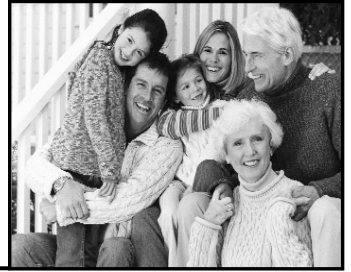


Generation Protector[®]

Application for the state of:

Maryland



Product requirements:

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

- 10-A-MD – Completed application (return signed form to Home Office)
 - Include physician information for each insured (section 9)
 - If replacement is involved, applicant must acknowledge receiving replacement notice (section 10)
 - Applicant(s) must acknowledge receiving and completing (if applicable) the required listed documents (section 11)
- WS1-MD – LTCi Personal Worksheet, one for each applicant (refer to the Suitability Standards on our Web site)
- NB3046 – HIPAA Health Information (Must complete for Authorization of Release of Medical Records)

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

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

Required forms not available in application packet:

- 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 10-UG
- For questions contact the FASTeam at 800/950-7372 (press 1, then 3 for Sales Support/LTC)
- All forms are available on the Web site at www.accessallianz.com or call the Supply Department at 800/358-8585

Long Term Care 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.accessallianz.com

10-A-MD (R-7/2004)

For agent use only

Allianz

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 Life® 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 Life gather?

Depending on your age and the type of coverage you are requesting, Allianz Life 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.

Allianz Life Insurance Company
of North America

Home Office: Minneapolis, MN 55416-1297

PO Box 1292

Minneapolis, MN 55440-1292

Application for Generation Protector® Long Term Care Insurance

- New application
- Existing policy change/reinstatement

Home Office use only	
Allianz Life® assigned policy number(s)	
Primary:	<input type="text"/>
Spouse:	<input type="text"/>

1. Tell us about yourself

Proposed primary insured

First <input type="text"/>	Middle <input type="text"/>	Last <input type="text"/>	
Occupation <input type="text"/>		Social Security number <input type="text"/>	
Residence address <input type="text"/>			
City <input type="text"/>		State <input type="text"/>	Zip code <input type="text"/>
Day phone number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"><input type="text"/></input>		Evening phone number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Date of birth (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Age <input type="text"/> <input type="text"/>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Height <input type="text"/> <input type="text"/> ' <input type="text"/> <input type="text"/> "		Weight <input type="text"/> <input type="text"/> <input type="text"/> lbs.	
Tobacco use <input type="checkbox"/> Nonsmoker of cigarettes in past 24 months <input type="checkbox"/> Smoker of cigarettes in past 24 months <input type="checkbox"/> Other tobacco use _____			
Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		If married, is spouse currently covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	With whom do you currently live? <input type="checkbox"/> Spouse <input type="checkbox"/> Alone <input type="checkbox"/> Other _____

Proposed insured spouse

First <input type="text"/>	Middle <input type="text"/>	Last <input type="text"/>	
Occupation <input type="text"/>		Social Security number <input type="text"/>	
Residence address <input type="text"/>			
City <input type="text"/>		State <input type="text"/>	Zip code <input type="text"/>
Day phone number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"><input type="text"/></input>		Evening phone number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Date of birth (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Age <input type="text"/> <input type="text"/>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Height <input type="text"/> <input type="text"/> ' <input type="text"/> <input type="text"/> "		Weight <input type="text"/> <input type="text"/> <input type="text"/> lbs.	
Tobacco use <input type="checkbox"/> Nonsmoker of cigarettes in past 24 months <input type="checkbox"/> Smoker of cigarettes in past 24 months <input type="checkbox"/> Other tobacco use _____			



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 of this long term care insurance policy for nonpayment of premium. I understand that this notice to my designee 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 insured spouse

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		Insured Spouse	
	YES	NO	YES	NO
1. In the past 6 MONTHS – or currently:				
a. Are you receiving disability benefits or worker's compensation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Due to any present or past mental or physical disability that you now have or have had in the past 7 years, is any person or institution authorized to act on your behalf?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you dependent on the use of a walker or wheelchair or are you confined to bed or home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Are you using any medical appliance such as a catheter, oxygen equipment, respirator, or dialysis machine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past 6 MONTHS, have you required assistance or supervision with, or are you currently limited in any way from performing, any of the following daily activities: eating, bathing, dressing, toileting, bladder or bowel control, or mobility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 7 YEARS, have you ever been diagnosed as having or been treated by a member of the medical profession for any of the following:				
a. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes treated with insulin or arthritis treated with chronic steroid use or gold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Alzheimer's Disease, Organic Brain Syndrome, senility, confusion, disorientation, recurring memory loss, or dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Parkinson's Disease, Multiple Sclerosis, ALS (Lou Gehrig's Disease), or Muscular Dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Stroke, congestive heart failure, emphysema/COPD with continued smoking, cirrhosis of the liver, or unoperated aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Medical history - Part II

If any questions in Part II of the Medical History are answered "YES," please provide details on page 7.

	Primary Insured		Insured Spouse	
	YES	NO	YES	NO
1. In the past 7 YEARS, have you received medical advice or treatment for the following conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If "YES" check all that apply. PI = Proposed Primary Insured. IS = Proposed Insured Spouse.)

<input type="checkbox"/> <input type="checkbox"/> Alcoholism	<input type="checkbox"/> <input type="checkbox"/> Cane use	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> <input type="checkbox"/> Neurological disorder
<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Carotid artery disease	<input type="checkbox"/> <input type="checkbox"/> Falls	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <input type="checkbox"/> Arrhythmia	<input type="checkbox"/> <input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> <input type="checkbox"/> Pacemaker
<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Circulatory disorder	<input type="checkbox"/> <input type="checkbox"/> Fractures	<input type="checkbox"/> <input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> COPD/emphysema	<input type="checkbox"/> <input type="checkbox"/> Heart attack/disease	<input type="checkbox"/> <input type="checkbox"/> Respiratory disorders
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Skin ulcers
<input type="checkbox"/> <input type="checkbox"/> Auto-Immune Disorder	<input type="checkbox"/> <input type="checkbox"/> Crohn's disease or ulcerative colitis	<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Spine/Back disorders
<input type="checkbox"/> <input type="checkbox"/> Back disorder/surgery	<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Joint replacement	<input type="checkbox"/> <input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> <input type="checkbox"/> Blindness	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Lupus	<input type="checkbox"/> <input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> <input type="checkbox"/> Blood disorders	<input type="checkbox"/> <input type="checkbox"/> Drug or substance abuse	<input type="checkbox"/> <input type="checkbox"/> Melanoma	
<input type="checkbox"/> <input type="checkbox"/> Cancer		<input type="checkbox"/> <input type="checkbox"/> Mental/nervous disorder	

9. Medical history - Part II (continued)

	Primary Insured		Insured Spouse	
	YES	NO	YES	NO
2. In the past 7 YEARS, have you been treated by a health professional for any condition not named above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 12 MONTHS, have you:				
a. Been confined to a hospital, nursing home, or sanitarium?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Received home care services, physical therapy, or rehabilitative therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Sought medical advice or treatment for loss of appetite, falling, fainting, problems with balance, dizziness, or deterioration of vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Had any surgical procedure recommended or scheduled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Medical history - Part III

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 insured spouse

Physician name

Phone number
 () - -

Mailing address

City State Zip code -

Medical specialist name

Phone number
 () - -

Mailing address

City State Zip code -

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.

By state law, the insurance company must 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 insurance producer)

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 45 days before your premium changes.

Rate Increase History

The company has sold long term care insurance since 1990 and has sold this policy since 2003. 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



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.

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 \$30-50,000 Over \$50,000

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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 \$89,650 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, agent and applicant must complete the next sections 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 insurance producer (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.

Signed: _____
(Insurance producer) (Date)

Insurance Producer's Printed Name: _____

My insurance producer 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**

1. **Premium Rate:** The premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is \$ _____.
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:** Premium rate adjustments will be effective on the next policy anniversary date.
4. **Potential Rate Revisions:**

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.

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:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***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:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

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.

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.

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%

Issue Age	Percent Increase Over Initial Premium
70	40%
71	38%
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%

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 Life®, 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 <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Number Routing Number	Process entries <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> 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-7/2003)

Conditional Premium Receipt

Allianz Life Insurance Company
of North America

PO Box 1292
Minneapolis, MN 55440-1292



RECEIVED on behalf of _____, the Proposed Insured, the sum of \$ _____
tendered for application on the first premium, if the policy applied for is issued on the plan and for the amount stated in the application.

Agent signature _____ Dated _____

IT IS UNDERSTOOD AND AGREED THAT SUBMISSION OF THE APPLICATION AND TENDER OF THE AMOUNT STATED DOES NOT PLACE ANY INSURANCE IN FORCE.

No agent or medical examiner has authority to determine insurability, or to make or modify any contract of insurance or to waive any requirement of the Company.

The effective date of the policy, date of insurability and billing date will be established as of the later of:

1. the application date; or
2. the requested policy date.

It is understood and agreed that the amount stated is tendered by, or on behalf of the Proposed Insured and is accepted by the Company subject to the following conditions:

1. the amount tendered must be the first full modal premium, or equal to at least two months premium;
2. the Proposed Insured must be insurable according to the Company's Underwriting Rules and Standards as of the date the application is signed, or as of the requested policy date, whichever is later;
3. the policy must be issued as applied for within 60 days of the application date; and
4. the Proposed Insured must not have made any misrepresentations or misstatements on the application for insurance.

IF ANY ONE OF THE ABOVE CONDITIONS IS NOT MET, THE SOLE LIABILITY OF THE COMPANY IS TO RETURN ALL TENDERED PREMIUM. ANY DELAY IN THE RETURN OF THE AMOUNT TENDERED WILL NOT BE CONSTRUED AS APPROVAL OF THE APPLICATION.

CPR (6/2003)

Leave with Applicant

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.

OUTLINE OF COVERAGE FOR COMPREHENSIVE LONG TERM CARE INSURANCE POLICY FORM 10-P-Q-MD

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 Time Limit On Certain Defenses 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.

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!**

Federal Tax Consequences - THE CONTRACT IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended. In the event that future changes in federal law require the Contract to be amended in order to maintain its status as a qualified long term care insurance contract, you will be provided with the opportunity to accept or reject any such amendments. You should consult with your attorney, accountant or tax advisor regarding the tax implications of purchasing long term care insurance.

Terms Under Which the Contract May Be Continued In Force or Discontinued - 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 - If you are eligible for Benefit Payments and the Elimination Period has been satisfied, we will waive your premium as it comes due. 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 III.

Grace Period - Except for the first premium, you will have 65 days after each due date to pay the premium due. If your premium is not paid by the 30th day of the Grace Period, we will notify you and an individual designated by you to receive notice of possible Lapse due to non-payment of premium. You have an additional 35 days beyond the date this notice was given to pay your premium. The Contract remains In Force during the Grace Period.

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 45 days before your premium changes.

Terms Under Which the Contract May Be Returned and Premium Refunded - If your application for the Contract is denied, we will refund any premium paid with the application within 30 days of the date of denial. You may surrender the Contract without penalty or obligation within 30 days from the date of delivery of the Contract. If you decide to surrender the Contract, you must provide notice of the surrender to the Company or its insurance producer. Any attempt by the Company to obtain a waiver of your right to surrender is unlawful. Your notice of surrender will cause the Contract to be void and without benefit from its beginning. Surrender entitles you to a refund of all monies within 30 business days after receipt by the Company or its insurance producer of notice of surrender. 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, on a pro-rata basis. We will return this unearned premium within 30 days of receipt of proof of your death. If you Cancel the Contract after 30 days, any unearned premium will be returned to you on a pro-rata basis as of the Cancellation date.

This Is Not Medicare Supplement Coverage - It is not designed to fill the “gaps” of Medicare. 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 insurance producers 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, rehabilitative, 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. The Contract provides coverage for Qualified Long Term Care Services on an expense incurred basis, subject to Contract provisions, limitations, exclusions, and the Elimination Period.

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 Care, Home Health Care, and Hospice Care. Benefits are also provided for Bed Reservation, Caregiver

Training, Respite Care, Nursing Facility Recovery, Care Coordination Advisor, 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 and is the number of days in which you: must be Chronically Ill; are receiving care in either a Nursing Facility or an Assisted Living Facility, or are receiving Home and Community Care; and are not receiving Benefit Payments under the Contract. You may choose an Elimination Period of 7, 30, 60, 90, or 180 days. 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 calculated as the Facility Care Daily Benefit times the Benefit Period (in years) times 365. The Facility Care Daily Benefit available ranges from \$100 to \$500 per day.

Facility Care Benefit - If you are eligible for Benefit Payments and 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. Benefits paid accumulate toward the Maximum Lifetime Benefit. The Facility Care Daily Benefit and Maximum Lifetime Benefit are shown on the Policy Schedule.

Home and Community Care Benefit - If you are eligible for Benefit Payments, we will pay up to the Home and Community Care Daily Benefit elected on the application for covered Adult Day Care, Home Health Care, and Hospice Care, as long as you are not receiving Facility Care Benefits, and are not confined in a Hospital.

Home Health Care services provide assistance with Activities of Daily Living and supervision due to a Severe Cognitive Impairment. This includes professional nursing care by or under the supervision of an RN or nurse; care by a Home Health Aide; therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist licensed under state law, if any, or incidental Homemaker Services.

Benefits paid accumulate toward the Maximum Lifetime Benefit; however, the maximum daily amount of benefits

accumulated will not exceed the Facility Care Daily Benefit amount. The Home and Community Care Daily Benefit and Maximum Lifetime Benefit are shown on the Policy Schedule.

Bed Reservation Benefit - If you are eligible for Benefit Payments, we will continue to pay the Facility Care Daily Benefit 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.

Benefits paid accumulate toward the Maximum Lifetime Benefit. This benefit is payable for a maximum of 60 days per calendar year.

Caregiver Training Benefit - If you meet the Eligibility for Benefits provision, we will pay up to the Maximum Caregiver Training Benefit (five times the Facility Care Daily Benefit) shown on the Policy Schedule for expenses incurred for an Informal Caregiver to receive training to take care of you in your Home.

Benefits paid accumulate toward the Maximum Lifetime Benefit. The Elimination Period does not apply to this benefit and days of caregiver training will not be used to satisfy the Elimination Period.

Respite Care Benefit - If you meet the Eligibility for Benefits provision, 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 Facility Care Daily Benefit elected, or the actual expenses you incur for each day you receive Home and Community Care, up to the Home and Community Care Daily Benefit elected.

Benefits paid accumulate toward the Maximum Lifetime Benefit. 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.

Nursing Facility Recovery Benefit - The Contract is paid up and no additional premium payments will be required to keep the policy In Force if Facility Care Daily Benefits are paid for at least 12 continuous months, due to a confinement in a Nursing Facility, and you are no longer Chronically Ill.

Care Coordination Advisor Benefit - 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.

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.

Benefits paid accumulate toward the Maximum Lifetime Benefit.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Benefit Payments - Once you meet the Eligibility for Benefits and Limitations or Conditions on Eligibility for Benefits provisions, 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.

Eligibility for Benefits - To be eligible for benefits under the Contract, you must be Chronically Ill. You must provide proof of such Chronic Illness as shown in the Claim Procedures section of the policy.

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

- the Contract must be In Force;
- you must have satisfied the Elimination Period; and
- you must be receiving Qualified Long Term Care Services pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

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. Moving into or out of a bed, chair, or wheelchair.

Chronically Ill means you have been certified, within the previous 12 months, 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 due to Loss of Functional Capacity; or
- requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment.

Class means a population segment with similar characteristics such as issue age, underwriting and rating classification, elected benefit options, or Elimination Period.

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 may be prescribed by the Secretary of 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.

Loss of Functional Capacity is the inability to perform the prescribed ADLs without the Substantial Assistance of another person.

Maintenance or Personal Care Services are services provided primarily to give needed assistance to you as a result of your being Chronically Ill (including protection of your health and safety due to a Severe Cognitive Impairment).

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 necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services, which are required by a Chronically Ill individual and 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 deficiency, which is confirmed by a Physician, in an individual's:

- 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 your alcoholism or drug addiction.
- that result from participating in a felony, in a riot, or an insurrection.
- for which benefits are provided under any state or federal worker's compensation law.
- that result from an act of war, whether declared or not.
- that result from your intentionally self-inflicted injury.
- provided outside the fifty United States, the District of Columbia, or Canada, except as described in the International Coverage Benefit Endorsement.

- provided to you by an Immediate Family Member or someone living in your Home, unless pre-approved by us.
- for which you have no financial liability or that are provided at no charge in the absence of insurance.
- provided in a government facility (unless otherwise required by law).
- that are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.
- any claim, bill or other demand or request for payment for health care services provided and determined to be furnished as a result of a prohibited referral.

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.

Alzheimer's Disease - Subject to any applicable Elimination Period and Limitations or Exclusions described above, the Contract provides coverage for Alzheimer's Disease and forms of senility and irreversible dementia that result in a Severe Cognitive Impairment.

PREMIUM WORKSHEET – LONG TERM CARE INSURANCE

ELIMINATION PERIOD: 7 days 30 days 60 days 90 days 180 days

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

MAXIMUM FACILITY CARE DAILY BENEFIT APPLIED FOR:
(choice of \$100 - \$500 in increments of \$10): \$ _____

MAXIMUM HOME AND COMMUNITY CARE DAILY BENEFIT APPLIED FOR:
(Choose percentage of Maximum Facility Care Daily Benefit) 70% 100% 130%

BENEFIT PERIOD APPLIED FOR: 2 years 3 years 4 years 5 years 8 years Lifetime

OPTIONAL BENEFITS

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

PREMIUM PAYMENT OPTION:

- Continuous Pay

MONTHLY INDEMNITY BENEFIT RIDERS:

- Comprehensive Monthly Indemnity Benefit Rider
 - \$250 \$500 \$750
 - \$1,000 \$1,250 \$1,500
- Home and Community Care Monthly Indemnity Benefit Rider
 - \$250 \$500 \$750

ADDITIONAL BENEFIT RIDERS:

- Home and Community Care Monthly Benefit Rider
- Waiver of Home and Community Care Elimination Period Rider (not available with 180-day Elimination Period)
- Calendar Day Elimination Period Rider
- Restoration of Benefits Rider (not available with Lifetime Benefit Period or Spousal Shared Care Rider)
- Spousal Shared Care Rider (the two insureds' plans must be identical)
- Spousal Waiver of Premium Rider
- Spousal Survivorship Rider

PREMIUM SUMMARY INFORMATION

Long Term Care Policy:	\$ _____
Home and Community Care Monthly Indemnity Benefit Rider:	+ _____
Comprehensive Monthly Indemnity Benefit Rider:	+ _____
Subtotal:	= _____
Elimination Period Factor:	x _____
Underwriting Rate Class Factor:	x _____
Inflation Protection Rider Factor:	x _____
Nonforfeiture Benefit Rider Factor:	x _____
Spousal Waiver of Premium Rider Factor:	x _____
Spousal Survivorship Rider Factor:	x _____
Spousal Shared Care Rider Factor:	x _____
Calendar Day Elimination Period Rider Factor:	x _____
Home and Community Care Monthly Benefit Rider Factor:	x _____
Waiver of Home and Community Care Elimination Period Rider Factor:	x _____
Restoration of Benefits Rider Factor:	x _____
Premium Payment Option Factor:	x _____

TOTAL ANNUAL PREMIUM: \$ _____

PREMIUM PAYMENT MODE (must elect one)

- Annual Semi-Annual Quarterly Monthly/PAC

TOTAL MODAL PREMIUM: \$ _____

Leave with Applicant

PREMIUM WORKSHEET – LONG TERM CARE INSURANCE

ELIMINATION PERIOD: 7 days 30 days 60 days 90 days 180 days

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

MAXIMUM FACILITY CARE DAILY BENEFIT APPLIED FOR:
(choice of \$100 - \$500 in increments of \$10): \$ _____

MAXIMUM HOME AND COMMUNITY CARE DAILY BENEFIT APPLIED FOR:
(Choose percentage of Maximum Facility Care Daily Benefit) 70% 100% 130%

BENEFIT PERIOD APPLIED FOR: 2 years 3 years 4 years 5 years 8 years Lifetime

OPTIONAL BENEFITS

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

PREMIUM PAYMENT OPTION:

- Continuous Pay

MONTHLY INDEMNITY BENEFIT RIDERS:

- Comprehensive Monthly Indemnity Benefit Rider
 - \$250 \$500 \$750
 - \$1,000 \$1,250 \$1,500
- Home and Community Care Monthly Indemnity Benefit Rider
 - \$250 \$500 \$750

ADDITIONAL BENEFIT RIDERS:

- Home and Community Care Monthly Benefit Rider
- Waiver of Home and Community Care Elimination Period Rider (not available with 180-day Elimination Period)
- Calendar Day Elimination Period Rider
- Restoration of Benefits Rider (not available with Lifetime Benefit Period or Spousal Shared Care Rider)
- Spousal Shared Care Rider (the two insureds' plans must be identical)
- Spousal Waiver of Premium Rider
- Spousal Survivorship Rider

PREMIUM SUMMARY INFORMATION

Long Term Care Policy:	\$ _____
Home and Community Care Monthly Indemnity Benefit Rider:	+ _____
Comprehensive Monthly Indemnity Benefit Rider:	+ _____
Subtotal:	= _____
Elimination Period Factor:	x _____
Underwriting Rate Class Factor:	x _____
Inflation Protection Rider Factor:	x _____
Nonforfeiture Benefit Rider Factor:	x _____
Spousal Waiver of Premium Rider Factor:	x _____
Spousal Survivorship Rider Factor:	x _____
Spousal Shared Care Rider Factor:	x _____
Calendar Day Elimination Period Rider Factor:	x _____
Home and Community Care Monthly Benefit Rider Factor:	x _____
Waiver of Home and Community Care Elimination Period Rider Factor:	x _____
Restoration of Benefits Rider Factor:	x _____
Premium Payment Option Factor:	x _____

TOTAL ANNUAL PREMIUM: \$ _____

PREMIUM PAYMENT MODE (must elect one)

- Annual Semi-Annual Quarterly Monthly/PAC

TOTAL MODAL PREMIUM: \$ _____

Leave with Applicant

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.

CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE CONTRACT.

International Coverage Benefit Endorsement – If you are eligible for Benefit Payments and require Qualified Long Term Care Services which would otherwise be covered under the Contract while you are outside the fifty 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 Home and Community Care Daily Benefit.

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 times 730 days.

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 five full Policy Years and Lapses due to nonpayment of premiums. Under the Shortened Benefit Rider, coverage will continue during your lifetime, but benefits will only be payable until the total of benefits paid under the Contract, including benefits paid before the date the Contract Lapses, equals the Shortened Maximum Lifetime Benefit. 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.

Contingent Benefit Upon Lapse Endorsement – This Endorsement is included in all Contracts that do not include the Shortened Benefit Rider. Each time premiums are increased above the level defined by the state as a “substantial premium increase,” and the Contract Lapses within 120 days of the due date for the payment of the increased premium, then the following options will be 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. This option must be elected within 120 days of a “substantial premium increase.”

If you elect to convert the Contract to a paid-up status, the Maximum Lifetime Benefit becomes equal to 100 percent of the sum of all premiums paid for the policy and any attached Riders, including the premiums paid before any changes in benefits, but the benefit may not be less than thirty times the Facility Care Daily Benefit in effect on the date of Lapse. 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 under this Endorsement 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, if attached to the policy.

Calendar Day Elimination Period Rider – For additional premium, if you are Chronically Ill, each calendar day beginning with the first day that you receive Qualified Long Term Care Services until you are no longer Chronically Ill will count toward the Elimination Period.

Home and Community Care Monthly Benefit Rider - For additional premium, if you are eligible for Benefit Payments under the Home and Community Care Benefit, we will pay up to the number of days in the month times the Home and Community Care Daily Benefit on a monthly basis for the actual expenses incurred during the month.

Waiver of Home and Community Care Elimination Period Rider – For additional premium, the Elimination Period will be waived while you are Chronically Ill and are receiving Home and Community Care. In addition, each day that you receive Benefit Payments for Home and Community Care will count toward the Elimination Period.

Home and Community Care Monthly Indemnity Benefit Rider - For additional premium, this Rider provides a Home and Community Care Monthly Indemnity Benefit amount in any month that a Home and Community Care benefit payment is received. The Home and Community Care Monthly Indemnity Benefit is not payable if the only benefit of the policy being paid is the Facility Care Benefit or the Alternative Plan of Care Benefit. This Rider pays the lesser of two times the Benefit Period in months or 120 Home and Community Care Monthly Indemnity Benefit payments.

Comprehensive Monthly Indemnity Benefit Rider - For additional premium, this Rider provides a Monthly Indemnity Benefit amount in any month that a benefit payment is received. The Monthly Indemnity Benefit is not payable if the only benefit of the policy being paid is the Alternative Plan of Care Benefit. This Rider pays the lesser of two times the Benefit Period in months or 120 Monthly Indemnity Benefit payments.

Restoration of Benefits Rider - For additional premium, if benefits have been paid and deducted from the Maximum Lifetime Benefit, the Maximum Lifetime Benefit will be restored, if for a period of 180 consecutive days:

- the Contract is In Force;
- you are not receiving Benefit Payments; and
- you are no longer Chronically Ill.

The Maximum Lifetime Benefit may be restored an unlimited number of times.

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.

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.

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. Written notification will be given to you when the Insured Spouse begins to access your benefits.

Spousal Waiver of Premium Rider - For additional premium, if the Insured Spouse is eligible for Benefit Payments and has satisfied the Elimination Period, this Rider will waive your premium as it comes due.

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 the Insured Spouse's premiums are being waived. Once the Insured Spouse is no longer Chronically Ill or this Rider Terminates, you must pay each premium that comes due according to the Mode of Payment in effect.

Spousal Survivorship Rider - For additional premium, this Rider provides for premiums to be paid up if:

- the Contract is In Force for 10 Policy Years;
- the Insured Spouse's contract is in force for 10 policy years; and
- the Insured Spouse dies.

Inflation Protection Riders - For additional premium, these Riders provide that on each Policy Anniversary, the benefits provided by the Contract will be increased. The 5% Lifetime Compound Benefit Increase Rider must be rejected before other inflation protection Riders can be offered.

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 Comprehensive Monthly Indemnity Benefit Rider is elected) **OR** the Home and Community Care Monthly Indemnity Benefit (if the Home and Community Care Monthly Indemnity Benefit Rider 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.

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 Comprehensive Monthly Indemnity Benefit Rider is elected) **OR** the Home and Community Care Monthly Indemnity Benefit (if the Home and Community Care Monthly Indemnity Benefit Rider 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 would otherwise exceed two times the original benefit amount.

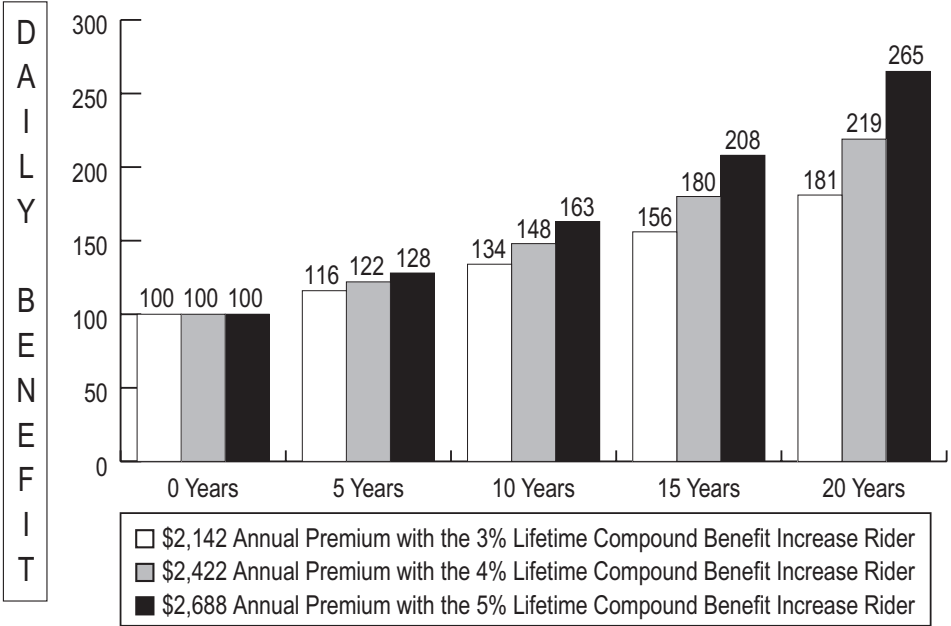
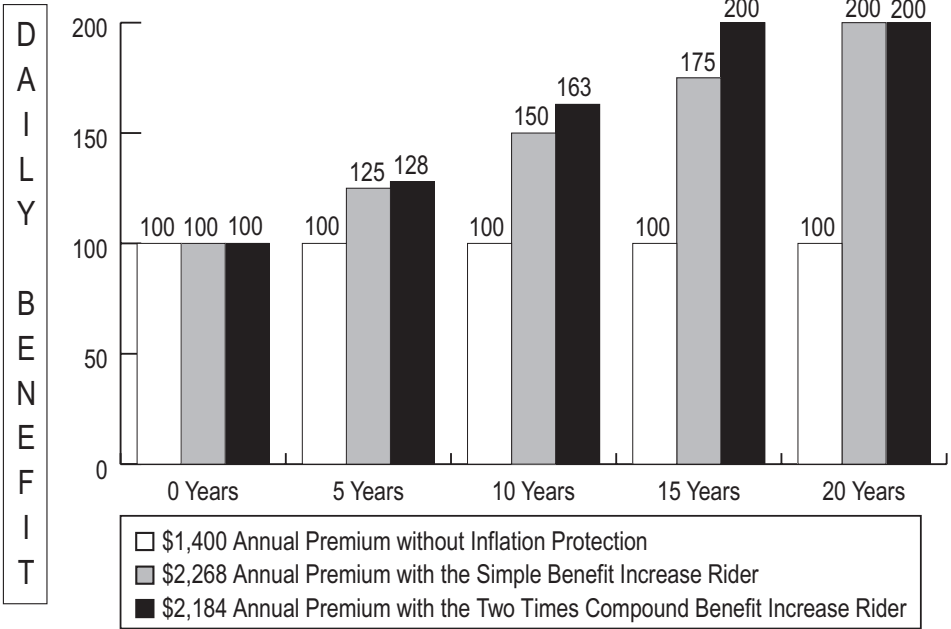
The annual increases will occur even if benefits are being paid.

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 original amount issued to you.
- the Monthly Indemnity Benefit (if the Comprehensive Monthly Indemnity Benefit Rider is elected) **OR** the Home and Community Care Monthly Indemnity Benefit (if the Home and Community Care Monthly Indemnity Benefit Rider is elected) will be increased by 5% of the of the original amount issued to you.
- 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.

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 90-day Elimination Period, a \$100 Facility Care Daily Benefit, a \$100 Home and Community Care Daily Benefit, a Lifetime Benefit Period, and a Preferred rating classification.



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 a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long Term Care 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.

**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 INSURANCE PRODUCER (BROKER OR OTHER REPRESENTATIVE)
(Use additional sheets as necessary)**

I have reviewed your current medical or health insurance 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 (preexisting 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. The law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent time elapsed under the original policy or certificate.
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 everything that is involved in replacing your present coverage.
4. If, after you have thought about it, 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.

The above "NOTICE to Applicant" was delivered on: _____
Date

Applicant's signature

Insurance producer's signature

**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, the Medical Information Bureau (MIB), employers, consumer reporting agencies, health plan administrators, relatives, or government agencies ("Other Persons") that has any records or knowledge of me or my health, 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 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 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.

**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, the Medical Information Bureau (MIB), employers, consumer reporting agencies, health plan administrators, relatives, or government agencies ("Other Persons") that has any records or knowledge of me or my health, 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 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 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.

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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.