

**Allianz Life Insurance Company  
of North America**

5701 Golden Hills Drive  
Minneapolis, MN 55416-1297

**PART II OF application of insurance to  
PROPOSED  
INSURED:**

Date of Birth \_\_\_\_\_  
Mo. Day Year

Male  
 Female

First Name Initial Last Name

1. a. Name and address of your personal physician? \_\_\_\_\_
- b. Date and reason last consulted? \_\_\_\_\_
- c. What treatment was given or medication prescribed? \_\_\_\_\_
- d. What medications are you presently taking? \_\_\_\_\_

2. WITHIN THE PAST FIVE YEARS HAVE YOU:
- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| a. Consulted, been examined or been treated by any physician or practitioner? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Had an X-ray, EKG or any laboratory test or study? .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had observation or treatment at a clinic, hospital or sanitarium? ....           | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had or been advised to have a surgical operation? .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Had dizziness, shortness of breath, pain or pressure in the chest? .....         | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS OF "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.)

3. HAVE YOU BEEN TOLD YOU HAD:
- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Epilepsy, fainting spells, nervous or mental condition, paralysis, or any disease or abnormality of the brain or nervous system? .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart attack, murmur, high blood pressure, anemia, or any disease or abnormality of the heart, blood or blood vessels? .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, or respiratory system? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Ulcer, indigestion, colitis, hernia or any disease or abnormality of the stomach, intestines, rectum, gall bladder or liver? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Urinary sugar, albumin or stone, syphilis, or disease or abnormality of the breasts, kidneys, prostate, urinary or genital systems? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Diabetes, gout, or any disease or abnormality of the thyroid or other glands? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones? .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any disease or abnormality of the eyes, ears or skin? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cancer or tumor? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any physical deformity or defect? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)? .....                           | <input type="checkbox"/> | <input type="checkbox"/> |

4. a. Within the past ten years, have you used amphetamines, barbiturates, cocaine, heroin, morphine, LSD, marijuana, PCP, or any other hallucinogenic or narcotic drug? .....
- b. Have you ever received treatment or joined an organization for alcoholism or drug addiction? .....
- c. Has your weight changed more than 15 pounds in the past year? .....

5. Family History: Diabetes, cancer, high blood pressure, heart or kidney disease, nervous or mental illness or suicide? .....

	Age	If Living: State of Health	Age at Death	If Deceased: Cause of Death
Father				
Mother				
Brothers & Sisters				

I DECLARE that, to the best of my knowledge and belief, the statements and answers in Part II of this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon.

I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company any such information. This authorization is good for 30 months from the application date.

To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information.

A photographic copy of this authorization shall be as valid as the original.

Signed at: (City & State) \_\_\_\_\_ On \_\_\_\_\_ 20\_\_\_\_

Signature of Witness

Signature of PROPOSED INSURED

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE (Not a part of the application)  
 The questions on the reverse side must be completed and signed before the Medical Examiner.  
 The Medical Examiner must ask the Proposed Insured each question and record the answer.

1. NAME OF PROPOSED INSURED

2. HEIGHT

Ft. In.

3. WEIGHT

Lbs. Did you weigh?

MALES ONLY

4. a. CHEST EXPANDED \_\_\_\_\_ In./

b. CHEST CONTRACTED \_\_\_\_\_ In./

c. ABDOMEN \_\_\_\_\_ In./

5. BLOOD PRESSURE Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_ (Phase V) \_\_\_\_\_

6. PULSE RATE

Before Exercise Immediately After 3 Minutes After

IRREGULARITIES (minute)

7. URINALYSIS: (dipstick method is adequate)

Amount of albumin \_\_\_\_\_ Amount of sugar \_\_\_\_\_  
 Other abnormalities noted \_\_\_\_\_

INSTRUCTION TO EXAMINER

Complete questions above and mail specimen for laboratory analysis to:  
 Clinical Reference Lab  
 8433 Quivira St., Lenexa, KS 66216

8. a. Has Proposed Insured smoked one or more cigarettes in the last 12 months? Yes No

b. Any other tobacco use?

9. a. Does Proposed Insured consume alcoholic beverages? Yes No

b. If yes, how many drinks per day? \_\_\_\_\_

10. a. Does Proposed Insured engage in regular exercise? Yes No

b. If yes, what type and how often? \_\_\_\_\_

11. Is appearance unhealthy or older than stated? Yes No

DETAILS - PLEASE GIVE FULL DETAILS OF ADVERSE FINDINGS AND OPINIONS.

M.D. ONLY COMPLETE THIS SECTION.

12. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:

Yes No

- a. BRAIN, NERVOUS SYSTEM? (Test reflexes and coordination)
- b. EARS, NOSE, EYES, THROAT, TEETH OR GUMS?
- c. THYROID OR LYMPH GLANDS?
- d. HEART, BLOOD VESSELS?
- (If you find any abnormality of heart size, rhythm or sounds, please complete Question No. 14.)
- e. LUNGS?
- f. STOMACH OR ABDOMINAL ORGANS?
- g. GENITO-URINARY SYSTEM?
- h. SKIN OR EXTREMITIES?

- 13. a. Is there a hernia? (If so, describe it.)
- b. Is there any evidence of varicose veins, ulcers, hemorrhoids?
- c. Do you know any facts about this risk not brought out above?

14. TO BE COMPLETED IF QUESTION 12 d. IS ANSWERED "YES"

- a. Is there a murmur?
- b. If yes, murmur is:
  - Apical  Systolic  Constant  Soft (Gr. 1-2)
  - Basal  Presystolic  Inconstant  Mod. (Gr. 3-4)
  - Diastolic  Loud (Gr. 5-6)
- c. On exercise, does the murmur
  - Intensify?
  - Decrease?
  - Disappear?

d. Show location of murmur:

Apex by



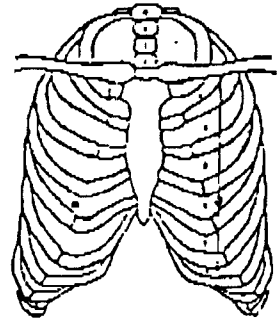
Area of murmur by outline



Point of greatest intensity



Transmission



e. What is your impression of the murmur? \_\_\_\_\_

EXAMINATION WAS MADE IN PRIVATE AT:

- My Office
- Residence of Proposed Insured
- Place of Business of Proposed Insured.

At \_\_\_\_\_ AM on \_\_\_\_\_, 20\_\_\_\_ PM

Name of agent requesting exam \_\_\_\_\_  
 If not an appointed examiner of the Company: Medical school where graduated \_\_\_\_\_

Date of Graduation \_\_\_\_\_ Name of companies for which you examine: \_\_\_\_\_

\* \_\_\_\_\_  
 Signature of Examiner

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_