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

Allianz

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.

Name of Proposed Insured (please print) _____ Date of Birth _____

Street Address of Proposed Insured _____ City _____ State _____ Zip Code _____

Health Information Release Authorization

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 infections. 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 health plan administrators, government agencies, Pharmacy Benefit Managers, that have any records or knowledge of me relating to my health/medical history, to give to the Company, its agents, employees, representatives, and reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted infections. 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 to restrict my protected health information and other information and I instruct My Providers 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.

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.

Investigative Consumer Report Authorization

I also authorize consumer reporting agencies to give to the Company, its agents, employees, and reinsurers any information or records regarding my credit history, character, general reputation, personal characteristics, or mode of living.

Company Release of Information Authorization

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.

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 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.

MIB, LLC Acknowledgment

I authorize MIB, 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.

Further, I authorize the Company, its reinsurers or authorized third party administrators to make a brief report of my protected health information to MIB.

Signature of Proposed Insured or Personal Representative _____ Date _____

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

Submit original to Home Office with application. Leave copy with owner. Keep copy in financial professional file.