

Allianz Life Insurance Company  
of North America  
Home office: Minneapolis, MN 55403-2195  
PO Box 4243  
Woodland Hills, CA 91365-4243  
888/503-8106 Fax #: 818/867-2506



## Claim For Long Term Care Claimant's Statement

### Part 1 — Claimant Identification

		Policy number
Claimant's Name (last, first)	Social Security number	Date of birth (mm/dd/yyyy) / /
Home address	Daytime telephone number	Fax number ( )
Name of responsible party	Relationship	Telephone number ( )
Address	<input type="checkbox"/> Power of Attorney	
	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other	
If the responsible party is a Power of Attorney or Guardian, attach a copy of documents supporting financial authority on the claimants behalf.		

### Part 2 — Claimant Condition

Cause or condition requiring the need for long term care services	
Date symptoms were first noticed	First date of medical treatment for this condition

### Part 3 — Activities of Daily Living (ADL's)

Check the appropriate box that best describes the assistance you/claimant require with each ADL.

	Independent	Needs Stand-by Assistance	Needs Hands-on Assistance	Date Assistance Began	Date Assistance no Longer Needed
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /

\*Applies to CA residents only.

### Part 4 — Physician Information

Current treating physician	Telephone number ( )
Address	Fax number ( )
If you are being treated by other physicians, please provide the name and telephone number on a separate sheet of paper.	

### Part 5 — Hospital Information

Were you hospitalized?  Yes  No    If yes, indicate the name, address, and telephone number where you were hospitalized

Name	Address	Telephone Number	Admission Date(s)	Discharge Date(s)
		( )	/ /	/ /
		( )	/ /	/ /

**Part 6 — Long Term Care Services Information**

<b>Facility Services</b> <input type="checkbox"/> Nursing Home Facility <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Hospice Care <input type="checkbox"/> Respite Care <input type="checkbox"/> Other (specify) _____		<b>Home and Community Services</b> <input checked="" type="checkbox"/> Home Health Care <input checked="" type="checkbox"/> Homemaker Services <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Respite Care <input type="checkbox"/> Hospice Care <input type="checkbox"/> Other (specify) _____	
Name of Facility		Name of Home and Community provider	
Contact person at Facility		Contact person at agency	
Address		Address	
Telephone number ( )	Fax number ( )	Telephone number ( )	Fax number ( )
<b>Date of confinement in Facility</b> Admission date: / / Discharge date: / /		<b>Date of Home and Community services</b> First day of services: / / Last day of services: / / <input type="checkbox"/> Ongoing services	

**Part 7 — Other insurance information**

Are you eligible or enrolled in Medicare Part A?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Medicare Part B?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you filing for reimbursement of expenses under Medicare? .....	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you filing for reimbursement of expenses under Medicaid? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you have any other long term care insurance policies? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, please provide company name, address, policy number, and daily or monthly benefit amount				
<b>Company Name</b>	<b>Address</b>	<b>Policy Number</b>	<b>Daily Amount</b>	<b>Monthly Amount</b>

Date / /	Name (print)	Signature
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**Important: Prior to submitting this completed form, please read the enclosed Fraud Notice.**

Allianz Life Insurance Company  
of North America

PO Box 59060  
Minneapolis, MN 55459-0060



**Authorization for Release of Health Information  
To Allianz Life Insurance Company of North America ("Company")**  
(This authorization complies with the HIPAA Privacy Rule)

Name of Insured (Please print)

Policy number

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, the Medical Information Bureau (MIB), employers, consumer reporting agencies, health plan administrators, government agencies, relatives, friends, neighbors, and others with whom I am acquainted ("Other Persons") that have any employment, law enforcement, financial, insurance or medical records or knowledge of me or my health, to give to the Company, its agents, its employees, its representatives and its reinsurers any such records and information. These include records and information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

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

This protected health information is to be disclosed under this Authorization so that the Company, its agents, employees, representatives, and reinsurers, may administer claims and determine or fulfill responsibility for coverage and provision of benefits in respect to the above Policy.

The Company, its agents, employees, representatives, and reinsurers may release information obtained by this Authorization to the MIB, reinsurers, and other persons and entities performing business or legal services in connection with my claim.

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. Except as stated above, a revocation is effective immediately after receipt by the Company. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization or revoke this Authorization, the Company may not be able to make any claim or benefit payments under the above Policy and a pending insurance action may be adversely affected.

I acknowledge that I have received a copy of this Authorization.

Signature of Insured or Personal Representative

Date

Description of Personal Representative's authority or relationship to Insured