Allianz Life Insurance Company
of North America
PO Box 59060
Minneapolis, MN 55459-0060
800.950.5872

Allianz

Medical Examination-Part II

Medical Section

Proposed Insured First Name _____ MI _____ Last Name _____

☐ Male ☐ Female Date of Birth _____

Personal Physician First Name _____ MI _____ Last Name _____

City _____ State _____ Phone Number _____

Date of Last Visit _____ Reason for Last Visit _____

Diagnosis made – treatment prescribed _____

1. Have you ever received medical advice or has treatment been recommended or received by a licensed member of the medical profession for any cancer, tumor, cyst, or other abnormal growth or lump?
   ☐ No
   ☐ Yes, please complete the **MEDICAL DETAILS on the next page**
2. Have you ever tested positive for exposure to the HIV infection, HIV antibodies in a test taken for the purpose of obtaining insurance, or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?
   ☐ No
   ☐ Yes, please complete the **MEDICAL DETAILS on the next page**
3. Over the last 10 years, please indicate for which of the following you have received advice, treatment, or a diagnosis from a licensed member of the medical profession (check ALL that apply)

a. BRAIN/NERVOUS SYSTEM

☐ Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease
☐ Aneurysm
☐ Anxiety including PTSD, ADD, ADHD, and OCD
☐ Cerebral Hemorrhage
☐ Depression
☐ Dizziness, Numbness, or Weakness
☐ Eating Disorder
☐ Huntington's Disease
☐ Mental Disorder
☐ Multiple Sclerosis (MS)
☐ Muscular Dystrophy
☐ Nervous Disorder
☐ Neuromuscular Degeneration
☐ Paralysis
☐ Parkinson's Disease
☐ Psychiatric Disorder
☐ Seizure/Epilepsy
☐ Stroke or Transient Ischemic Attack (TIA)/Mini-Stroke
☐ Other disease or disorder of the brain/nervous system
☐ NONE OF THESE

Complete the MEDICAL DETAILS on the next page for all Checked Boxes above, excluding "None of These"

b. HEART/BLOOD SYSTEM

- ☐ Anemia
- ☐ Cardiomyopathy
- ☐ Chest pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Elevated Cholesterol or Triglycerides
- ☐ Heart Arrhythmia
- ☐ Heart Attack
- ☐ Heart Disease or Valvular Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease (excluding varicose veins)
- ☐ Other disease or disorder of the heart/blood system
- ☐ NONE OF THESE

c. LUNGS/RESPIRATORY SYSTEM

- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Sleep apnea
- ☐ Other disease of the lungs/respiratory system
- ☐ NONE OF THESE

d. DIGESTIVE SYSTEM

- ☐ Barrett's Esophagus
- ☐ Biliary Cholangitis
- ☐ Cirrhosis
- ☐ Colitis/Ulcerative Colitis
- ☐ Crohn's/Regional Enteritis
- ☐ Gluten Intolerance/Celiac
- ☐ Hepatitis
- ☐ Other disease or disorder of the liver or an abnormal liver enzyme test
- ☐ Other disease or disorder of the pancreas
- ☐ Other disease or disorder of the rectum or intestines
- ☐ Other disease or disorder of the stomach or esophagus
- ☐ NONE OF THESE

Complete the MEDICAL DETAILS for all Checked Boxes above, excluding "None of These"

MEDICAL DETAILS

Question Number	**Detail and Date of Each of the Following As Applicable: Medication** (include name, dosage, frequency); **Emergency room visit, hospitalization, biopsy, surgery** (include description of event); **Therapy - physical, counseling, etc.** (include type and frequency); **Tests** (include type and result); **Assistive device - CPAP, etc.** (include type and nature of usage); **Activity restrictions or limitations - work, driving, etc.**(include description); **Other treatment** (include description)	**Medical Source or Facility Name Address Phone Number**

e. EXCRETORY & REPRODUCTIVE SYSTEMS

- ☐ Disease or disorder of the Breasts
- ☐ Disease or disorder of the Genitals
- ☐ Disease or disorder of the Prostate
- ☐ Disease or disorder of the Kidneys or an abnormal urine test or blood kidney function test
- ☐ Disease or disorder of the Reproductive System
- ☐ Disease or disorder of the Urinary System
- ☐ Sexually Transmitted Diseases (excluding HIV, AIDS, and ARC)
- ☐ NONE OF THESE

f. GLANDULAR SYSTEM

- ☐ Diabetes including Borderline Diabetes, Impaired Glucose Intolerance (IGT), and Gestational Diabetes
- ☐ Disease or disorder of the Thyroid or other Endocrine Glands
- ☐ Disease or disorder of Lymph Glands
- ☐ NONE OF THESE

g. SKELETAL SYSTEM

- ☐ Arthritis
- ☐ Back Trouble or Back Surgery
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Joint Replacement
- ☐ Osteoporosis
- ☐ Systemic Lupus (SLE)
- ☐ Other disease or disorder of the joints, muscles, or bones
- ☐ NONE OF THESE

h. EYES, EARS, NOSE, THROAT, & SKIN

- ☐ Disease or disorder of the nose
- ☐ Disease or disorder of the skin
- ☐ Disease or disorder of the throat
- ☐ Disease or disorder of the ears
- ☐ Disease or disorder of the eyes (excluding glasses, corrective lens, & Lasik)
- ☐ NONE OF THESE

i. IMMUNE SYSTEM

- ☐ Disease or disorder of the Immune System (excluding HIV, AIDS, and ARC)
- ☐ NONE OF THESE

Complete the MEDICAL DETAILS for all Checked Boxes above, excluding "None of These"

MEDICAL DETAILS

Question Number	**Detail and Date of Each of the Following As Applicable: Medication** (include name, dosage, frequency); **Emergency room visit, hospitalization, biopsy, surgery** (include description of event); **Therapy - physical, counseling, etc.** (include type and frequency); **Tests** (include type and result); **Assistive device - CPAP, etc.** (include type and nature of usage); **Activity restrictions or limitations - work, driving, etc.**(include description); **Other treatment** (include description)	**Medical Source or Facility Name Address Phone Number**

4. Over the last 5 years, please indicate which of the following you've had completed by a licensed member of the medical profession that was not disclosed in a previous question (check ALL that apply).
   - ☐ Consultation or check-up
   - ☐ Prescription for medication(s)
   - ☐ In-patient or out-patient in a hospital, clinic, medical facility, or similar entity (other than for normal childbirth)
   - ☐ Diagnostic test, including EKG, mammogram, colonoscopy, MRI, CT Scan, ultrasound, blood test, or urine test (excluding any disorder related to HIV Antibody, T-Cell, AIDS, or ARC)
   - ☐ Surgical operation
   - ☐ Treatment or diagnosis for any other medical condition not previously disclosed
   - ☐ **Refusal of** or **not yet completed** recommended medical test, medical treatment, surgery or hospitalization, (excluding any disorder related to HIV Antibody, T-Cell, AIDS, or ARC)
   - ☐ NONE OF THESE

5. Over the last 5 years, please indicate if you have received benefits from any of the following (check ALL that apply).
   - ☐ Disability or long-term care insurance plan
   - ☐ Medical assistance/Medicaid
   - ☐ State or county assistance program
   - ☐ State or federal disability program
   - ☐ Worker's compensation
   - ☐ NONE OF THESE

6. Over the last 5 years, please indicate for which of the following you have received advice, treatment, or a diagnosis from a licensed member of the medical profession (check ALL that apply).
   - ☐ Alzheimer's Disease
   - ☐ Confusion
   - ☐ Dementia or Memory Loss
   - ☐ Imbalance, gait disturbance, or falling
   - ☐ Incontinence or bowel function abnormality
   - ☐ Tremor
   - ☐ Trouble swallowing
   - ☐ NONE OF THESE

Complete the MEDICAL DETAILS for all Checked Boxes above, excluding "None of These"

MEDICAL DETAILS

Question Number	**Detail and Date of Each of the Following As Applicable: Medication** (include name, dosage, frequency); **Emergency room visit, hospitalization, biopsy, surgery** (include description of event); **Therapy - physical, counseling, etc.** (include type and frequency); **Tests** (include type and result); **Assistive device - CPAP, etc.** (include type and nature of usage); **Activity restrictions or limitations - work, driving, etc.**(include description); **Other treatment** (include description)	**Medical Source or Facility Name Address Phone Number**

7. Over the last 12 months, please indicate for which of the following you have required or currently require assistance or supervision or for which your performance was limited (check ALL that apply).

☐ Bathing ☐ Eating ☐ Mobility ☐ Dressing
☐ Managing Medication ☐ Toileting ☐ Driving ☐ Managing Money
☐ Using the Telephone ☐ NONE OF THESE

8. Over the last 12 months, please indicate for which of the following you have required or currently require the use of (check ALL that apply).

☐ Brace ☐ Dialysis machine ☐ Walker
☐ Cane ☐ Oxygen equipment ☐ Wheelchair
☐ Catheter ☐ Respirator ☐ Other medical equipment or appliance
☐ NONE OF THESE

Complete the MEDICAL DETAILS for all Checked Boxes above, excluding "None of These"

9. To the best of your knowledge, please tell us about your family members:

Mother: Current Status: ☐ Living Current Age: _____ ☐ Deceased Age at Death: _____ Cause of Death: _____
☐ Unknown

Father: Current Status: ☐ Living Current Age: _____ ☐ Deceased Age at Death: _____ Cause of Death: _____
☐ Unknown

Siblings: Current Status: ☐ None
Any deceased? ☐ Yes ☐ No
Age at Death: _____ Cause of Death: _____
Age at Death: _____ Cause of Death: _____
Age at Death: _____ Cause of Death: _____
☐ Unknown

MEDICAL DETAILS

Question Number	**Detail and Date of Each of the Following As Applicable: Medication** (include name, dosage, frequency); **Emergency room visit, hospitalization, biopsy, surgery** (include description of event); **Therapy - physical, counseling, etc.** (include type and frequency); **Tests** (include type and result); **Assistive device - CPAP, etc.** (include type and nature of usage); **Activity restrictions or limitations - work, driving, etc.**(include description); **Other treatment** (include description)	**Medical Source or Facility Name Address Phone Number**

10. Have you ever been charged an extra premium, been declined for coverage, or had coverage canceled for a life insurance policy with another company?

☐ No

☐ Yes

If yes, please explain: _____

_____

_____

11. Please provide your height: _____ ft. _____ in.

12. Please provide your weight: _____ lbs.

13. Which of the following describes how your weight has changed in the past 12 months?

☐ Increased by more 10 pounds ☐ Increased by more than 20 pounds

☐ Decreased by more than 10 pounds ☐ Decreased by more than 20 pounds

☐ Did not increase or decrease by more than 10 pounds

If increased or decreased by more than 20 pounds, please provide the following:

a. Amount of increase/decrease: _____

b. Reason for increase/decrease:

☐ Pregnancy ☐ Intentional dieting/exercise

☐ Other: _____

c. Is your doctor aware of your weight change?

☐ No ☐ Yes

Acknowledgment and signatures

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

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

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

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

_____

Signed At (City and State)

_____ _____

Signature of Examiner Date

_____ _____

Proposed Insured's Signature Date

Please submit the form using one of the options below:

Email completed forms to: lifeinsurance@send.allianzlife.com

OR

Web Upload: You can upload your signed and completed form(s) by logging into your account at Allianzlife.com

OR

Mail:

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

Overnight Mail
Allianz Life Insurance Company of North America
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

OR

Fax: 763.582.6002

Any questions? Call us at 800.950.5872

Allianz Life Insurance Company
of North America

Allianz

Medical Examiner's Report

Notice to examiner: If the NB6009 is used in conjunction with this form (NB6008), please make sure that the medical examiner asks the proposed insured each question and records the answer. The NB6009 must be completed and signed before the medical examiner.

Medical examiner's report to be filled out in private (not a part of the application):

1. Proposed Insured Information

Proposed Insured First Name _____ MI _____ Last Name _____

1. Height: _____ ft. _____ in. 2. Weight: _____ lbs. Did you weigh? ☐ No ☐ Yes

3. Males only:
   a. Chest expanded _____ in. b. Chest contracted _____ in. c. Abdomen _____ in.

4. Blood pressure
   Systolic: _____ _____ _____
   Diastolic (Phase V): _____ _____ _____

5. Pulse rate: Irregularities (minute)

Before exercise	Immediately after	3 minutes after

6. a. Has the proposed insured smoked one or more cigarettes in the last 12months? ☐ No ☐ Yes
   b. Any other tobacco use? ☐ No ☐ Yes

7. Does the proposed insured drink alcoholic beverages? ☐ No ☐ Yes
   If yes, please indicate frequency, number of drinks per occasion and type of alcohol used: _____

8. Does the proposed insured engage in regular exercise? ☐ No ☐ Yes
   If yes, please indicate type of exercise, how often and for how long do you exercise: _____

9. Is appearance unhealthy or older than stated? ☐ No ☐ Yes

2. M.D. only complete this section

11. After careful inquiry and physical examination, do you find any evidence of past or present diseases or disorders of the:
    a. Brain, nervous system? (test reflexes and coordination) ☐ No ☐ Yes
    b. Ears, nose, eyes, throat, teeth or gums? ☐ No ☐ Yes
    c. Thyroid or Lymph glands? ☐ No ☐ Yes
    d. Heart, blood vessels? ☐ No ☐ Yes
       If you find any abnormality of heart size, rhythm, or sounds, please complete question 12.
    e. Lungs? ☐ No ☐ Yes
    f. Stomach or abdominal organs? ☐ No ☐ Yes
    g. Genito-Urinary system? ☐ No ☐ Yes
    h. Skin or extremities? ☐ No ☐ Yes

Return to Home Office

2. M.D. only complete this section *(continued)*

12. a. Is there a hernia? ☐ No ☐ Yes If yes, please describe_____
    b. Is there any evidence of varicose veins, ulcers, hemorrhoids? ☐ No ☐ Yes
    c. Do you know any facts about this risk not brought out above? ☐ No ☐ Yes

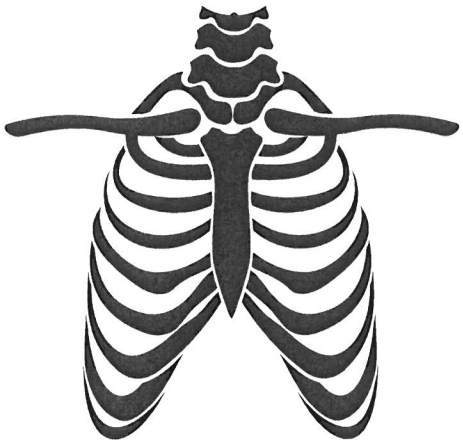
13. To be completed if question 11d is answered "Yes"
    a. Is there a murmur? ☐ No ☐ Yes
    b. If yes, murmur:
    ☐ Apical ☐ Systolic ☐ Constant ☐ Soft (Gr 1-2) ☐ Basal ☐ Presystolic ☐ Inconstant ☐ Soft (Gr 1-2)
    ☐ Diastolic ☐ Loud (Gr. 5-6)
    c. On exercise, does the murmur
    ☐ Intensify? ☐ Decrease? ☐ Disappear?
    d. Show location of murmur:

    Apex by **X**

    Area of murmur by outline ◌

    Point of greatest intensity ○

    Transmission →



    e. What is your impression of the murmur? _____

_____

_____

_____

Details - please give full details of adverse findings and opinions: _____

_____

_____

_____

_____

_____

_____

_____

3. M.D. Signature

Examination was made in private at:

☐ My office ☐ Residence of proposed insured ☐ Place of business of proposed insured

At _____ ☐ a.m. ☐ p.m. on _____
Date

_____
Name of agent requesting exam

_____ _____
If not an appointed examiner of the Company, medical school where graduated Date of graduation

_____
Names of companies for which you examine

_____ _____
Signature of examiner Date

_____ _____ _____ _____
Address City State ZIP code

Please submit the form using one of the options below:

Email completed forms to:
lifeinsurance@send.allianzlife.com

OR

Web Upload:
You can upload your signed and completed form(s) by logging into your account at Allianzlife.com

OR

Mail:

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

Overnight Mail
Allianz Life Insurance Company of North America
5701 Golden Hills Drive
Minneapolis, MN 55416-1297

OR

Fax: 763.582.6002

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Return to Home Office