Application Options

Allianz

PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

How would you like to apply for this policy?

[X] Worksheet Process

- Phone History Interview
- May be eligible for Accelerated Underwriting
- Abbreviated Exam (if ineligible for Accelerated Underwriting)

[ ] Traditional Application Process

- Full Paramedical Exam
- Required for High Net Worth Foreign National Program
- Ineligible for Accelerated Underwriting

Primary/First Insured

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Christian — First Name
— M.I.
Fierfelder — Last Name

Male — Gender
01/21/2015 — Date of Birth
5 — Age
624-87-6057 — Social Security Number/TIN

5259 Maxon Terrace — Street Address
32771 — ZIP Code
SANFORD — City
FL — State

mfierfelder@gmail.com — Email Address
561-346-7193 — Mobile Phone
— Other Phone

— Driver's License Number
— State of Issue
— Expiration Date

Place of Birth (State and Country) [X] United States FL [ ] Other _____

In which country are you considered a legal citizen/permanent resident? [X] United States [ ] Other _____

Best time to Call for Client Interview [ ] Morning [ ] Afternoon [X] Evening

Special Requests [ ] Hearing Impaired [ ] Interpreter Needed, Language _____

[ ] Other _____

Michael Fierfelder
Parent or Legal Guardian Name

Parent
Relationship to Juvenile

Primary/First Insured

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Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

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Are you currently employed?

- ☐ Yes, full-time (more than 30 hours per week)
- ☐ Yes, part-time (30 hours per week or less)
- ☐ Self-Employed _____
- ☐ No, homemaker, student, or retired
- ☒ Not currently employed

If employed, please provide your current:

Employer's Name: _____

Job Title and Type/Line of Business: _____

Length of Employment: _____

Is this a U.S. based company? ☐ Yes ☐ No

$ 0.00 _____ Annual Earned Income

$ _____ Annual Unearned Income

_____ Source of Unearned Income

$ _____ Annual Income of Spouse/Domestic Partner/Civil Union Partner

$ 0.00 _____ Household Net Worth

$ 0.00 _____ Household Liquid Assets

$ 0.00 _____ Household Annual Expenses

Have you ever filed for bankruptcy? ☐ Yes ☒ No

If yes, provide dates and details for each bankruptcy filing:

Medical Information

PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

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Within the past 12 months has the Proposed Primary/First Insured received treatment or advice from a member of the medical profession for heart disease, Type 1 diabetes, stroke or cancer? ☐ Yes ☒ No

Physician/Medical Facility Name for Proposed Primary/First Insured

Phone Number

Street Address

City

State

ZIP Code

Replacement and Insurance Activity

(PRIMARY/FIRST INSURED)

Allianz

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www.allianzlife.com

Allianz Life Pro + Advantage

How many Life/Annuity products do you own and/or have applied for? 0

Policy/Contract 1 Details:

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

Policy/Contract 2 Details:

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

Policy/Contract 3 Details:

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

Policy/Contract 4 Details:

_____ $_____
Name of Company Face Amount

_____ _____
Date Issued/Applied for Surrender Charge

Type: _____ Status: ☐ Inforce ☐ Applied for To be replaced? ☐ Yes ☐ No

If applied for will both policies be taken? ☐ Yes ☐ No

Replacement and Insurance Summary

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Allianz Life Pro + Advantage

Primary/First Insured

Do you have existing life insurance/annuity contracts? ☐ Yes ☒ No

Will this insurance replace any existing life insurance/annuity contracts? ☐ Yes ☒ No

Amount of life insurance currently inforce $ _____

Amount of life insurance currently applied for $ 0.00

Owner

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Is the Owner the same as the Primary/First Insured? ☐ Yes ☒ No

Type: ☐ Individual ☐ Joint ☒ Trust ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

First Name | M.I. | Last Name

Fierfelder Revocable Trust
Non-Individual Owner Name

Grand Parent
Relationship to Proposed Insured | Gender

06/02/2016
Date of Birth/Date of Trust

26-3926434
Social Security Number/TIN

14653 Horseshoe Trace
Street Address

33414
ZIP Code

WELLINGTON
City

FL
State

561-846-1821
Mobile Phone

Other Phone

fierfelderj@bellsouth.net
Email Address

$ 250,000.00
Amount of Insurance Inforce on Proposed Policy Owner

$
Household Annual Income

$
Household Net Worth

$
Household Liquid Assets

$
Household Annual Expenses

Are there additional proposed owners? ☐ Yes ☒ No

John Fierfelder
Trustee Name

Trustee Name

Trustee Name

Beneficiary

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

[X] Primary [ ] Contingent

[ ] Individual [X] Trust [ ] Corporation

Trust — Relationship
100 — Percentage

First Name — M.I. — Last Name

Fierfelder Revocable Trust — Trust/Corporation Name
John Fierfelder — Trustee Name

Gender — 06/02/2016 — Date of Birth/Date of Trust — 26-3926434 — Social Security Number/TIN — 561-846-1821 — Telephone Number

14653 Horseshoe Trace — Street Address

Wellington — City
FL — State
33414 — ZIP Code
United States — Country

[ ] Primary [ ] Contingent

[ ] Individual [ ] Trust [ ] Corporation

Relationship — Percentage

First Name — M.I. — Last Name

Trust/Corporation Name — Trustee Name

Gender — Date of Birth/Date of Trust — Social Security Number/TIN — Telephone Number

Street Address

City — State — ZIP Code — Country

Primary Total _____ Contingent Total _____

FL6407ALZ20100530446

Premium/Billing

Allianz
PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Frequency: ☐ Single Premium ☒ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

$ 3,000.00
Billed/Planned Premium Amount

$
Total Amount Submitted with the Worksheet Acknowledgement

$
First Year Lump Sum Amount

$
1035 Exchange Amount

How many years will the premium amount be paid? _____

Is lump sum coming from a 1035 Exchange of a life insurance policy? ☐ Yes ☒ No

If this is a replacement of a life insurance policy, was the contract a Modified Endowment Contract (MEC)? ☐ Yes ☒ No

The Payor is: ☐ Proposed Primary Insured ☒ Proposed Owner ☐ Other

Payor Name

Relationship to Proposed Insured | Gender | Date of Birth | Social Security Number/TIN

Street Address | City | State | ZIP Code

Mobile Phone | Other Phone | Email Address

$
Amount of Insurance Inforce on Proposed Payor

$
Household Annual Income

$
Household Net Worth

$
Household Liquid Assets

$
Household Annual Expenses

Reason this Person is the Payor

Product Information

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Allianz Life Pro + Advantage

$ 297,135.00
Specified Face Amount

Juvenile
Risk Class

Death Benefit Option

- [ ] A - Specified Amount
- [X] B - Specified Amount Plus Accumulation Value
- [ ] C - Specified Amount Plus Total Premium Paid

Definition of Life Insurance Test

- [ ] Cash Value Accumulation Test (CVAT)
- [X] Guideline Premium Test (GPT)

Product Information

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Allianz Life Pro + Advantage

☐ Child Term Rider Units _____

☐ Enhanced Liquidity Rider ☐ 50% ☐ 100%

☐ Premium Deposit Fund Rider Amount $ _____ Period _____

☐ Supplemental Term Rider Amount $ _____

☐ Waiver of Specified Premium Rider Amount $ _____

Bonused Indexed Allocations

34 % Blended Index Annual Point-to-Point

33 % Bloomberg US Dynamic Balance II ER Index Annual Point-to-Point

_____ % NASDAQ 100® Index Monthly Sum

33 % PIMCO Tactical Balanced ER Index Annual Point-to-Point

_____ % S&P 500® Index Annual Point-to-Point

_____ % S&P 500® Index Monthly Sum

_____ % S&P 500® Index Trigger Method

Select Indexed Allocations

_____ % Blended Index Annual Point-to-Point

_____ % Bloomberg US Dynamic Balance II ER Index Annual Point-to-Point

_____ % PIMCO Tactical Balanced ER Index Annual Point-to-Point

_____ % S&P 500® Index Annual Point-to-Point

Standard Indexed Allocations

_____ % Blended Index Annual Point-to-Point

_____ % NASDAQ 100® Index Monthly Sum

_____ % S&P 500® Index Annual Point-to-Point

_____ % Fixed Allocation

Total 100 %

FL6407ALZ20100530446

Purpose of Insurance

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Allianz Life Pro + Advantage

Personal Insurance:

- [ ] Income Replacement
- [ ] Final Expenses
- [ ] Charitable Giving
- [X] Retirement Planning
- [ ] Estate Conservation
- [ ] College Funding
- [ ] Mortgage Protection

Mortgage Amount $ _____

Business Insurance:

- [ ] Deferred Compensation
- [ ] Buy/Sell
- [ ] Key Person
- [ ] Business Continuation
- [ ] Split Dollar
- [ ] Executive Bonus
- [ ] Other: _____

How was the face amount determined? _____

Minimum Face for planned Premium

Do both the proposed owner(s) and the proposed insured(s) believe this life insurance policy being applied for will meet the insurance needs and objectives of each person? [X] Yes [ ] No

Did the agent discuss with both the proposed owner(s) and the proposed insured(s) the current life insurance policies and other assets of each person prior to the decision to purchase this life insurance policy? [X] Yes [ ] No

Does the proposed owner(s) feel sufficient liquid assets are available to them for living expenses and emergencies in addition to the money allocated to pay the life insurance premiums? [X] Yes [ ] No

Please indicate which of the following discussions have been had with the proposed owner(s) and the proposed insured(s) of this life insurance policy. Select ALL that apply.

- [ ] Been offered “free insurance”, a cash payment, or some other promised benefit as an incentive
- [ ] Discussed selling this life insurance policy
- [ ] Had an evaluation to determine the insured’s life expectancy (how long the insured will live)
- [ ] Discussed changing ownership or beneficiaries once this policy is issued
- [X] None of these

Provide details for any discussions indicated above: _____

Source of Funds

Allianz

PO Box 59060
Minneapolis, MN 55459
800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

- [ ] Earned Income
- [ ] Annuity Contract
- [ ] Money Market Fund
- [X] Savings
- [ ] Inheritance
- [ ] Other
- [ ] Qualified Funds
- [ ] Loans
- [ ] Other Life Insurance Policy
- [ ] Mutual Fund/Brokerage Account

Qualified Fund details (ie: IRA, 401k, 403b): _____

Inheritance details: _____

Other details: _____

Will this policy be funded using Premium Financing? [ ] Yes [X] No

_____
Name of the Company who is administering the Premium Finance

_____
Name of Lender

Type of loan? [ ] Recourse [ ] Non-Recourse

Is the client obligated to repay the loan? [ ] Yes [ ] No

Does the financial professional have a signed Premium Finance Addendum on file with Allianz? [ ] Yes [ ] No

Additional Questions

Allianz

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800.950.7372
www.allianzlife.com

Allianz Life Pro + Advantage

Electronic Transaction Authorization

By selecting "yes", I am authorizing and directing Allianz Life Company of North America (Allianz) to act on electronic instructions from my financial professional and anyone authorized by him/her to initiate such instructions. Electronic instructions include, but are not limited to, requests received by telephone, fax, email, or the Allianz website. I understand must make the decision or approve the transactions recommended by my financial professional and that my financial professional does not have discretion over my life insurance policy. By selecting no, electronic instructions will only be accepted from me, the Owner. Allianz will use reasonable procedures to confirm these electronic instructions are valid. As long as these procedures are followed, the company and it officers, employees, representatives and producers will be held harmless for any claim, liability, loss, or cost arising from unauthorized or fraudulent instructions. Allianz reserves the right to deny any electronic instruction and to discontinue or modify our electronic instruction privileges at any time and for any reason.

☒ Yes ☐ No

Certification of Taxpayer Information

If you are applying for this product and/or requesting payments as a U.S. Person, the IRS requires you to agree to the following statements. If you are not a U.S. Person, you are not eligible to apply for this product.

Under penalties of perjury, I certify that:

- The Taxpayer Identification Number shown on this form is correct or I am waiting for a number to be issued to me.
- I am not subject to backup withholding because:
  a. I am exempt from backup withholding, or
  b. I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or
  c. The IRS has notified me that I am no longer subject to backup withholding.
- I am a U.S. person, and
- The Foreign Account Tax Compliance Act (FATCA) code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Has the IRS notified you that you are currently subject to backup withholding because you failed to report interest and dividends on your tax return?

☐ Yes ☒ No

ELECTRONIC TRANSMISSION AND SIGNATURES CONSENT AGREEMENT AND DISCLOSURE

This Electronic Transaction Consent Agreement and Disclosure ("Agreement") authorizes Allianz Life Insurance Company of North America ("Allianz") to conduct business electronically, and I consent to electronic transactions and document delivery, as set forth below.

Contract owner's email address: fierfelderj@bellsouth.net

Joint contract owner's email address: _____

Annuitant/Insured's email address: mfierfelder@gmail.com

Trustee's email address: fierfelderj@bellsouth.net

Attorney-in-fact's email address: _____

Scope of Consent: I consent to the following electronic transactions and document delivery, if available:

- My signature electronically;
- Electronic submission to Allianz of my completed request for an annuity contract or life insurance policy, including all accompanying forms and required point of sale disclosures; and
- Electronic delivery to me of a copy of my completed request.

How it Works: I understand that how it works depends on the electronic order entry system used to submit my completed request and if I sign electronically to complete my request:

- When my completed request has my electronic signature, a valid email address is required. My email address will be used to either send me a confirmation email or a copy of my completed request. If I receive a confirmation email, it will include a link to a secure site, from which, once I verify my identity, I will be able to view and retain a copy of my completed request for a limited time.
- When my completed request has my written signature, I can ask my financial professional for a copy.
- Alternatively, I can always contact Allianz for a copy. See Contact Information below for how to do so.

Effect of Electronic Signatures and Electronic Delivery: I acknowledge that my electronic signature on this Agreement and other documents requiring my signature will have the same validity and enforceability as my written signature. I also acknowledge that any documents that are delivered to me by electronic means are equivalent to paper copies. The withdrawal of my consent will not diminish the legal effectiveness or enforcement of any transaction agreed to while I have given consent.

Hardware and Software Requirements: I understand the following computer hardware and software requirements are necessary to receive, view, and retain documents delivered electronically: access to a personal computer or electronic device, Internet access, an Internet browser, an active email and Adobe Acrobat Reader. More information on viewing PDFs and free downloads are available at www.adobe.com. If there are any changes in the hardware or software requirements, I understand that Allianz will notify me of the changes and remind me that I may withdraw my consent to receive documents electronically.

Right to Paper Copies: By consenting to electronic transactions and document delivery, I understand that I will not receive paper copies of the documents specified in this Agreement. See Scope of Consent above. I further understand that I may, at any time, request and receive paper copies of these documents at no cost. See Contact Information below for how to do so. Although I have consented, Allianz may require paper copies of certain documents to be mailed.

Email Address: The email address indicated above is my current email address. I further understand that I need to let Allianz know if my email address changes. Allianz is not responsible for an invalid email address. With an invalid email address, Allianz may be required to mail a paper copy of the document (and all future documents). State law may also require me to consent again once I update my email address.

Withdrawal of Consent: I understand that my consent to electronic transactions and document delivery is voluntary. I may withdraw my consent to have this transaction completed electronically at any time prior to submitting my request to Allianz by advising the attending financial professional. By withdrawing my consent, I understand that my request for an annuity contract or life insurance policy will not be submitted electronically and instead a paper application and paper copies of all accompanying forms and required point of sale disclosures must be completed to continue the application process.

Contact Information:
Website: https://www.allianzlife.com/contact-us
Phone: 800.950.5872 (Monday-Friday from 8:00 a.m. to 5:00 p.m. CT)
Mail: Allianz Life Insurance Company of North America, P.O. Box 1344, Minneapolis, MN 55416-1297

Agreement and Signature

I acknowledge and agree that:

- I have read, understand, and accept this Agreement.
- I consent to the electronic transactions and document delivery specified in this Agreement.
- My electronic signature will have the same validity and enforceability as my written signature.
- I confirm that I have ready access to a computer or electronic device with Internet access and a browser, an active email account to receive documents electronically and the ability to read and retain them.

Contract owner's signature: _____ Date: _____

Joint contract owner's signature: _____ Date: _____

Annuitant/Insured's signature: eSigned By FireLight: Michael Fierfelder 2020-10-08T17:58:11 Michael Fierfelder 8e8b53537ee145b6bb1c94eec82d5503 _____ Date: 10/8/2020

Alternate signatures, if applicable

Trust: _____ eSigned By FireLight: John J Fierfelder 2020-10-07T21:48:56 John J Fierfelder 3667494b9eea47bbb3326adbfdca2f5f _____
TRUSTEE'S SIGNATURE

as trustee of the: Fierfelder Revocable Trust Date: 10/7/2020
TRUST NAME

Power of attorney: _____
CONTRACT OWNER'S NAME

by: _____ Date: _____
ATTORNEY IN FACT'S SIGNATURE

ALLIANZ LIFE INSURANCE COMPANY
OF NORTH AMERICA
5701 Golden Hills Drive
Golden Valley, MN 55416-1297

Worksheet for Individual and Joint Life Insurance Acknowledgement

Product: Allianz Life Pro + Advantage

Identification eNumber: FL6407ALZ20100530446

Agent Information

Name(s): JOSEPH COROZZA

Proposed Primary/First Insured

Name: Christian Fierfelder

Address: 5259 Maxon Terrace, SANFORD, FL, 32771

Email address: mfierfelder@gmail.com

Date of birth: 01/21/2015

SSN/TIN: 624-87-6057

Gender: Male

Mobile Phone: 561-346-7193

Proposed Joint/Other Insured

Name:

Address:

Email address:

Date of birth:

SSN/TIN:

Gender:

Mobile Phone:

Proposed Policy Owner

Name: Fierfelder Revocable Trust

Address: 14653 Horseshoe Trace , WELLINGTON, FL, 33414

Email address: fierfelderj@bellsouth.net

Date of birth: 06/02/2016

SSN/TIN: 26-3926434

Gender:

Mobile Phone: 561-846-1821

Proposed Joint Policy Owner

Name:

Address:

Email address:

Date of birth:

SSN/TIN:

Gender:

Mobile Phone:

Allocation Selection(s)

34% Blended Index Annual Point-to-Point (bonus)
33% Bloomberg US Dynamic Balance Index II ER Annual Point
33% PIMCO Tactical Balanced ER Index Annual Point-to-Point

Product Features

Specified Face Amount: 297,135.00

Risk Class: Juvenile

Optional Riders:

Verification of Existing Policies or Contracts

Proposed Primary/First Insured

1. Do you have existing life insurance policies or annuity contracts?	☐ Yes	☒ No
2. Will the life policy applied for replace or change existing contracts or policies?	☐ Yes	☒ No

Proposed Joint/Other Insured

1. Do you have existing life insurance policies or annuity contracts?	☐ Yes	☐ No
2. Will the life policy applied for replace or change existing contracts or policies?	☐ Yes	☐ No

Existing Policies and Contracts to be replaced

Insured Name	Company Name	Life or Annuity	Amount In force

Beneficiary Designation

Type	Name	Relationship	%
Primary	Fierfelder Revocable Trust	Trust	100

Illustration Certification

A signed illustration conforming to the policy described on this worksheet must be submitted with the completed worksheet. If a conforming illustration has not been submitted, this section must be completed.

By signing this worksheet acknowledgment, I confirm that:

Applicant Acknowledgement:

I did not receive an illustration conforming to the policy I applied for. I understand that an illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

Transaction Authorization

☒ Yes ELECTRONIC TRANSACTION AUTHORIZATION: By selecting "yes", I am authorizing and directing Allianz Life Insurance Company of North America (Allianz) to act on electronic instructions from my agent and anyone authorized by him/her to initiate such instructions. Electronic instructions include, but are not limited to, requests received by telephone, fax, email, or the Allianz website. I understand I must make the decision or approve the transactions recommended by my agent and that my agent does not have discretion over my policy. If the box is not checked, electronic instructions will only be accepted from me, the Owner. Allianz will use reasonable procedures to confirm these electronic instructions are valid. As long as these procedures are followed, the company and it officers, employees, representatives and agents will be held harmless for any claim, liability, loss, or cost arising from unauthorized or fraudulent instructions. Allianz reserves the right to deny any electronic instruction and to discontinue or modify our electronic instruction privileges at any time and for any reason.

Certification of Taxpayer Identification Number

If you are applying for this product and/or requesting payments as a U.S. Person, the IRS requires you to agree to the following statements. If you are not a U.S. Person, prior approval is required before submitting this application. If approved, the appropriate IRS Form W-8BEN is required to be completed.

Under penalties of perjury, I certify that:

1. The Taxpayer Identification Number shown on this form is correct or I am waiting for a number to be issued to me.
2. I am not subject to backup withholding because:
    a. I am exempt from backup withholding, or
    b. I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or
    c. The IRS has notified me that I am no longer subject to backup withholding.
3. I am a U.S. person, and
4. The Foreign Account Tax Compliance Act (FATCA) code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

☐ Check here **ONLY** if the IRS has notified you that you are currently subject to backup withholding because you failed to report interest and dividends on your tax return.

Life Insurance Confirmation and Acknowledgement

The State of Florida requires applicants to read and acknowledge the below statement.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Each of the undersigned declares, understands and agrees that:

- Coverage under any policy approved or issued by Allianz a result of the worksheet shall be considered effective and in force only when, during the insured's lifetime and continued insurability
  a. a policy is issued, delivered, received and accepted by the policy owner;
  b. the first full premium has been received by Allianz; and
  c. all answers material to the risk are still true and complete to the best of the owner's and insured's knowledge.
- The MIB, Inc. Disclosure and Investigative Consumer Report Notice has been received by me.

CAUTION: If the answers on the worksheet are incorrect or untrue, Allianz may have the right to deny benefits or rescind the policy.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

FL

Signed at (State)

Proposed Policy Owner's signature — Date

Proposed Joint Policy Owner's signature — Date

eSigned By FireLight: Michael Fierfelder
2020-10-08T17:58:11
Michael Fierfelder
8e8b53537ee145b6bb1c94eec82d5503

Proposed Primary/First Insured signature — Date

Proposed Joint/Other Insured signature — Date

10/8/2020

Alternate signatures, if applicable

Trust:[1] eSigned By FireLight: John J Fierfelder 2020-10-07T21:48:56 John J Fierfelder 3667494b9eea47bbb3326adbfdca2f5f as trustee of the: Fierfelder Revocable Trust — 10/7/2020

Trustee's signature — Trust name (please print) — Date

Trust:[1] _____ as trustee of the: _____ — _____

Second trustee's signature (as applicable) — Trust name (please print) — Date

I understand that I have the right to designate at least one person, other than myself, to receive notice of possible lapse of this life 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 (name and home address):

[1] Submit a current copy of the trust certification form if not already on file.

Statement of Agent

By signing below, the Agent certifies to the following:

- I certify that the statements of the Owner have been correctly recorded.
  - ☐ Yes ☒ No Does the proposed insured(s) have an existing life insurance policy or an existing annuity contract?
  - ☐ Yes ☒ No Will this life insurance replace or change an existing life insurance policy or annuity contract?
- I only used sales materials that were previously approved by Allianz in my presentation.
- I left a copy of all sales material used during my presentation with the applicant.
- I have provided the Owner with all appropriate disclosure and replacement requirements prior to the completion of this application.
- I understand all instructions I submit to Allianz on behalf of the owner must be approved by the owner prior to submitting to Allianz.
- I understand I do not have discretion over the owner's policy.

A signed illustration conforming to the policy described on this worksheet must be submitted with the completed worksheet. If a conforming illustration has not been submitted, this section must be completed.

By signing this worksheet:

Agent Certification:

I did not provide an illustration conforming to the policy described on this worksheet acknowledgement.

eSigned By FireLight: JOSEPH L COROZZA
2020-10-07T14:31:13 JOSEPH L COROZZA 347d7fdce6c4477aac0352cdd5c70368

Writing Agent's Signature

10/7/2020
Date

JOSEPH COROZZA
Agent's Name (Please Print)

800-325-8907
Phone Number

W113685
Florida License Identification Number

jcorozza@seemanholtz.com
Agent's Email

For questions, contact Allianz at 800.950.7372

FL6407ALZ20100530446

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

Allianz

Producer Report

1. Proposed Primary/First Insured

First Name	MI	Last Name
Christian		Fierfelder

2. Producer Information

First Name	Last Name	Producer Number	Phone Number	Split %
JOSEPH	COROZZA	795001660	800-325-8907	100

3. Commission Choice (Select one option)

☒ Option A (Level)	☐ Option B (Spread)

4. Proposed Insured(s) Information

Question	Proposed Primary/First Insured	Proposed Other/Second Insured
a. How long have you known the insured?	Never Met	
b. Did you meet with the proposed insured(s)?	☐ Yes ☒ No	☐ Yes ☐ No
c. If you did not meet with the proposed insured(s), give reason (e.g. previous relationship, application via mail, etc):	Advisor to Grandparents	
d. The proposed insured is:	☒ Single ☐ Married ☐ Divorced ☐ Widowed	☐ Single ☐ Married ☐ Divorced ☐ Widowed
e. If married, amount of life insurance in force on spouse:	$	$
f. Is the proposed insured related to you or your spouse?	☐ Yes ☒ No	☐ Yes ☐ No
g. If related, state relationship:		
h. Is the proposed insured(s) an employee of Allianz Life Insurance Company of North America?	☐ Yes ☒ No	☐ Yes ☐ No

5. Companion File Information

Is there another person or persons applying for coverage with Allianz that is in connection with this client?	☐ Yes ☒ No	☐ Yes ☐ No
If yes, provide name(s):		

Return to Home Office

6. Requirement Ordering

If you prefer that the Home Office schedule and follow-up on all requirements, check 'Home Office' below

Who will be ordering the medical requirements? ☒ Home Office ☐ Producer/Field Office

If exam has been scheduled, provide name of vendor and phone number:

Paramedical Company _____ Phone Number _____

If an APS is required, who should order? ☒ Home Office ☐ Producer/Field Office

If an APS has already been ordered, provide doctor/facility name: _____

7. Military Sales Disclosure

a. Is the applicant(s) a member of the armed services, on active duty or a dependent of such a person? ☐ Yes ☒ No

b. If yes, I have provided the applicant(s) with a copy of the **Military Sales Disclosure Statement**. ☐ Yes ☐ No

8. Replacement

a. Is a replacement involved? ☐ Yes ☒ No

b. If yes, the existing life insurance policy is being replaced and cannot meet the client(s) objectives because:

9. Suitability

a. Did you discuss with the client their current life insurance policies and other assets prior to their decision to purchase this life insurance policy? ☒ Yes ☐ No

b. In discussing this sale with the client, the client has indicated to you that they have sufficient liquid assets available for living expenses and emergencies other than the money allocated to pay the life insurance premiums? ☒ Yes ☐ No

c. In reviewing the purchase of this insurance policy as to the suitability of such purchase for the client, you have reasonable grounds for believing this purchase is suitable in meeting their insurance needs and financial objectives? ☒ Yes ☐ No

Provide details to any **'No'** answers:

10. Life Settlement

a. To the best of your knowledge, has this client(s) sold, viaticated or settled any previous life insurance policies? ☐ Yes ☒ No

b. To the best of your knowledge, does this client(s) have any intention to sell or settle this policy, if issued? ☐ Yes ☒ No

Provide details to any **'Yes'** answers:

11. Insurability

a. Do you know if any information not given on the worksheet/application which might affect the insurability of any person to be insured ☐ Yes ☒ No

Provide details to any **'Yes'** answers:

12. Special Requests/Remarks

13. Anti Money Laundering (AML) Requirement

- The following customer verification is required for AML
- Please indicate the document that was used to verify identification, the state of issue, number and expiration date

I have verified the proposed insured(s)/owner(s) identity by reviewing the government issued photo ID selected below:

Proposed Primary/First Insured

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue | Number | Expiration Date

Proposed Other/Second Insured

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue | Number | Expiration Date

Policy Owner (if other than Insured)

☒ Drivers License ☐ Passport ☐ State or Military Photo ID

FL | F614470502660 | 07 / 26 / 2025

State of Issue | Number | Expiration Date

Joint Policy Owner (if other than Insured)

☐ Drivers License ☐ Passport ☐ State or Military Photo ID

State of Issue | Number | Expiration Date

14. Producer Attestation and Signature - To be Answered by a Licensed Producer

- To the best of my knowledge the information contained in the producer report is accurate.

► **Producer's Signature:** eSigned By FireLight: JOSEPH L COROZZA JOSEPH L COROZZA 2020-10-07T14:31:13 347d7fdce6c4477aac0352cdd5c70368 **Date:** 10/7/2020

JOSEPH COROZZA | 800-325-8907

Producer Name (please print) | Phone Number

jcorozza@seemanholtz.com

Please submit the form using one of the options below:

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

OR

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

OR

Mail:

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

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

OR

Fax: 763.582.6002

Any questions? Call us at 800.950.7372

Return to Home Office

FL6407ALZ20100530446

Trustee Certification Form

Allianz

Section I – Policy Information

A. Policy or application number _____

B. Insured or Proposed Insured name Christian Fierfelder

Section II – Trust Information

A. Name of trust Fierfelder Revocable Trust

B. Date of trust 06/02/2016

C. State where sitused FL

D. State law applicable to trust (if different than Section II.C) _____

E. Trust tax identification number 26-3926434

F. Is trust a grantor trust under IRC's Sections 671-679? ☐ Yes ☒ No

Section III – Grantor Information (complete only if Section II. F. above is checked "Yes"

A. Name of grantor _____

B. Address of grantor _____

_____

C. Grantor's Social Security number_____

Section IV – Settlor of Trust (person that created the Trust)

A. Settlor name John Fierfelder

B. Settlor address 14653 Horseshoe trace

Wellington FL 33414

C. Settlor's Social Security number 263-92-6434

Section V – Revocable or Irrevocable Trust

A. ☐ Trust is irrevocable

B. ☒ Trust is revocable

Section VI – Multiple Trustees (complete only if there are multiple Trustees)

Check only one of the boxes below:

A. ☐ All trustees must act together

B. ☒ Each trustee can independently act for the trust

C. ☐ A majority of trustees is required to act for the trust

D. ☐ Other (explain)

Section VII – Trustee Contact Information

A. [X] Check this box if one specific trustee is to get all communications from Allianz. If this box is checked, then state the trustee name, address, and phone number.

John Fierfelder
14653 Horseshoe Trace
West Palm Beach FL 33414
561 793 6858

Section VIII – Trust Certifications

The undersigned trustee(s) certify as follows:

A. The Trustee(s) may be named as policy owner and have the power to exercise all rights of ownership in the policy.

B. Allianz may rely on the validity of these Certifications unless the Trustee(s) notify Allianz in writing of any amendment to the trust, any change of trustee(s) or any other event that might change the validity of these Certifications.

C. Beneficial interest under the trust can and will only be established for persons who (1) are related to the Insured or Proposed Insured by blood or by law; (2) have a substantial interest in the Insured or Proposed Insured engendered by love and affection; or (3) will hold a lawful interest in the benefits provided by the policy.

D. Allianz has no obligation to investigate the terms of the trust or the authority of the trustee(s) and will not be accountable for knowledge about the terms of the trust beyond this certification.

E. The trustee(s) has had an opportunity to consult with tax and/or legal counsel in the preparation of the trust agreement and the Trustee(s) has not relied upon any representations or advice of any Allianz agents, employees or representatives with respect to the terms or validity of the trust.

F. The undersigned trustee(s) indemnifies Allianz, its agents, employees and representatives and agrees to hold them harmless against all obligations, demands, losses, or liabilities, including attorney fees, that may be incurred or paid because of reliance upon these certifications.

Section IX - Signatures

Name of trustee (print) John Fierfelder
Street address 14653 Horseshoe Trace
City, state, ZIP code West Palm Beach FL 33414

eSigned By FireLight: John J Fierfelder
Signature of trustee 2020-10-07T21:48:56 John J Fierfelder 3667494b9eea47bbb3326adbfdca2f5f Date 10/7/2020

fierfelderj@bellsouth.net

Name of trustee (print) _____
Street address _____
City, state, ZIP code _____

Signature of trustee _____ Date _____

Name of trustee (print) _____
Street address _____
City, state, ZIP code _____

Signature of trustee _____ Date _____

Name of trustee (print) _____
Street address _____
City, state, ZIP code _____

Signature of trustee _____ Date _____

Allianz Life Insurance Company
of North America

Allianz

By electing the Trustee signer type, I acknowledge and represent that I am signing the accompanying electronic forms in the capacity as the Trustee of the proposed owner.

Trust: eSigned By FireLight: John J Fierfelder John J Fierfelder 2020-10-07T21:48:56 3667494b9eea47bbb3326adbfdca2f5f as trustee of the: Fierfelder Revocable Trust Date: 10/7/2020
TRUSTEE'S SIGNATURE — TRUST NAME (PRINTED)

Trust: _____ as trustee of the: _____ Date: _____
CO-TRUSTEE'S SIGNATURE — TRUST NAME (PRINTED)

Power of attorney: _____ by: _____ Date: _____
CONTRACT OWNER'S NAME (PRINTED) — ATTORNEY IN FACT'S SIGNATURE(S)

Allianz Life Insurance Company
of North America

5701 Golden Hills Drive
Minneapolis, MN 55416-1297

Authorization for Release of 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.

Christian Fierfelder
Name of Proposed Insured (please print)

01/21/2015
Date of birth

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

I also authorize any insurance company, my insurance agent, employers, consumer reporting agencies, health plan administrators, Pharmacy Benefit Managers, government agencies, relatives, friends, neighbors, and others with whom I am acquainted ("Other Persons"), that have any records or knowledge of me relating to my health/medical history, character, general reputation, personal characteristics, or mode of living, to give to the Company, its agents, its employees, its representatives, and its reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

I authorize MIB, Inc, and any MIB member insurer, to provide any medical or personal information that it has about me to the Company, its reinsurers or any MIB authorized third party administrator performing underwriting services for the Company.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and other information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

This protected health information and other information is to be disclosed under this Authorization so that the Company, its agents, employees, representatives, and reinsurers may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

The Company, its agents, employees, representatives, and reinsurers may release information obtained by this Authorization to reinsurers, and other persons and entities performing business or legal services in connection with my application. Further, I authorize the Company, its reinsurers or authorized third party administrators to make a brief report of my protected health information to MIB, Inc.

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 understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my entire medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

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.

eSigned By FireLight: Michael Fierfelder
Michael Fierfelder
2020-10-08T17:58:11 8e8b53537ee145b6bb1c94eec82d5503
Signature of Proposed Insured or Personal Representative

10/8/2020
Date

Parent
Description of Personal Representative's authority or relationship to Proposed Insured

Allianz Life Insurance Company
of North America

PO Box 59060
Minneapolis, MN 55459-0060

Notice of Disclosure

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. Allianz Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc. a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Allianz Life, or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.