

**Electronic signatures
are not permitted
with this form**

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Life Claim Form

We want to ensure you receive your benefit payment promptly, so please complete the applicable sections and be sure to attach the documentation requested.

Important Information:

- Each named beneficiary will need to complete a separate claim form.
- If a named beneficiary is deceased, include a copy of the death certificate with your claim.
- If all or some of the proceeds are to cover funeral expenses, we will need an assignment from the funeral home signed by all the beneficiaries.
- If the policy owner used the policy to secure a debt, the individual or entity who received the assignment will need to complete a separate claim form and provide a written statement of the current balance owed to them. Also, each named beneficiary will need to file a claim for the proceeds that are in excess of the balance owed.

Section 1: Claim details - about the beneficiary

1a. _____
Policy number(s) you are claiming benefits for

Please provide your full legal name, including full first name, full middle name and all last names. No abbreviations please.

Individual beneficiary first name _____ Middle name _____ ☐ Middle name does not exist

Last name _____

Non-individual beneficiary name (e.g. trust, estate, charity) _____

Social Security Number or EIN if beneficiary is a trust or estate _____ Date of birth or date of trust _____

Residential address _____

City _____ State _____ Zip code _____

Mailing address (if different than residential address) _____

City _____ State _____ Zip code _____

Phone number _____ Mobile number _____ Email address _____

Relationship to deceased: ☐ Spouse under a legally recognized marriage
☐ Other: _____

(continued on next page)

Section 1: Claim details - about the beneficiary (continued)

1b. A copy of a valid, unexpired, and legible Government-issued ID has been provided with this form. Acceptable ID types include a Driver's license, State ID, Passport, or Military ID.

☐ Yes ☐ No (We are unable to process your request until this has been received)

Please note: If your name, address or date of birth do not match the ID you've submitted, please explain why:

1c. _____
Country/place of birth Country of current residence

Current citizenship

Do you have dual citizenship? ☐ Yes ☐ No Other citizenship: _____

1d. In what capacity are you claiming benefits?

- ☐ Named beneficiary (if you are not a U.S. citizen, please call us for additional information)
- ☐ Trustee - complete the **Certification of Trust Form**
- ☐ Executor, administrator, or personal representative of the estate (include court certificate of appointment)
- ☐ Charity or corporation (include a copy of the corporate resolution)
- ☐ On behalf of a minor child or as attorney-in-fact under a power of attorney (include appropriate document and a copy of a valid, unexpired, and legible Government-issued ID)
- ☐ Plan administrator of retirement plan (include plan documents as proof of authorization and contact us for benefit options)
- ☐ Other: _____

Section 2: About the deceased

2a. _____
First name Middle initial Last name

Social Security Number Date of birth

Street address

City State Zip code

Date of death Cause of death

2b. We need a copy of the certified death certificate.

Is a copy attached? ☐ Yes ☐ No, please state why: _____

If available, please provide a copy of the obituary.

(continued on next page)

Section 2: About the deceased *(continued)*

2c. If the policy was issued or reinstated within two years of the insured's date of death, please complete the following:

- a. When did the insured first complain of or give other indications of last illness? _____
- b. When did the insured first consult a physician for last illness? _____
- c. Names of all physicians or practitioners who attended the insured within five years preceding death
(Attach additional sheet if necessary)

Names	Addresses	Condition(s)	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 3: Death benefit options

- Please consider the death benefit options carefully as once we have processed your request, it is not reversible.

Select one of the 2 options below:

☐ **Option 1: Receive a lump-sum payment**

If you select this option, you will receive the death benefit as a lump-sum payment by check or wire transfer/electronic funds transfer (EFT).

Remember to: Provide certification of a taxpayer identification number in Section 5.

☐ **Option 2: Receive the death benefit under one of the available settlement options (Not available on all products)**

Please contact us to discuss the settlement options available to you or to receive a quote of your estimated payment amount. Note that some settlement options may be eligible for a bonus.

Settlement options include:

- **Installments for a Guaranteed Period** – Receive the death proceeds in equal annual installments (or more frequently if requested) for a guaranteed period of time that you select. Depending on the terms of the policy, you may be eligible for an increased death benefit amount if you select a payment period of 10 to 30 years. Under this option, payments continue until the guaranteed period expires.
- **Installments for a Selected Amount** – Receive the death proceeds in equal annual installments (or more frequently if requested) in an amount that you select. Under this option, payments continue until the entire benefit has been paid.
- **Installments for Life with a Guaranteed Period** – Receive the death proceeds in equal annual installments (or more frequently if requested) for as long as you are living, and for at least the guaranteed period of time that you select. Depending on the terms of the policy, under this option you may be eligible for an increased death benefit amount.

Section 4: Electronic deposit

- You can choose to receive your death benefit electronically.
- The money will be forwarded via Electronic Funds Transfer (EFT).
- If funds are payable to a trust or estate, the account must be in the name of the trust or estate.
- We will accept either a voided check or a letter on bank letterhead that must include:
 - Account holder name (needs to be the same as the person listed in Section 1)
 - Full account and routing number
 - Bank name/logo
- **NOTE:** If you don't have the option to do ACH/EFT and require a wire transfer, please contact Allianz Life Insurance Company of North America (Allianz). Lump sum payments may be sent as a wire in which your bank may assess an additional fee.
- If required information is not attached or already on file with Allianz, the payment cannot be transferred electronically and a check will be sent to the address on record.

Payment to be deposited to: ☐ Checking account ☐ Savings account

What documentation has been included (only one is required): ☐ Voided check ☐ Bank letter on bank letterhead

Section 5: Certification of taxpayer identification number

If you are 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, please complete Form W-8BEN.

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 the box 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.

Section 6: Signatures

- As the authorized signer, please sign your name and date below in the appropriate space.
- If you do not sign and date this page, we will not be able to process your claim.
- Allianz reserves the right to request additional information we consider necessary to pay the claim.
- By signing, I acknowledge and represent all information provided in this claim form is true, accurate and complete to the best of my knowledge and I authorize Allianz to process the requested death benefit payment. I am aware that this transaction is NOT reversible. Once a payment has been made, any federal or state tax withholding cannot be reversed.

New York fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New York state residents only: I have read and understand the New York state fraud warning.

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

Beneficiary signature _____ Date _____

Beneficiary name (please print) _____

Trust:¹ _____ as trustee of the: _____
Trustee's signature Trust name (please print) Date

Trustee's name (please print) _____

_____ as executor/administrator of the estate of: _____
Executor/administrator signature Deceased's name (printed)

Executor/administrator name (printed) _____ Date _____

_____ as _____ of _____
Corporate authorized signature Title Company

Corporate authorized name (please print) _____ Date _____

Power-of-Attorney:¹ _____ By: _____
Policy owner's name Attorney-in-Fact signature Date

Attorney-in-Fact name (please print) _____

Power of Attorney's Email _____ Cell Phone Number _____

Plan Administrator's signature² _____ Date _____

Plan Administrator's name (please print) _____

¹ Submit Certification of Trust Form or legal documents such as power-of-attorney paperwork.

² Submit Plan documents.

Section 7: Fraud notice

IMPORTANT: This is part of the claim form. Please review the applicable fraud notice required by your state of residence.

Arkansas, Alabama, Louisiana, Rhode Island, Texas, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska, Delaware, Florida, Idaho, Indiana: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a contract holder or claimant for the purpose of defrauding or attempting to defraud the contract holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia, Maine, Tennessee, Virginia, Washington: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact, material thereto commits a fraudulent insurance act, which is a crime. In PA, this activity may subject such person to criminal and civil penalties.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Ohio and Oregon: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

To ensure you receive your benefit payment promptly, please check to make sure you have:

- Selected the death benefit payment option in Section 3,
- Read and agreed to the certification of your taxpayer ID terms in Section 5,
- Attached a copy of the death certificate and other documentation, such as trust paperwork or the trust agreement, power-of-attorney papers, letters testamentary for estates, plan documents for a qualified plans, any other required state or federal forms, and
- Secured the required signatures in Section 6.

Mailing addresses

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

Fax number: 763.582.6501

Any questions? Call us at 800.950.1962