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

Allianz

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	☐ Power of Attorney ☐ Legal Guardian	☐ 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	☐	☐	☐	/ /	/ /
Continence	☐	☐	☐	/ /	/ /
Dressing	☐	☐	☐	/ /	/ /
Eating	☐	☐	☐	/ /	/ /
Toileting	☐	☐	☐	/ /	/ /
Transferring	☐	☐	☐	/ /	/ /

[1]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

Facility Services	Home and Community Services
☐ Nursing Home Facility ☐ Assisted Living Facility ☐ Residential Care Facility ☐ Hospice Care ☐ Respite Care ☐ Other (specify)_____	☐ Home Health Care ☐ Homemaker Services ☐ Adult Day Care ☐ Respite Care ☐ Hospice Care ☐ 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 ( )
Date of confinement in Facility Admission date / / / Discharge date / /	**Date of Home and Community services** First day of services / / / Last day of services / / / ☐ Ongoing services

Part 7 — Other insurance information

Are you eligible or enrolled in Medicare Part A?	☐ Yes	☐ No
Medicare Part B?	☐ Yes	☐ No
Are you filing for reimbursement of expenses under Medicare?	☐ Yes	☐ No
Are you filing for reimbursement of expenses under Medicaid?	☐ Yes	☐ No
Do you have any other long term care insurance policies?	☐ Yes	☐ No

If yes, please provide company name, address, policy number, and daily or monthly benefit amount

Company Name	Address	Policy Number	Daily Amount	Monthly Amount

Date	Name (print)	Signature
/ /		

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

Allianz

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 _____