

# Annuity Application

Application for the state of:

**Indiana** (MUST complete pages 1-5 of the Annuity Application)

## Product requirements:

- All products must meet the **minimum premium** requirements
- If the Instant Cash Bonus or Systematic Withdrawal of Interest is desired, please verify that the appropriate boxes are checked in Section 5 – Annuity Product.
- A4-01 – Complete the Supplemental Application if the product chosen allows a choice of the indexes or interest earning value. In addition, you **MUST** indicate point-to-point or monthly averaging for the FlexDex Multi-Choice Elite<sup>®</sup> Annuity.
- IN-A3 – Immediate Elite<sup>™</sup> Annuity Supplemental Application and proof of age
- IN-A2 – Agreement and signature page **MUST** be signed for every application
- S2056 – if transfer is involved. Always include an estimated transfer amount if a rollover or 1035 exchange is taking place.
- NB5029 – Complete the Agent's Report if the product chosen is a MasterDex<sup>™</sup> Annuity, a MasterDex 5<sup>™</sup> Annuity, or a MasterDex 10<sup>™</sup> Annuity (return signed form to Home Office with application)
- NB3018 – Replacement form if life insurance or annuities are being replaced (return signed form to Home Office with application)
  - If a replacement is involved, copies of all sales material used during the sales presentation must be left with the applicant and submitted to the Home Office with application. Sales material is any individualized material, including illustrations. This does not include company approved sales aids of a generally descriptive nature.

## Required forms not available in application packet:

- Trustee Representations (return signed form to Home Office with application if designating a trust or corporation as owner)<sup>1</sup>
- Statement of Understanding (sign and return entire form to Home Office with application)<sup>1</sup>

## Additional information:

- **Special Note:** Section 9 (Agent Information) must be completed
- To ensure distributions at death are payable to the intended person or entity, see the product Statement of Understanding for details
- **DO NOT** use white out. If you have a correction, cross it out and have the owner/annuitant initial the change
- Prior approval may be required on cases \$500,000.00 or more
- Additional beneficiary pages **MUST** be signed and dated by the owner
- For questions contact the **FASTeam at 800/950-7372** (press 1, then 1 for Sales Support/Annuities)

<sup>1</sup>All forms are available on the Web site at [www.accessallianz.com](http://www.accessallianz.com) or call the Supply Department at 800/358-8585.

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

Allianz Life Insurance Company  
of North America

PO Box 59060  
Minneapolis, MN 55459-0060

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

[www.accessallianz.com](http://www.accessallianz.com)  
IN-Annuity (R-4/2005)

For agent use only

**Allianz** 







**3. Beneficiary (percentage must equal 100% for Primary and 100% for Contingent)**

Primary  Contingent

First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage	Relationship to owner	Social Security number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary  Contingent

First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage	Relationship to owner	Social Security number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary  Contingent

First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage	Relationship to owner	Social Security number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary  Contingent

First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage	Relationship to owner	Social Security number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary  Contingent

First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage	Relationship to owner	Social Security number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary  Contingent

First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage	Relationship to owner	Social Security number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary  Contingent

Trust  Corporation

Full name (if applicable)		
<input type="text"/>		
If Trust is named, provide Trustee's (first name)	Last name	
<input type="text"/>	<input type="text"/>	
Percentage	Date of Trust (mm/dd/yyyy)	Tax or Employer ID number (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

#### 4. Replacement

Do you have any existing annuity contracts or life insurance policies? ..... YES\*  NO  
 If yes, will the annuity contract applied for replace or change existing contracts or policies? ..... YES\*  NO

Amount of coverage in force

\$   ,    ,    .

\*Complete the replacement sections that follow in order for the transfer to proceed.

#### 5. Annuity product (select one of the following)

##### Flexible premium:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accumulator Bonus Maxxx Elite™ Annuity | <input type="checkbox"/> Cash Bonus Elite® Annuity   | <input type="checkbox"/> Power 7 Elite™ Annuity♦   |
| <input type="checkbox"/> BonusDex Elite® Annuity#               | <input type="checkbox"/> Elect monthly payment of bonus  | <input type="checkbox"/> Elect Systematic Withdrawal of Interest   |
| <input type="checkbox"/> FlexDex Multi-Choice Elite® Annuity#   | <input type="checkbox"/> Withhold federal taxes at a rate of <input type="text"/> <input type="text"/> % | Payment mode (check one)   |
| <input type="checkbox"/> MasterDex™ Annuity#•                   | <input type="checkbox"/> (will default at a rate of 10%)   | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly                                      |
| <input type="checkbox"/> MasterDex 5™ Annuity#•                 | <input type="checkbox"/> Do <b>not</b> withhold federal taxes  | <input type="checkbox"/> Semiannually <input type="checkbox"/> Annually                                  |
| <input type="checkbox"/> MasterDex 10™ Annuity#•                |  | <input type="checkbox"/> Withhold federal taxes at a rate of <input type="text"/> <input type="text"/> % |
| <input type="checkbox"/> PowerDex Elite® Annuity                |  | <input type="checkbox"/> (will default at a rate of 10%)   |
| <input type="checkbox"/> 10% Bonus PowerDex Elite™ Annuity#     |  | <input type="checkbox"/> Do <b>not</b> withhold federal taxes  |
| <input type="checkbox"/> Power Rate 5 Elite® Annuity            |  |  |
| <input type="checkbox"/> Other _____                            |  |  |

##### Single premium:

- Dominator® Annuity\* (choose term)  5  6  7  8  9  10  
 Other \_\_\_\_\_

##### Single Premium Immediate Annuity (SPIA):

- Immediate Elite™ Annuity (Complete the Immediate Elite Annuity Supplemental Application IN-A3)  
 Other \_\_\_\_\_

- ♦ Premium payments are allowed during the first year **ONLY**.
- # Complete Supplemental Annuity Application.
- \* Complete section 12 if applicable.
- Complete Agent's Report.

#### 6. Type of annuity

- |   |  |
|---|--|
| <input type="checkbox"/> Qualified  | <input type="checkbox"/> Nonqualified  |
| <input type="checkbox"/> Rollover <input type="checkbox"/> Transfer   | <input type="checkbox"/> 1035 Exchange |
| <input type="checkbox"/> IRA <input type="checkbox"/> Roth IRA <input type="checkbox"/> Simple IRA For tax year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Other _____ (401(k), 403(b), KEOGH, SEP, etc.)   |  |

If no box is checked, nonqualified will be issued.

#### 7. Premiums

Cash submitted with application

\$   ,    ,    .

Estimated transfer/rollover/1035 amount

\$   ,    ,    .

Billed premium amount

\$   ,    ,    .

Select mode:  Single  Annually  Semiannually  Quarterly

Monthly (complete PAC authorization and provide void check)

**8. Complete only if payroll deduction**

Employer's name \_\_\_\_\_

Premium mode desired \_\_\_\_\_ Group ID number \_\_\_\_\_  
Add on  New \_\_\_\_\_

Length of employment \_\_\_\_\_ Currently working full time (minimum 30 hours per week)?  Yes  No  
Employer's contribution (if applicable) \$ \_\_\_\_\_

**Payroll Deduction is no longer available**

**9. Agent information**

Agent first _____	Middle initial _____	Last _____
Phone number (____)____-____-____	% Split ____	Agent number _____
Agent first _____	Middle initial _____	Last _____
Phone number (____)____-____-____	% Split ____	Agent number _____

**10. Special Requests**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**11. Home Office changes to the application (for internal use only)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**12. Contingent Owner, if applicable**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Trust  Corporation

Full name  
\_\_\_\_\_

If Trust is named, provide Trustee's (first name) \_\_\_\_\_ Last name \_\_\_\_\_

Date of Trust (mm/dd/yyyy) \_\_\_\_\_ Tax or Employer ID number \_\_\_\_\_

## Supplemental Application

**Complete the following if you have selected the FlexDex Multi-Choice Elite<sup>®</sup> Annuity, BonusDex Elite<sup>®</sup> Annuity, MasterDex<sup>™</sup> Annuity, MasterDex 5<sup>™</sup> Annuity, MasterDex 10<sup>™</sup> Annuity, or the 10% Bonus PowerDex Elite<sup>™</sup> Annuity.**

1. Select from the Index(es)\* and/or the interest choices and indicate the allocation percentage for each.

- S&P 500\*\* – Allocation Percentage: \_\_\_\_\_ %\*  
(0, 25, 50, 75, 100)
- Nasdaq-100<sup>®\*\*\*\*</sup> – Allocation Percentage: \_\_\_\_\_ %\*  
(0, 25, 50, 75, 100)
- Interest – Allocation Percentage: \_\_\_\_\_ %\*  
(0, 25, 50, 75, 100)

\*The Allocation Percentages must be in increments of "25" and must total 100%.

2. For FlexDex Multi-Choice Elite Annuity, select the index calculation methodology (Choose one):

- Point-to-point
- Monthly Averaging

\*\* "Standard & Poor's<sup>®</sup>," "S&P<sup>®</sup>," "S&P 500<sup>®</sup>," "Standard & Poor's 500," and "500" are trademarks of The McGraw-Hill Companies, Inc. and have been licensed for use by Allianz Life Insurance Company of North America. The product is not sponsored, endorsed, sold or promoted by Standard & Poor's and Standard & Poor's makes no representation regarding the advisability of purchasing the product.

\*\*\* The Nasdaq-100<sup>®</sup>, Nasdaq-100 Index<sup>®</sup>, and Nasdaq<sup>®</sup> are trade or service marks of The Nasdaq Stock Market, Inc. (which with its affiliates are the Corporations) and are licensed for use by Allianz Life Insurance Company of North America. The product(s) have not been passed on by the Corporations as to their legality or suitability. The product(s) are not issued, endorsed, sold, or promoted by the Corporations.

**THE CORPORATIONS MAKE NO WARRANTIES AND BEAR NO LIABILITY WITH RESPECT TO THE PRODUCT(S).**





## Immediate Elite™ Annuity Supplemental Application

### 1. Select one of the following annuity options

**Attach a copy of a birth certificate or driver's license when proof of age is requested.** These qualified plans: (401(k), 403(b), Pension Plan, Keogh), will require the submission of the Qualified Disbursement Request form (S2085).

- Option A: Installments for a Guaranteed Period  
 10 years  20 years  Other \_\_\_\_\_
- Option B: Installments for Life (*submit proof of age*)
- Option C: Installments for Life with a Guaranteed Period (*submit proof of age*)  
 10 years  15 years  20 years
- Option D: Joint and Survivor Annuity with a Guaranteed Period (*submit proof of age for annuitant and survivor*)  
 10 years  15 years  20 years  Other \_\_\_\_\_
- Option E: Joint and Survivor Annuity (*submit proof of age for annuitant and survivor*)
- Option F: Joint and 2/3 Survivor Annuity (*submit proof of age for annuitant and survivor*)
- Option G: Joint and 50% Survivor Annuity (*submit proof of age for annuitant and survivor*)

**Joint annuitant information** (*Complete for annuity options D, E, F, and G:*)

First <input type="text"/>	Middle <input type="text"/>	Last <input type="text"/>
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	Social Security number <input type="text"/> - <input type="text"/> - <input type="text"/>
Mailing address <input type="text"/>		
City <input type="text"/>	State <input type="text"/>	Zip code <input type="text"/> - <input type="text"/>

### 2. Payment mode (*choose only one*)

- Monthly  Quarterly  Semiannually  Annually

### 3. Payment method (*choose only one*)

- Send payment to my bank via Electronic Funds Transfer (*Attach a void check for a checking account or a deposit slip with a valid routing number for a savings account.*)
- Send payments to owner at address on record.
- Send payments to an address other than the owner's.

Name

Mailing address

City <input type="text"/>	State <input type="text"/>	Zip code <input type="text"/> - <input type="text"/>
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### 4. Notice of taxability, withholding, and election (*check the appropriate box*)

- Withhold federal income at a rate of % (will default at a rate of 10%).  
You will be subject to state income tax withholding if you elect federal withholding and reside in a mandatory state.
- Do **not** withhold federal taxes.

Certain qualified plans may be subject to a mandatory 20% federal tax withholding.



**Agreement and signatures**

It is agreed that: (1) All statements and answers given above are true and complete to the best of my knowledge; (2) This application shall become part of any annuity contract issued by the Company; (3) If proof of the annuitant's age is not given with the application, the Annuitant will furnish the Company such proof before annuity payments begin; (4) Any changes made in this application shall be subject to written consent of the Owner/applicant; (5) I understand that I may return my policy within the free look period (shown on the first page of my policy) if I am dissatisfied for any reason; and (6) I believe this annuity is suitable for my financial goals.

If this application is for the Dominator® Annuity, this policy contains a Market Value Adjustment that may increase or decrease the values in the policy.

Signed at \_\_\_\_\_ on this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City, State month year

\_\_\_\_\_  
Owner

**To be answered by Licensed Resident Agent:** I certify that the statements of the applicant have been correctly recorded in this application. To the best of my knowledge, the insurance applied for in this application  will not or  will replace existing insurance.

\_\_\_\_\_  
Joint owner

\_\_\_\_\_  
Proposed annuitant's signature (if other than owner)

\_\_\_\_\_  
Agent's signature/witness

**Agent's Report (Must be completed with MasterDex™ Annuity, MasterDex 5™ Annuity, or MasterDex 10™ Annuity)**

1. What commission choice are you selecting? (Please check only one option. Refer to the applicable MasterDex Agent Guide or call the FASTeam at 800/950-7372 should you have any questions on these options.)

- Option A
- Option B
- Option C

2. Complete agent information

First <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 type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MI <input type="text"/>	Last <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 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 type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature	Agent 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 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 type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Allianz Life Insurance Company  
of North America

PO Box 59060  
Minneapolis, MN 55459-0060

### 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 <b>X</b>		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, and Zip Code		Telephone	

**Return to Home Office**

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

NB5023 (R-7/2003)



Allianz Life Insurance Company  
of North America

PO Box 59060  
Minneapolis, MN 55459-0060



### PREMIUM RECEIPT

***Make all checks payable to the company.  
Do not make checks payable to an agency, broker, agent, or leave blank.***

A payment of \$ \_\_\_\_\_ was received from \_\_\_\_\_

for the annuity application dated \_\_\_\_\_

This receipt is not valid unless it is signed by an agent of the Company. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment.

Date \_\_\_\_\_ By \_\_\_\_\_  
Agent

NB5030 (6/2003)

**Leave with Applicant**



### PAYROLL DEDUCTION AUTHORIZATION

Name of employee member	Social Security number	
Department/ID number	Branch location	
Deduction frequency	First deduction date	Deduction amount

**Payroll Deduction is no longer available**

I hereby request \_\_\_\_\_ to deduct the amount indicated above from my wages or account and  
Name of Employer  
remit to Allianz Life Insurance Company of North America in payment of my policy premiums.

Signature \_\_\_\_\_ Date \_\_\_\_\_

NB5031 (6/2003)

**Submit to Employer**

#### NOTICE OF DISCLOSURE

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

#### NOTICE OF INSURANCE INFORMATION PRACTICES

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

#### FAIR CREDIT REPORTING ACT

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

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

#### MEDICAL INFORMATION BUREAU NOTICE

Information regarding your insurability will be treated as confidential. 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 files, 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. The telephone number is 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.

NB5025 (R-5/2003)

**Leave with Applicant**



## Authorization to Transfer Funds

### 1. Address of company where the funds are coming from – (No PO Boxes)

Company name

Address

City

State

Zip code

Phone number

Insured/annuitant(s) \_\_\_\_\_

Social Security number(s) \_\_\_\_\_

Owner(s) if other than annuitant \_\_\_\_\_

Social Security number(s) \_\_\_\_\_

Address \_\_\_\_\_

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

The undersigned hereby requests and directs that the following action be taken in order to transfer the account/policy funds identified below.

### 2. Certificate of Deposit – must specify

Account number

Liquidate Certificate of Deposit on the maturity date of / /

Liquidate Certificate of Deposit upon receipt of this request. I am aware of any penalty that may be imposed from an early withdrawal.

• If partial transfer, indicate the amount to be transferred \$ \_\_\_\_\_

### 3. Liquidate (See box 10 for Medallion Stamp Signature Guarantee) – select only one

**Brokerage account**

Account number

All  Partial liquidation (Quantity or \$ amount) \_\_\_\_\_  
(List assets) \_\_\_\_\_  
\_\_\_\_\_

**Mutual fund(s)**

Account number

All  Partial liquidation (\$ amount) \_\_\_\_\_

**Money market(s)**

Account number

All  Partial liquidation (\$ amount) \_\_\_\_\_

**401(k)/Pension Plan(s)** require their own withdrawal paperwork. Clients must contact their former employer to initiate transfer.

Account number

All  Partial liquidation (\$ amount) \_\_\_\_\_



**4. Annuity contracts**

My existing plan:  KEOGH  SEPP  Roth IRA  Converted Roth IRA  457  
 TSA/403(b)  IRA  Simple IRA  Nonqualified annuity  Other

Account number

**1035 tax-free exchange** (See cost basis in block 8)  
Surrender a nonqualified annuity contract(s) for the purchase of another nonqualified contract under Sec. 1035 of the Internal Revenue Code.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**Transfer**  
Surrender of qualified annuity contract(s) established under Sec. 402 or 408 of the Internal Revenue Code for reinvestment in a qualified annuity contract established under same section of the Internal Revenue Code.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**Surrender**  
The undersigned as owner of this contract elects to surrender the said contract for its net cash value and directs the transferring company to make payment(s) to the named Assignee.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**TSA/403(b) transfer** (TSA to TSA)  
This transaction is intended to qualify as a tax-free transfer under Rev. Rul. 90-24.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**For TSA/403(b) contracts only** Loan balance: \$ \_\_\_\_\_  
Loan default: Has the policy ever defaulted on a loan?  Yes  No  
If yes, state the defaulted amount: \$ \_\_\_\_\_  
Is the defaulted loan still outstanding?  Yes  No

**Direct rollover**  
This amount represents all or part of my eligible rollover distribution. I understand there will be no mandatory 20% withholding from this distribution because it is a direct rollover to an eligible retirement plan as defined under applicable tax law.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**5. Life contracts**

Account number

**1035 tax-free exchange** (See cost basis in block 8)  
Surrender a life insurance contract for the purchase of another contract under Sec. 1035 of the Internal Revenue Code.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**Surrender**  
The undersigned as owner of this contract elects to surrender the said contract for its net cash value and directs the transferring company to make payment(s) to the named Assignee.  
 All  Partial liquidation (% or \$ amount) \_\_\_\_\_

**6. Assignment**

**Absolute Assignment:**  
The owner of the above contract(s) hereby assigns  All  Partial ownership and beneficial rights under the contract(s) absolutely to the following assignee, Allianz Life Insurance Company of North America,  
Assignee ID Number: 41-1366075 If partial, specify amount: \$ \_\_\_\_\_  
All previous designations of beneficiary and payee, and all previous elections of payment options under the contract(s), as to the partial or total amounts shown above, are irrevocably transferred. The sole beneficiary and payee of the partial or total amounts shown above, shall be the above named assignee. The assignment is subject to any prior collateral assignments affecting the contract(s).



**7. Lost policy statement**

- Contract is attached.
- Certificate of lost contract** – I/We certify that the above numbered contract has been lost or destroyed, and to the best of my/our knowledge and belief, is not in anyone's possession.

Owner's signature \_\_\_\_\_

**8. Cost basis**

- Cost basis requested:** In accordance with the Tax Equity and Fiscal Responsibility Act of 1982, furnish a statement to the Assignee and to the former contract holder of the cost basis in the contract.

**9. Tax withholding election for payees of surrenders**

Even if you elect not to have federal income tax withheld, you are liable for payment of federal income tax on the taxable portion of your surrender. You also may be subject to tax penalties under estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

- I do not want to have federal income tax withheld from my surrender.
- I do want to have federal income tax withheld from my surrender. Please withhold \$ \_\_\_\_\_

**10. Required minimum distribution (must specify if applicable)**

Important note to existing carrier: If I am 70½ or older, do not transfer or roll over my current year's required minimum distribution (RMD). I direct the present Custodian/Trustee to (check one box):

- Proceed with the transfer as I have already taken my current year's RMD.
- Distribute my RMD to me before transferring my funds.
- Retain my RMD amount until such time as it is required to be distributed.

**11. Transaction authorization**

**I am aware of any surrender/withdrawal penalties which may apply, and I authorize the transaction described above. This transfer request also authorizes Allianz Life® to receive information on the status of this transfer or exchange.**

The undersigned represents and agrees that the Company is participating in this transaction at the undersigned's specific request and as an accommodation to the undersigned. It is further agreed that the Company has made no representations and that it has no responsibility nor liability concerning the undersigned's tax treatment under the Internal Revenue Code.

Please make check payable to: Allianz Life Insurance Company of North America

For the benefit of \_\_\_\_\_

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Insured/Annuitant(s) \_\_\_\_\_

Signature of Insured/Annuitant(s) \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Owner(s) \_\_\_\_\_  
(if other than the annuitant)

Signature of Owner(s) \_\_\_\_\_

Signature of Spouse¹ \_\_\_\_\_

**Medallion Stamp Signature Guarantee (if required)**

¹If you reside in one of the following community property states, the spouse must also sign: Alaska, Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, and Wisconsin.

**12. Acceptance: This is to certify that the above individual has established a:**

Tax-qualified annuity \_\_\_\_\_  Nonqualified annuity  Life policy  Roth  Qualified TSA/403(b) annuity

The authorized signature below certifies acceptance of the assignment and surrender or transfer of funds as instructed in this request. After deducting any sums as are permitted under the plan, please complete this transaction and send a check with a copy of this form to:

**Please make checks payable to issuer/assignee:**

Allianz Life Insurance Company of North America

For the benefit of \_\_\_\_\_

**If shipping overnight, please send checks to:**

5701 Golden Hills Drive  
Minneapolis, MN 55416-1297

**Please send checks to:**

NW 7340  
PO Box 1450  
Minneapolis, MN 55485-7340

**Please send correspondence to:**

PO Box 59060  
Minneapolis, MN 55459-0060

By:  
Assistant Secretary \_\_\_\_\_

Date \_\_\_\_\_

### Important Notice Regarding Replacement of Life Insurance or Annuities

If you are thinking about DISCONTINUING or CHANGING an existing life insurance policy or annuity contract and BUYING a replacement, your decision could be a good one—or possibly a mistake. Make sure that you understand the facts. You should:

- Make a careful comparison of your existing policy and the proposed policy.
- Ask the company or agent that sold you your existing policy to provide you with complete information about it.
- Consider both sides before you decide.
- Determine what you want your insurance program to do.
- Consider your present health. You may have had a change which could affect your insurability, so make sure to continue your present policy until a new policy is delivered to you and accepted by you.

This form MUST be completed in triplicate and the original given to you by the agent proposing replacement no later than at the time you apply for the new policy. (This form must be complete and given to you even though the proposed replacement policy is with the same company that sold you your existing policy.)

EXISTING POLICY INFORMATION on \_\_\_\_\_ (name of Insured)

COMPANY	TYPE OF* POLICY	POLICY NO.	DATE OF ISSUE	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

(If more policies are involved, use additional sets of forms.)

PROPOSED POLICY INFORMATION on \_\_\_\_\_ (name of Insured)

COMPANY	TYPE OF* POLICY	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

Indiana Department of Insurance Regulation, 760 IAC 1-16.1 requires that company making replacement notify your existing insurance company that you may be replacing your existing policy. (You have the right, within twenty days after delivery of a replacement policy, to return it to the company and to claim an unconditional refund of all premiums paid on it.)

\_\_\_\_\_  
Applicant's/Insured's Signature

\_\_\_\_\_  
Replacing Agent's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Indiana License Number



NOTE: PLEASE REMOVE THIS FORM FROM PACKET BEFORE COMPLETING THE APPLICATION.