium increase, by class, for everyone in your state, on the experience of this policy form. We will notify you in writing at least 60 days before your premium changes.

Rate Increase History
The company has sold long term care insurance since 1990 and has sold this policy since 2006. The company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related to Your Income
(to be filled out by applicant – proceed to "Disclosure Statement" if you choose not to complete this information)

How will you pay each year's premium?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one) ☐ Under $10,000 ☐ $10-20,000 ☐ $20-30,000 ☐ $30-50,000 ☐ Over $50,000

How do you expect your income to change over the next 10 years? (check one)
☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in 2001 was $55,000, but this figure varies across the country.[1] In ten years the national average cost would be about $89,589 if costs increase 5% annually.

What elimination period are you considering?
Number of days _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

---

Questions Related to Your Savings and Investments
(to be filled out by applicant)

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

Disclosure Statement
(to be filled out by applicant)

☐ The answers to the questions above describe my financial situation.

Or

☐ I choose not to complete this information. **(If this box is checked, applicant must complete "Authorization to Process Application" (form X-0183) in order for application to be processed.)**

(One of the above boxes, as well as the below box, must be checked.)

PLEASE READ – THE BELOW BOX MUST BE CHECKED

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signed: _____ _____
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information. **(This box must be checked.)**

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name: _____

In order for us to process your application, please return this signed statement to Allianz Life Insurance Company of North America along with your application.

My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

[1] Long Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services, United States General Accounting Office, March 2001

Allianz Life Insurance Company
of North America

PO Box 1292
Minneapolis, MN 55440-1292

Allianz

Long Term Care Insurance Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

The insurance company will fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information
(to be filled out by agent)

Policy Form Number(s) _____

The premium for the coverage you are considering will be $ _____ per month, or $ _____ per year.

Type of Policy: Guaranteed Renewable.

The Company's Right to Increase Premiums: The company has a right to increase premiums on this policy form in the future, provided we base the premium increase, by class, for everyone in your state, on the experience of this policy form. We will notify you in writing at least 60 days before your premium changes.

Rate Increase History
The company has sold long term care insurance since 1990 and has sold this policy since 2006. The company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related to Your Income
(to be filled out by applicant – proceed to "Disclosure Statement" if you choose not to complete this information)

How will you pay each year's premium?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one) ☐ Under $10,000 ☐ $10-20,000 ☐ $20-30,000 ☐ $30-50,000 ☐ Over $50,000

How do you expect your income to change over the next 10 years? (check one)
☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in 2001 was $55,000, but this figure varies across the country.[1] In ten years the national average cost would be about $89,589 if costs increase 5% annually.

What elimination period are you considering?
Number of days _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

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Questions Related to Your Savings and Investments
(to be filled out by applicant)

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

Disclosure Statement
(to be filled out by applicant)

☐ The answers to the questions above describe my financial situation.

Or

☐ I choose not to complete this information. **(If this box is checked, applicant must complete "Authorization to Process Application" (form X-0183) in order for application to be processed.)**

(One of the above boxes, as well as the below box, must be checked.)

PLEASE READ – THE BELOW BOX MUST BE CHECKED

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signed: _____ _____
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information. **(This box must be checked.)**

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name: _____

In order for us to process your application, please return this signed statement to Allianz Life Insurance Company of North America along with your application.

My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

[1] Long Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services, United States General Accounting Office, March 2001

LONG TERM CARE INSURANCE
POTENTIAL RATE INCREASE DISCLOSURE FORM

Allianz Life Insurance Company of North America
PO Box 1292
Minneapolis, MN 55440-1292

1. **This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may increase based, by class for everyone in your state, on the experience of this policy form. We will notify you in writing at least 45 days before your premium changes.

2. **If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**
   (a) Pay the increased premium and continue your policy in force as is.
   (b) Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   (c) Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   (d) Exercise your contingent nonforfeiture rights – See number 3 below. (This option is available if you do not purchase the separate nonforfeiture option mentioned in (c) above.)

3. **Contingent Nonforfeiture**

   If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

   (a) You will keep some long term care insurance coverage, if:
      (1) Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
      (2) You lapse (not pay more premiums) within 120 days of the increase.
   (b) The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.
   (c) Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

      Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Leave with Applicant

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase Over Initial Premium
that qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from the date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%

Issue Age	Percent Increase Over Initial Premium
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. Premium Rate

The premium rate that is applicable to you and that will be in effect until a request is made and filed with the Texas Department of Insurance for an increase is $_____. **The premium for this policy will be shown on the schedule page of your policy.**

5. Rate Schedule Adjustments

Premium rate adjustments will be effective on the next policy anniversary date. The new premium rate will remain in effect until another request is made and filed with the Texas Department of Insurance. You have the right to receive a revised policy schedule page if the premium rate is adjusted.

6. Rate Increase History

We have sold long term care insurance since 1990 and have sold this policy (form# _____) since 2003. We have never raised rates for any long term care policy sold in this state or any other state.

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Allianz Life Insurance Company of North America

PO Box 1292
Minneapolis, MN 55440-1292

Automatic Payment Plan—EFT Authorization

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

Name on bank account (please print)		Name of applicant/owner (if other than account holder)	
Signature of account holder **X**		Date of authorization	Withdrawal day (1st thru 28th)
Type of account ☐ Checking ☐ Savings	Account number Routing number	Process entries ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual	In the amount of $
Name of financial institution or bank			Apply payments to policy number:
Address			
City, State, ZIP code		Telephone	

Return to Home Office

*** PLEASE SUBMIT A VOID CHECK WITH THIS FORM ***

EFT (R-2/2006)

Allianz

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 and the right to receive the specific reason for an adverse underwriting decision. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Allianz Life Insurance Company of North America to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize.

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. The Company, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617/426-3660.

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

0-C4 (R-6/2003)

Leave with Applicant

Allianz Life Insurance Company
of North America
PO Box 1292
Minneapolis, MN 55440-1292

Conditional Long Term Care Insurance Premium Receipt

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.

A long term care insurance policy with Allianz Life Insurance Company of North America (the "Company") will not become effective unless and until a policy is delivered and accepted by you. However, if you have paid us the first full modal premium selected on the application, or your payment is equal to at least two months premium, we will provide the following conditional insurance. Please read the following carefully.

1. Conditional long term care insurance coverage is determined separately for each proposed insured under the policy. **Conditional long term care insurance coverage identical in terms to the policy you have applied for will become effective before delivery of the policy applied for only if all of the conditions listed below have been completely satisfied.**
   (a) The amount of advance premium taken with the application is at least equal to the first full modal premium selected on the application or a minimum of two month's premium;
   (b) The proposed insured is age 75 or less;
   (c) Completion of the application and telephone interview/application, as deemed necessary by the Company, within 75 days from the application signed date;
   (d) All answers on the application and telephone application are true and complete; and
   (e) The proposed insured is insurable and acceptable for the insurance coverage applied for according to the Company's underwriting rules and standards.
2. If your premium payment is not honored, this Conditional Long Term Care Insurance Premium Receipt is void.
3. Except as provided in this Conditional Long Term Care Insurance Premium Receipt, any policy approved by the Company will not take effect until the full premium is paid and the policy is delivered and accepted during the lifetime of the applicant.
4. No agent or any other person is authorized by Allianz Life Insurance Company of North America to waive any requirement or modify, in any way, any of the provisions of this Conditional Long Term Care Insurance Premium Receipt; nor are they authorized to accept risks or make decisions regarding insurability on behalf of the Company.
5. Any insurance effective under this Conditional Long Term Care Insurance Premium Receipt will expire and be void upon the earlier of:
   (a) The effective date of the policy for which the application was made;
   (b) The date the Company sends you written notification denying your application;
   (c) The date the Company sends you written notification that the application is deemed incomplete due to failure to complete the application process; or
   (d) The date the application is withdrawn by the applicant or agent on the applicant's behalf.
6. In no event will coverage exist under both this Conditional Long Term Care Insurance Premium Receipt and the long term care insurance policy the Company offers you.

I certify that I have reviewed and explained the conditions of this premium receipt with _____, the proposed insured, and I have received advance premium totaling $_____ in connection with the application for long term care insurance with Allianz Life Insurance Company of North America.

_____ _____
Date Signature of agent

CPR **Leave with Applicant** (R-3/2005)

Allianz Life Insurance Company
of North America

Home Office: Minneapolis, MN

PO Box 1292
Minneapolis, MN 55440-1292

800/950-1962

Outline of Coverage for Long Term Care Insurance Policy Form 11-P-Q-TX

CAUTION: The issuance of the long term care insurance Contract is based upon your responses to the questions on your application. A copy of your application will be attached to the policy. If your responses are incorrect or untrue, we may have the right to deny benefits or rescind the Contract, subject to the policy's Incontestability provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your responses are incorrect, write or call us at the address or telephone number shown above.

NOTICE TO BUYER: The Contract may not cover all of the costs associated with long term care incurred by you during the period of coverage. You are advised to carefully review all limitations. In addition, you are advised that based on current health care cost trends, the benefits provided by the Contract may be significantly diminished in terms of real value to you, depending upon the amount of time which elapses between the date of purchase and the date upon which you first become eligible for benefits.

POLICY DESIGNATION – The Contract is an individual Contract of insurance.

PURPOSE OF OUTLINE OF COVERAGE - This outline of coverage provides a very brief description of the important features of the Contract. You should compare this outline of coverage to outlines of coverage for other contracts available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Contract contains governing contractual provisions. This means that the Contract sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ THE CONTRACT CAREFULLY!**

TERMS UNDER WHICH THE CONTRACT MAY BE RETURNED AND PREMIUM REFUNDED – If you are not satisfied with the Contract, you have 30 days to return it to us or the agent from whom it was purchased for a full refund of any premium you have paid. If you Cancel the Contract after 30 days, any unearned premium will be returned to you as of the date we receive your written Cancellation request or a later date specified in your written Cancellation request, whichever is later. Upon your death, we will return any unearned premium for the Contract to your Beneficiary, or to your estate if no Beneficiary has been designated. We will return this unearned premium within 30 days of your written request to Cancel the Contract, or within 30 days of receipt of proof of your death.

MEDICARE SUPPLEMENT INSURANCE DISCLAIMER – This is not Medicare Supplement Coverage. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Allianz Life Insurance Company of North America nor its agents represent Medicare, the federal government, or any state government.

LONG TERM CARE COVERAGE – Contracts of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, provided in a setting, other than an acute care unit of a Hospital, such as in a Nursing Facility, in the community, or in the Home. Coverage is provided for the benefits outlined in the "BENEFITS PROVIDED BY THE POLICY" section. The benefits described in such section may be limited by the limitations and exclusions outlined in the "LIMITATIONS AND EXCLUSIONS" section.

BENEFITS PROVIDED BY THE POLICY

Covered Care – The Contract provides benefits for Qualified Long Term Care Services. This includes Facility Care provided in a Nursing Facility or an Assisted Living Facility and Home and Community Care, which provides benefits for Adult Day Services, Home Health Care Services, and Hospice Care Services. Benefits are also provided for Respite Care, Bed Reservation, Caregiver Training, and an Alternative Plan of Care.

Elimination Period – This is the period of time that must be satisfied before benefits become payable under the Contract. It is the number of calendar days in which you are Chronically Ill and have not received Benefit Payments under the Contract. The Elimination Period is shown on the Policy Schedule. Each calendar day beginning with the first day that you receive Qualified Long Term Care Services until you are no longer Chronically Ill counts toward the Elimination Period. Once you have satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period.

Maximum Lifetime Benefit – This is the total amount we will pay in your lifetime for all benefits (other than the Waiver of Premium Benefit) provided by the Contract. The Maximum Lifetime Benefit is shown on the Policy Schedule. The Maximum Lifetime Benefit is calculated as the Facility Care Daily Benefit times the Benefit Period (in years) times 365. The Facility Care Daily Benefit and Benefit Period are shown on the Policy Schedule. All benefits paid under the Contract accumulate toward the Maximum Lifetime Benefit, unless otherwise stated. However, for Home and Community Care Benefits, only an amount up to the Facility Care Daily Benefit will accumulate toward the Maximum Lifetime Benefit.

Facility Care Benefit – If you are confined in a Nursing Facility or Assisted Living Facility, we will pay up to the Facility Care Daily Benefit elected on the application for each day of care received in the Nursing Facility or Assisted Living Facility. Payment of this benefit is subject to the Eligibility for the Payment of Benefits section. The Facility Care Daily Benefit and Maximum Lifetime Benefit are shown on the Policy Schedule. The Facility Care Daily Benefit available ranges from $50 to $500 per day in increments of $10.

Home and Community Care Benefit – We will pay up to the Home and Community Care Daily Benefit elected on the application for covered Home Health Care Services, Adult Day Services, and Hospice Care Services, as long as you are not receiving Facility Care Benefits, and are not confined in a Hospital. Payment of this benefit is subject to the Eligibility for the Payment of Benefits section. The Home and Community Care Daily Benefit and Maximum Lifetime Benefit are shown on the Policy Schedule. The Home and Community Care Daily Benefit available is 70%, 100%, or 130% of the elected Facility Care Daily Benefit.

The purpose of these services must be primarily to give needed assistance to you as a result of your being Chronically Ill.

Respite Care Benefit – If you are Chronically Ill and are normally cared for by an informal caregiver, we will pay the actual daily charges you incur for each day of care received in a Nursing Facility or an Assisted Living Facility, up to the Respite Facility Care Daily Benefit, or the actual expenses you incur for each day you receive Home and Community Care, up to the Respite Home and Community Care Daily Benefit.

The purpose of this benefit is to temporarily relieve an informal caregiver who is providing care to you in your Home. An informal caregiver is any person who is not paid to care for you.

The Elimination Period does not apply to this benefit and days of respite care will not be used to satisfy the Elimination Period. The Respite Care Benefit is payable for a maximum of 30 days per calendar year.

Bed Reservation Benefit – If you are receiving Benefit Payments and are confined in a Nursing Facility or Assisted Living Facility, we will continue to pay the Facility Care Daily Benefit and Monthly Indemnity Benefit (if the Monthly Indemnity Benefit option is elected) as if you were still confined in the Nursing Facility or Assisted Living Facility if you:

- become hospitalized or temporarily leave the Nursing Facility or Assisted Living Facility; and
- are billed by the Nursing Facility or Assisted Living Facility to reserve your accommodations.

This benefit is subject to the Eligibility for Payment of Benefits section. However, if the Elimination Period has not been satisfied, we will count each day that you are billed by the Nursing Facility or the Assisted Living Facility to reserve your accommodations toward the Elimination Period. This benefit is available for a maximum of 60 days per calendar year.

Caregiver Training Benefit – If you are Chronically Ill, we will pay up to the Maximum Caregiver Training Benefit (five times the Facility Care Daily Benefit elected on the application) shown on the Policy Schedule for expenses incurred for an informal caregiver to receive training to take care of you in your Home. An informal caregiver is any person who is not paid to care for you.

The Elimination Period does not apply to this benefit and days of caregiver training will not be used to satisfy the Elimination Period.

Alternative Plan of Care Benefit – An Alternative Plan of Care Benefit is available, if agreed to by you, your Licensed Health Care Practitioner, and us.

The Alternative Plan of Care Benefit provides benefits for services which may include: equipment purchases or rentals; permanent or temporary modifications to your Home (such as ramps or rails); or care services not normally covered under other benefit provisions. We reserve the right to make the final decision on any request for the Alternative Plan of Care Benefit.

If the Elimination Period has not been satisfied, the remaining days needed to satisfy the Elimination Period will be multiplied by the Facility Care Daily Benefit and subtracted from the amount payable for the Alternative Plan of Care Benefit. We will count each day that has been multiplied by the Facility Care Daily Benefit toward the Elimination Period.

ADDITIONAL BENEFIT OPTIONS

Home and Community Care Monthly Benefit – For additional premium, if you are receiving Benefit Payments under the Home and Community Care Benefit, we will pay up to 30 times the Home and Community Care Daily Benefit on a monthly basis for the actual expenses incurred during the month.

Monthly Indemnity Benefit – For additional premium, this benefit provides a Monthly Indemnity Benefit amount in any month that you receive Benefit Payments under the Facility Care Benefit or Home and Community Care Benefit. The Monthly Indemnity Benefit amount is shown on the Policy Schedule. This amount is calculated as the percentage (25%) of the Facility Care Daily Benefit elected on the application multiplied by 30.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for Benefits – To be eligible for benefits under the Contract, you must be Chronically Ill. The Chronic Illness must have begun after the Effective Date.

Limitations or Conditions on Eligibility for Benefits – To receive Benefit Payments, you must meet the Eligibility for Benefits provision above, in addition to the following:

- the Contract must be In Force;
- you must have satisfied the Elimination Period, unless otherwise stated;
- you must be receiving Qualified Long Term Care Services pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner; and
- you must provide proof of such Chronic Illness as shown in the Claim Procedures section of the policy.

Benefit Payments – We will pay up to the Facility Care Daily Benefit or Home and Community Care Daily Benefit for actual expenses incurred. The Facility Care Daily Benefit and Home and Community Care Daily Benefit are shown on the Policy Schedule.

IMPORTANT DEFINITIONS

Activities of Daily Living (ADLs) are the following:

- Bathing. Washing yourself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence. The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
- Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating. Feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table), or by feeding tube or intravenously.
- Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring. Sufficient mobility to move into or out of a bed, chair, or wheelchair, or to move from place to place, either via walking, a wheelchair, or other means.

Chronically Ill means you have been certified, within the previous 12 months, but after the Effective Date, by a Licensed Health Care Practitioner as:

- being unable to perform without Substantial Assistance at least 2 ADLs and Substantial Assistance is expected to be required for a period of at least 90 continuous days; or
- requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment.

Licensed Health Care Practitioner is a person who is a Physician (as defined in section 1861(r)(1) of the Social Security Act), a Registered Professional Nurse, a Licensed Social Worker, or other individual who meets such requirements as prescribed by the Secretary of the Treasury.

Licensed Social Worker is a person who is:

- licensed by the state, if required; and
- acting within the scope of his or her professional responsibilities when providing an assessment indicating that you are Chronically Ill.

We will not recognize you or an Immediate Family Member as a Licensed Social Worker for claims that you make to us under the Contract.

Physician is a person who:

- is licensed to practice medicine and surgery and prescribe and administer drugs;
- is legally qualified as a medical practitioner and required to be recognized as a Physician, under the Contract for insurance purposes, according to applicable state insurance laws; or
- meets the requirements of section 1861(r)(1) of the Social Security Act.

We will consider a person to be a Physician only when the person is performing tasks that are within the limits of the person's medical license, and such tasks are appropriate to the care of your Chronic Illness. We will not recognize you or an Immediate Family Member as a Physician for claims that you make to us under the Contract.

Qualified Long Term Care Services are, generally, necessary diagnostic, preventive, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Specifically, under the Contract, Qualified Long Term Care Services are care provided to you, because you are Chronically Ill, in a Nursing Facility or an Assisted Living Facility under the Facility Care Benefit; and services provided to you, because you are Chronically Ill, through Home Health Care Services, Adult Day Services, or Hospice Care Services under the Home and Community Care Benefit. This care/these services must be provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Registered Professional Nurse (RN) is a duly registered nurse acting within the scope of his or her license at the time the treatment or service is performed.

We will not recognize you or an Immediate Family Member as a Registered Professional Nurse for claims that you make to us under the Contract.

Severe Cognitive Impairment is the deterioration or loss of your intellectual capacity which is confirmed by a Physician and measured by clinical evidence and standardized tests that reliably measure your impairment in:

- short or long term memory;
- orientation as to people (such as who you are), places (such as where you are), or time (such as day, date and year);
- judgement as it relates to safety awareness, which requires supervision or verbal cueing by another person to protect yourself and others; or
- deductive or abstract reasoning.

Coverage is provided for Alzheimer's Disease and forms of senility and irreversible dementia that result in a Severe Cognitive Impairment.

Substantial Assistance means stand-by or hands-on assistance without which you would not be able to safely and completely perform the ADL. Stand-by assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the ADL. Hands-on assistance means the direct physical assistance of another person.

Substantial Supervision means requiring continual supervision by another person to protect you or others from threats to health or safety as a result of a Severe Cognitive Impairment. Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

LIMITATIONS AND EXCLUSIONS

Limitations and Exclusions – No benefits will be paid for any confinement, care, treatment, or service(s):

- for alcoholism or drug addiction.
- that result from participating in a felony, in a riot, or an insurrection.
- that result from an act of war, declared or undeclared, or during service in the armed forces.
- that result from your intentionally self-inflicted injury.
- provided outside the 50 states of the United States, the District of Columbia, or Canada, except as described in the International Coverage Benefit Rider.
- provided to you by an Immediate Family Member or someone living in your Home.
- for which you have no financial liability or that are provided at no charge in the absence of insurance.
- that are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount, except expenses which are reimbursable under Medicare only as a secondary payor.

THE CONTRACT MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS - Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic Contract will not increase over time. For additional premium, you may purchase one of the optional Inflation Protection Riders described later in this outline.

TERMS UNDER WHICH THE CONTRACT MAY BE CONTINUED IN FORCE AND IS CONTINUED – RENEWABILITY: THE CONTRACT IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the Contract, to continue the Contract as long as you pay your premiums on time. Allianz Life Insurance Company of North America cannot change any of the terms of the Contract on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium Benefit – If you are Chronically Ill and have satisfied the Elimination Period, we will waive your premium as it comes due, subject to the Eligibility for the Payment of Benefits section. We will continue to waive each premium that comes due according to the Mode of Payment in effect at the time you become eligible for this benefit, as long as you continue to be Chronically Ill.

Premiums will not be waived if you are only using the Care Coordination Advisor feature or receiving benefits under the Respite Care Benefit, Caregiver Training Benefit, or Alternative Plan of Care Benefit.

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS – Premium rates are guaranteed not to change for the first five Policy Years. After the fifth Policy Year, the Company may change the premium rates for the Contract, only if we base the premium change, by class for everyone in your state, on the experience of this form. Any premium change will occur on the Policy Anniversary. We will notify you in writing at least 60 days before your premium changes.

ALZHEIMER'S DISEASE, OTHER ORGANIC BRAIN DISORDERS, AND BIOLOGICALLY BASED BRAIN DISEASES/SERIOUS MENTAL ILLNESS – Subject to any applicable Elimination Period and Limitations or Exclusions described above, the Contract provides coverage for a clinical diagnosis of Alzheimer's Disease or related degenerative illnesses and illnesses involving dementia, or due to biologically based brain diseases/serious mental illnesses, including schizophrenia, paranoia and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive) that result in a Severe Cognitive Impairment.

PREMIUM WORKSHEET – LONG TERM CARE INSURANCE

UNDERWRITING CLASS APPLIED FOR: ☐ Preferred Plus ☐ Preferred ☐ Standard ☐ Select I ☐ Select II

MAXIMUM FACILITY CARE DAILY BENEFIT APPLIED FOR:
(choice of $50 - $500 in increments of $10): $_____

BENEFIT PERIOD APPLIED FOR: ☐ 3 years ☐ 4 years ☐ 5 years

INFLATION PROTECTION RIDERS:

☐ None
☐ 3% Lifetime Compound Benefit Increase Rider
☐ 4% Lifetime Compound Benefit Increase Rider
☐ 5% Lifetime Compound Benefit Increase Rider
☐ Two Times Compound Benefit Increase Rider
☐ Simple Benefit Increase Rider

NONFORFEITURE BENEFIT RIDER:

☐ None
☐ Shortened Benefit Rider

OPTIONAL BENEFITS

☐ **PACKAGE A:**
70% Home and Community Care Daily Benefit
90-calendar day Elimination Period

☐ **PACKAGE B:**
100% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit

☐ **PACKAGE C:**
130% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit
25% Monthly Indemnity Benefit

PREMIUM SUMMARY INFORMATION

Long Term Care Policy:	$ _____
Elimination Period Factor:	x _____
Underwriting Rate Class Factor:	x _____
Inflation Protection Rider Factor:	x _____
Nonforfeiture Benefit Rider Factor:	x _____
Calendar Day Elimination Period Factor:	x _____
Home and Community Care Monthly Benefit Factor:	x _____
Monthly Indemnity Benefit Factor:	x _____
Spousal Shared Care Rider Factor:	x _____
Subtotal:	= _____
Discount Factor:	- _____
TOTAL ANNUAL PREMIUM:	$ _____

PREMIUM PAYMENT MODE (must elect one)

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly/PAC x _____

TOTAL MODAL PREMIUM: $ _____

PREMIUM WORKSHEET – LONG TERM CARE INSURANCE

UNDERWRITING CLASS APPLIED FOR: ☐ Preferred Plus ☐ Preferred ☐ Standard ☐ Select I ☐ Select II

MAXIMUM FACILITY CARE DAILY BENEFIT APPLIED FOR:
(choice of $50 - $500 in increments of $10): $_____

BENEFIT PERIOD APPLIED FOR: ☐ 3 years ☐ 4 years ☐ 5 years

INFLATION PROTECTION RIDERS:

☐ None
☐ 3% Lifetime Compound Benefit Increase Rider
☐ 4% Lifetime Compound Benefit Increase Rider
☐ 5% Lifetime Compound Benefit Increase Rider
☐ Two Times Compound Benefit Increase Rider
☐ Simple Benefit Increase Rider

NONFORFEITURE BENEFIT RIDER:

☐ None
☐ Shortened Benefit Rider

OPTIONAL BENEFITS

☐ **PACKAGE A:**
70% Home and Community Care Daily Benefit
90-calendar day Elimination Period

☐ **PACKAGE B:**
100% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit

☐ **PACKAGE C:**
130% Home and Community Care Daily Benefit
90-calendar day Elimination Period
Home and Community Care Monthly Benefit
25% Monthly Indemnity Benefit

PREMIUM SUMMARY INFORMATION

Long Term Care Policy:	$ _____
Elimination Period Factor:	x _____
Underwriting Rate Class Factor:	x _____
Inflation Protection Rider Factor:	x _____
Nonforfeiture Benefit Rider Factor:	x _____
Calendar Day Elimination Period Factor:	x _____
Home and Community Care Monthly Benefit Factor:	x _____
Monthly Indemnity Benefit Factor:	x _____
Spousal Shared Care Rider Factor:	x _____
Subtotal:	= _____
Discount Factor:	- _____
TOTAL ANNUAL PREMIUM:	$ _____

PREMIUM PAYMENT MODE (must elect one)

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly/PAC x _____

TOTAL MODAL PREMIUM: $ _____

GRACE PERIOD – Except for the first premium, you will have 31 days after each due date to pay the premium due. The Contract remains In Force during the Grace Period.

TEXAS DEPARTMENT OF INSURANCE'S CONSUMER HELP LINE – You may call the Texas Department of Insurance's Consumer Help Line at 800/252-3439 for agent, company, and any other insurance information, and 800/599-SHOP to order publications related to long term care coverage, and the Texas Department of Aging at 800/252-9240 to receive counseling regarding the purchase of long term care or other health coverage.

DENIAL OF APPLICATION – If your application for the Contract is denied, we will refund any premiums paid with the application within 30 days of the date of denial.

OFFER OF INFLATION PROTECTION

Inflation Protection Riders – For additional premium, these Riders provide that on each Policy Anniversary, the benefits provided by the Contract will be increased.

The **3%, 4%, and 5% Lifetime Compound Benefit Increase Riders** increase benefits as follows:

- the Facility Care Daily Benefit and Home and Community Care Daily Benefit will be increased by 3%, 4%, or 5% of the amount in effect on the previous Policy Anniversary.
- the Monthly Indemnity Benefit (if the Monthly Indemnity Benefit option is elected) will be increased by 3%, 4%, or 5% of the amount in effect on the previous Policy Anniversary.
- the remaining Maximum Lifetime Benefit will be increased by 3%, 4%, or 5%.

The annual increases will occur even if benefits are being paid. If you Cancel this Rider, you will forfeit all increases provided above.

The **Two Times Compound Benefit Increase Rider** increases benefits as follows:

- the Facility Care Daily Benefit and Home and Community Care Daily Benefit will be increased by 5% of the amount in effect on the previous Policy Anniversary.
- the Monthly Indemnity Benefit (if the Monthly Indemnity Benefit option is elected) will be increased by 5% of the amount in effect on the previous Policy Anniversary.
- the remaining Maximum Lifetime Benefit will be increased by 5%.

Annual increases will occur each year until the current benefit amount first exceeds two times the original benefit amount.

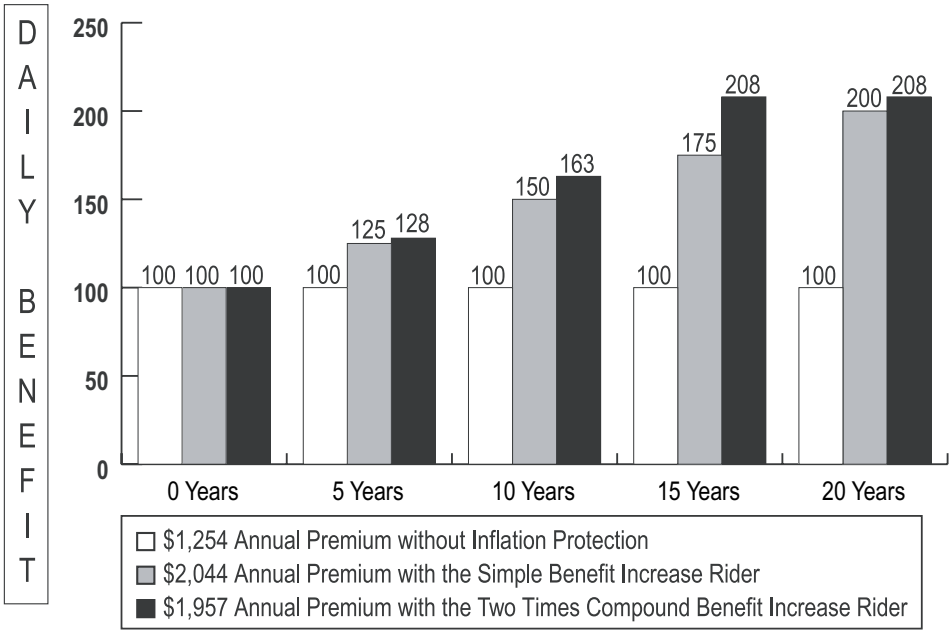
The annual increases will occur even if benefits are being paid. If you Cancel this Rider, you will forfeit all increases provided above.

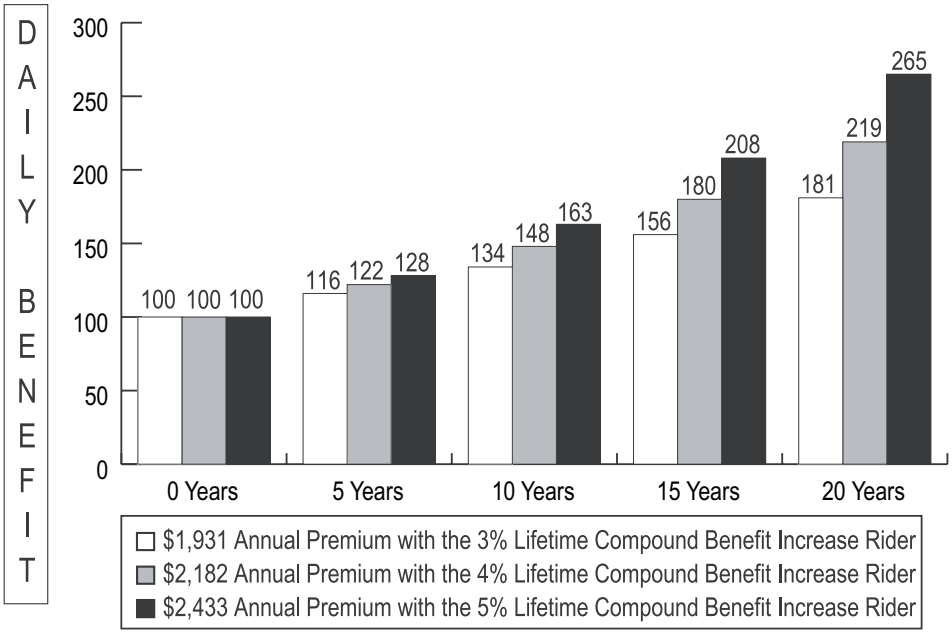
The **Simple Benefit Increase Rider** increases benefits as follows:

- the Facility Care Daily Benefit and Home and Community Care Daily Benefit will be increased by 5% of the amount shown on the current Policy Schedule.
- the Monthly Indemnity Benefit (if the Monthly Indemnity Benefit option is elected) will be increased by 5% of the amount shown on the current Policy Schedule.
- the remaining Maximum Lifetime Benefit will also increase by the same proportion as the increase in the daily benefits.

The annual increases will occur even if benefits are being paid. If you Cancel this Rider, you will forfeit all increases provided above.

The first graph compares the benefits and premiums between a policy with the Simple Benefit Increase Rider, the Two Times Compound Benefit Increase Rider, and a policy without either one. The second graph compares the benefits and premiums between a policy with the 3%, 4%, and 5% Lifetime Compound Benefit Increase Riders. For purposes of illustration, the sample shown is for a policy with an issue age of 65, a $100 Facility Care Daily Benefit, a 5-year Benefit Period, Package B, and a Preferred rating classification.





OFFER OF NONFORFEITURE BENEFIT

Shortened Benefit Rider - For additional premium, this Rider provides a benefit when the Contract has been In Force and premiums have been paid for at least three full Policy Years and Lapses due to nonpayment of premiums. Under the Shortened Benefit Rider, coverage will continue during your lifetime, but benefits will be payable only until the total of benefits paid under the Contract, including benefits paid before the date the Contract Lapses, equals the greater of 30 times the Facility Care Daily Benefit in effect on the date of Lapse or the total of premiums paid under the Contract. Benefits payable under this Rider are subject to the same Contract provisions that would have been in effect had the Contract not Lapsed. However, no further increases will occur under any benefit increase Rider, attached to the policy, after the date the Contract Lapses.

The following table illustrates the benefits and premiums for a policy with the Shortened Benefit Rider. The sample shown is for a policy with an issue age of 55, a 90-calendar day Elimination Period, a $100 Facility Care Daily Benefit, a $100 Home and Community Care Daily Benefit, a 5-year Benefit Period, and a Preferred rating classification.

Age	Total Premium Paid (no claims)	Total Rider Premium Paid	Shortened Benefit $100/day
60	$3,701.05	$692.05	37.01 days
70	$11,103.15	$2,076.15	111.03 days
80	$18,505.25	$3,460.25	185.05 days
90	$25,907.35	$4,844.35	259.07 days

Contingent Benefit Upon Lapse – This benefit is included in all Contracts that do not include the Shortened Benefit Rider. Each time premiums are increased, resulting in a "substantial premium increase," the following options are made available: a reduction of Contract benefits provided by your current coverage so that premiums are not increased; or a conversion of the Contract to paid-up status with a Shortened Benefit Period.

If you elect a reduction in Contract benefits, benefits will be provided at the level that the current premium payable under the Contract will purchase.

If you elect to convert the Contract to a paid-up status, the Maximum Lifetime Benefit becomes equal to the greater of the total premiums paid for the policy and any attached Riders or thirty times the Facility Care Daily Benefit in effect on the date of conversion. Under this option, coverage will continue during your lifetime, but benefits will be payable only until the total of benefits paid under the policy and any attached Riders equals the new Maximum Lifetime Benefit. This option may be elected at any time within 120 days of a "substantial premium increase." If the Contract Lapses for nonpayment of premium during this 120-day period, this option will automatically be provided under the Contract.

Benefits payable are subject to the same Contract provisions that would have been in effect had the Contract not been converted or Lapsed. However, no further increases will occur under any benefit increase Rider, if attached to the policy.

DISCLOSURE: FEDERAL TAX TREATMENT OF LONG TERM CARE INSURANCE CONTRACT - The Contract is intended to be a qualified long term care insurance contract as defined under section 7702b(b) of the Internal Revenue Code of 1986. There may be tax consequences associated with the purchase of a qualified long term care insurance contract, such as the tax deductibility of premiums and the exclusion from taxable income of benefits. You should consult your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

ADDITIONAL FEATURES

Medical Underwriting - Your insurability for the Contract will be determined by the answers given in your application and any other authorized medical information we obtain regarding your current state of health.

Care Coordination Advisor - If you choose, we will provide you with access to care management professionals who will work with you, your family member(s), and your Licensed Health Care Practitioner to determine and monitor your care, including assessment of your situation and investigation of available care resources. This may include assistance developing and monitoring a Plan of Care with you, your family member(s), and your Licensed Health Care Practitioner. This service is not required for you to obtain Benefit Payments under the Contract. This service will not accumulate toward the Maximum Lifetime Benefit. The Elimination Period does not apply to this benefit and days of care coordination will not be used to satisfy the Elimination Period.

International Coverage Benefit Rider – If you require Qualified Long Term Care Services, which would otherwise be covered under the Contract while you are outside the 50 states of the United States, the District of Columbia, or Canada, in a designated country as defined in the Visa Waiver Program, we will pay actual expenses up to 70% of

the Facility Care Daily Benefit or 70% of the Home and Community Care Daily Benefit. Payment of this benefit is subject to the Eligibility for the Payment of Benefits section.

Benefits paid accumulate toward the Maximum Lifetime Benefit and the International Coverage Maximum Lifetime Benefit. The International Coverage Maximum Lifetime Benefit is calculated as 70% of the Facility Care Daily Benefit elected on the application times 730 days.

Coverage Enhancement Rider – Every five years, any of the following enhancement options are available under this Rider without underwriting at an additional premium: (1) Increase the Facility Care Daily Benefit to reflect the Seasonally Adjusted Consumer Price Index for Nursing Homes and Adult Day Care; (2) Decrease the Elimination period to the next available Elimination period; and (3) Increase the Benefit Period to the next available Benefit Period.

Existing Policyholder Discount – If you have an existing in-force Allianz annuity contract or life insurance policy, you will receive a 5% discount on your long term care insurance policy premiums.

Household Discount Rider – This Rider provides a discount on the premium because you are living with someone who has, or is issued an, Allianz Life long term care insurance Contract that is still In Force. If someone with whom you are living is issued a Contract at a later date, we will provide the household discount once we are notified of such.

Married Discount Rider - This Rider provides a discount on the premium because you are married. If you are no longer married, you must provide written notice to Cancel this Rider. If you become married after the Contract is issued, we will provide the married discount once we are notified of such.

Spousal Discount Rider - This Rider provides a discount on the premium because both you and an Insured Spouse, with whom you are living and to whom you are married, were issued Contracts. If you are no longer living with or married to the Insured Spouse, you must provide written notice to Cancel this Rider. If your spouse was already issued a Contract or is issued a Contract at a later date, we will provide the spousal discount once we are notified of such.

Spousal Shared Care Rider - For additional premium, if you exhaust the Maximum Lifetime Benefit, you may access the Insured Spouse's benefits, upon our receipt of their signed consent, up to their maximum lifetime benefit, less the total of all claims paid, less 365 times the facility care daily benefit.

If the Insured Spouse exhausts their maximum lifetime benefit, the Insured Spouse may access your benefits, upon our receipt of your signed consent, up to the Maximum Lifetime Benefit less the total of all claims paid, less 365 times the Facility Care Daily Benefit.

UNINTENDED LAPSE PROTECTION - You have the right to elect a third party designee for us to notify before the Contract Terminates due to nonpayment of premium.

If the Renewal Premium remains unpaid 30 days into the Grace Period, we will mail, by postage paid, first-class US mail, a notice to you and your third party designee, if elected, stating that the Contract is about to Lapse. Notice is considered to have been given as of five days after the date of mailing. You have an additional 30 days beyond the date this notice was given to pay your premium. During this 35-day extension, the Contract is In Force. To keep the Contract In Force with no gap in coverage, you must pay your premium within this 35-day extension period. If your premium remains unpaid, the Contract will Terminate.

REINSTATEMENT - The Contract will Lapse if the premium is not paid before the end of the unintended lapse protection extension. If we receive evidence satisfactory to us that you have a Chronic Illness, we will reinstate the Contract without requiring an application, upon payment of all past due and unpaid premiums, at any time within 5 months of the date of Lapse.

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG TERM CARE INSURANCE

Long Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does not pay for most long term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of the publication titled "Long Term Care Insurance" developed by the Texas Department of Insurance. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance program in your state.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

✔ Check the coverage in all health insurance policies you already have.

✔ For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.

✔ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Leave with Applicant

Allianz Life Insurance Company
of North America

PO Box 1292
Minneapolis, MN 55440-1292

Allianz

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual long term care insurance policy to be issued by Allianz Life Insurance Company of North America. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE)

(Use additional sheets as necessary)

I have reviewed your current medical or health or long term care coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Leave with Applicant

ACKNOWLEDGEMENT OF NONDUPLICATION

PLEASE READ CAREFULLY BEFORE SIGNING

I, _____ , certify that I have
(Agent's Name)
done the following:

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of this policy.
2. Reviewed the policies listed below and have found that duplication ❑ WILL or ❑ WILL NOT *(check one)* occur with the issuance of the applied for policy.

_____
(Form Number)

COMPANY	POLICY NUMBER (#)	TYPE OF POLICY

Check one:

❑ a. Duplication will not occur because the above-listed polic(y)(ies) # _____ will be replaced by the applied-for policy _____*(form number).* Justification for the replacement is *(explain benefit to consumer).*

_____

_____

❑ b. No health policies in force at this time.

❑ c. Applicant has elected not to have the polic(y)(ies) reviewed.

_____ _____
DATE AGENT/COMPANY REPRESENTATIVE

NOTICE TO CONSUMERS

Age 65 and Older

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:
   - O SPECIFIED DISEASE (CANCER, STROKE, ETC.)
   - O HOSPITAL INDEMNITY
   - O BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)
   - O LONG TERM CARE

THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.

1. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.
2. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS, OR WAITING PERIODS MUST BE SERVED.
3. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE AGENT OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the agent named above.

❑ I have been informed that the policy for which I am applying ❑ WILL or ❑ WILL NOT *(check one)* result in duplicate coverage.

❑ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice. Dated this _____ day of _____ , in the year_____ .

_____
APPLICANT

ACKNOWLEDGEMENT OF NONDUPLICATION

PLEASE READ CAREFULLY BEFORE SIGNING

I, _____ , certify that I have
(Agent's Name)
done the following:

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of this policy.
2. Reviewed the policies listed below and have found that duplication ❑ WILL or ❑ WILL NOT *(check one)* occur with the issuance of the applied for policy.

_____
(Form Number)

COMPANY	POLICY NUMBER (#)	TYPE OF POLICY

Check one:

❑ a. Duplication will not occur because the above-listed polic(y)(ies) # _____ will be replaced by the applied-for policy _____*(form number).* Justification for the replacement is *(explain benefit to consumer).*

_____

_____

❑ b. No health policies in force at this time.

❑ c. Applicant has elected not to have the polic(y)(ies) reviewed.

_____ _____
DATE AGENT/COMPANY REPRESENTATIVE

NOTICE TO CONSUMERS

Age 65 and Older

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:
   - O SPECIFIED DISEASE (CANCER, STROKE, ETC.)
   - O HOSPITAL INDEMNITY
   - O BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)
   - O LONG TERM CARE

THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.

1. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.
2. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS, OR WAITING PERIODS MUST BE SERVED.
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❑ I have been informed that the policy for which I am applying ❑ WILL or ❑ WILL NOT *(check one)* result in duplicate coverage.

❑ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice. Dated this _____ day of _____ , in the year_____ .

_____
APPLICANT

Allianz Life Insurance Company
of North America

5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Allianz

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

(This authorization complies with the HIPAA Privacy Rule)

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

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

Name of Proposed Other Insured (please print) _____ Date of birth _____

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

I also authorize any insurance company, my insurance agent, the Medical Information Bureau (MIB), employers, consumer reporting agencies, health plan administrators, 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.

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 the MIB, reinsurers, and other persons and entities performing business or legal services in connection with my application.

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

Signature of Proposed Insured or Personal Representative _____ Date _____

Signature of Proposed Other Insured or Personal Representative _____ Date _____

Description of Personal Representative's authority or relationship to Proposed Insured/Other Proposed Insured. _____

Allianz Life Insurance Company
of North America

5701 Golden Hills Drive
Minneapolis, MN 55416-1297

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

(This authorization complies with the HIPAA Privacy Rule)

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

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

Name of Proposed Other Insured (please print) _____ Date of birth _____

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

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Signature of Proposed Insured or Personal Representative _____ Date _____

Signature of Proposed Other Insured or Personal Representative _____ Date _____

Description of Personal Representative's authority or relationship to Proposed Insured/Other Proposed Insured. _____