Privileged Choice® **Flex** Application and Forms

Company Submission Materials Enclosed

Complete and return the following forms
to Genworth Life Insurance Company:

- ☐ Coverage Selection
- ☐ Payment Authorization
- ☐ Application for Insurance
- ☐ Health Information Authorization (HIPAA Form)
- ☐ Long Term Care Insurance Personal Worksheet
- ☐ Potential Rate Increase Disclosure
- ☐ Acknowledgement of Release of Certain Health Information
- ☐ Couples Benefits Form (Optional)
- ☐ Beneficiary Designation Form (Optional)
- ☐ Replacement Notice (If Required)

Genworth®

Underwritten by Genworth Life Insurance Company, Richmond, VA

115971MOD-C WA 04/01/12

IMPORTANT INSTRUCTIONS FOR AGENTS/PRODUCERS

To avoid delays in processing your new business submission, be sure to complete the Application legibly and follow the instructions below.

1 Review Section A, Insurability Profile with the client. If the applicant answers "yes" to any question in this section, he/she may be uninsurable. You may want to contact the Pre-qualification hotline at 800 354.6892 before submitting an Application.

2 Complete the entire Application to avoid returned Applications and processing delays. Do NOT use correction fluid. Cross out and initial changes.

3 The fully completed Application must be received at Genworth Life's Administrative Office within 30 days of the date the Application is signed by the applicant(s.)

4 If an initial premium payment is being collected with the Application, please be sure to complete the Premium Receipt page in the Applicant Materials Booklet. A minimum of three (3) months premium must be submitted in order to be eligible for the Conditional Insurance Agreement (CIA) (only one month in NH for clients age 65 and older). If using Electronic Funds Transfer (EFT) or Credit Card payments, be sure to complete the Payment Authorization form. For questions, call 800 309.0047.

5 Review and/or complete the forms in the Applicant Materials Booklet and leave it with the applicant.

6 Confirm that the Application and all required forms have been signed where required and dated in all appropriate sections.

7 Prepare the client for the next steps.

MINIMUM UNDERWRITING REQUIREMENTS

Check the applicant's height and weight to see if they meet basic eligibility requirements using the Build Tables provided in:

- Long Term Care Insurance Underwriting Guide #85440
- Insurance Requirements and Underwriting Guidelines form #49566.

Provide applicants with the Guide and Checklist For Your Long Term Care Insurance Application (available online or by ordering form #81707), which explains the health interviews and other medical requirements that may be needed to process the application. Let applicants know that all costs associated with the interviews are paid for by us.

APPLICATION SUBMISSION CHECKLIST

Use this checklist to help ensure that you send in all necessary information.

- ◯ Fully completed Application and all required forms in the "Application and Forms" Company submission booklet.
- ◯ Check to be sure all signatures and dates are complete.
- ◯ If using Electronic Funds Transfer (EFT) for monthly premium deductions or initial Credit Card payments, be sure to complete and include the Payment Authorization Form.
- ◯ Include any optional forms needed (Requirements to Access Couples Benefits, Beneficiary Designation for Refund of Premium Rider or Replacement forms.)
- ◯ Health Information Authorization (HIPAA)
- ◯ Suitability form (Long Term Care Insurance Personal Worksheet)
- ◯ Potential Rate Increase Disclosure Notice
- ◯ Provide the applicant with the Applicant Materials Booklet, which includes the applicant copies of any state required forms, as well as the Outline of Coverage.

Submit the entire completed Application and Forms Booklet (with any collected premium payment) to:

Genworth Life Insurance Company, Administrative Office
3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

IMPORTANT NOTES

- Refund of Premium riders are not available with the Shared Coverage Benefit.
- Certain eligibility requirements must be met to qualify for the preferred health and couples discounts. The Couples Discount is 25% if only one becomes insured. Refer to the chart below:

	Couples Discount	Preferred Health Discount Applicant 1	Preferred Health Discount Applicant 2	Total Discount Applicant 1	Total Discount Applicant 2
2 Applicants; Both Issued Both Preferred	40%	10%	10%	50%	50%
2 Applicants; 1 Issued with Preferred Health	25%	10%	N/A	35%	N/A

- In addition to married couples, applicants who are not married but meet certain criteria may be eligible to apply for Survivorship, the Shared Benefit Rider or to receive a Couples Discount. Please refer to the "Requirements to Access Special (Couples) Benefits" form for an explanation of the state criteria and instructions on how to access these couples' benefits.

Genworth® Financial

Administrative offices:
Genworth Life Insurance Company
3100 Albert Lankford Drive
Lynchburg, VA 24501

Coverage Selection for Privileged Choice Flex Long Term Care Insurance

Coverage is intended to be federally tax-qualified long term care insurance within the context of Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191).

Applicant A *Print name*

.

Applicant B *Print name*

.

Coverage Selection

	Applicant A		Applicant B	
Shared Coverage Benefit	◯ Yes	◯ No		
	If Shared Coverage Benefit is chosen, both applicants must make identical selections below.			
Benefit Multiplier Months/Days Choose a Monthly or Daily benefit multiplier.	◯ Unlimited ◯ 120/3650 ◯ 96/2920 ◯ 72/2190	◯ 60/1825 ◯ 48/1460 ◯ 36/1095 ◯ 24/730	◯ Unlimited ◯ 120/3650 ◯ 96/2920 ◯ 72/2190	◯ 60/1825 ◯ 48/1460 ◯ 36/1095 ◯ 24/730
Monthly/Daily Maximum	$		$	
	◯ Per Day	◯ Per Month	◯ Per Day	◯ Per Month
	Choose a Monthly Maximum between $1,500 and $12,000 in $100 increments; or choose a Daily Maximum between $50 and $400 in $5 increments.			
Elimination Period	◯ 30 days ◯ 90 days	◯ 180 days ◯ 365 days	◯ 30 days ◯ 90 days	◯ 180 days ◯ 365 days
Elimination Period Type	◯ Service days*	◯ Calendar days	◯ Service days*	◯ Calendar days
	* Service days are days of Covered Care			
Waive Home and Community Care Elimination Period	◯ Yes	◯ No	◯ Yes	◯ No
Assisted Living Facility Maximum Percentage of Daily or Monthly Maximum	◯ 100%	◯ 50%	◯ 100%	◯ 50%
Home and Community Care Percentage of Daily or Monthly Maximum	◯ 100%	◯ 50%	◯ 100%	◯ 50%
Inflation protection / benefit increases Benefit increases not reduced by claims	◯ 5% Compound ◯ 3% Compound ◯ 5% Equal ◯ Future Purchase Option** ◯ None		◯ 5% Compound ◯ 3% Compound ◯ 5% Equal ◯ Future Purchase Option** ◯ None	
	**Future Purchase Option is not available with 10-Pay or Pay to 65.			

Other choices

	Applicant A		Applicant B	
Restoration Benefit	◯ Yes	◯ No	◯ Yes	◯ No
	Restoration Benefit not available with Shared Coverage Benefit or Unlimited Benefit Multiplier			
Transition Benefit	◯ Yes	◯ No	◯ Yes	◯ No
	Transition Benefit not available with Waiver of Home and Community Elimination Period			
Refund of Premium Benefit Refund of Premium not available with Shared Coverage Benefit.	◯ 10 year ◯ Graded* ◯ None		◯ 10 year ◯ Graded* ◯ None	
	Beneficiary designation for Refund of Premium Benefit is Your estate unless otherwise designated and submitted on a separate form. *Graded Refund of Premium is only available for ages 64 and younger.			

	Applicant A *Print name*	**Applicant B** *Print name*
	.	.

Other choices continued

Nonforfeiture Benefit	◯ Yes (Accept) ◯ No (Decline)	◯ Yes (Accept) ◯ No (Decline)
Survivorship Benefit	◯ 7 Years Enhanced ◯ None	◯ 7 Years Enhanced ◯ None

Survivorship only available for the couple who initially apply for and are both issued policies. Survivorship is not available for single applicants or when only one policy is issued. In such cases, premium will be reduced accordingly.

Discounts

Eligible for Preferred Health Discount

Did you answer "NO" to all parts of questions 1-7?
◯ Yes ◯ No ◯ Yes ◯ No

(If medical history is found inconsistent with your answers, premium will be adjusted accordingly.)

Eligible for Couples Discount
Criteria must be met.
See "Application Instructions."

◯ Yes ◯ No

If YES and second applicant is applying on this application, no further information is needed.
If second applicant is not applying on this application, please provide the following.

The second applicant on this form or the individual designated here will be the named individual for any Couples Discount, Survivorship Benefit or Shared Coverage Benefit, as applicable.

Print spouse/partner name
.

Social Security Number
.

Existing coverage number
.

Premium information

	Applicant A	**Applicant B**
Full modal premium	$	$
Premium Payments	◯ Lifetime ◯ 10 Pay ◯ Pay-to-65*	◯ Lifetime ◯ 10 Pay ◯ Pay-to-65*
Premium Payment mode	◯ Annual (1.0) ◯ Semi-annual (.51) ◯ Quarterly (.26) ◯ Monthly** (.09)	◯ Annual (1.0) ◯ Semi-annual (.51) ◯ Quarterly (.26) ◯ Monthly** (.09)

* Only available for ages 55 and younger.

** Automatic draft of checking account required. Must complete Payment Authorization Form.

MultiLife/List bill

List bill	◯ Yes ◯ No	◯ Yes ◯ No
MultiLife/List bill number	.	.

For Agent use only

Agent name	.	Agent producer code .
State in which application is signed	.	App. folder No. . 91051

Payment Authorization

Genworth Financial

Genworth Life Insurance Company
Administrative Office
3100 Albert Lankford Dr.
Lynchburg, Virginia 24501-4948

Applicant A *Print name*

Applicant B *Print name*

Initial premium

Complete only if paying initial premium by EFT or Credit Card

$ $

Amount of initial premium should match full modal premium in application. For CIA, three months minimum required. Only one month is allowed in CA and in NH for applicants over age 65.

Select electronic funds transfer or credit card

For any initial premium payments, Your Bank or Credit Card Account will be charged for the requested amount promptly after receiving authorization.

○ **Electronic Funds Transfer (EFT)**
- ○ Initial payment
- ○ Renewal payment only
- ○ Initial & renewal payments

○ Use same bank information for both applicants (optional)

Bank Name
Bank Account #
Bank Routing #
Account Holder Name (if different from Applicant)

Bank Name
Bank Account #
Bank Routing #
Account Holder Name (if different from Applicant)

○ **Credit Card**
(Available for initial payment only)

Credit card payment NOT available in the following application states: AK, CA, MD, NJ, NY, NC and PA.

○ Use same credit card for both applicants (optional)

○ Visa ○ MasterCard
Card Number
Exp (mm/yy)
Cardholder Name (if different from Applicant)

○ Visa ○ MasterCard
Card Number
Exp (mm/yy)
Cardholder Name (if different from Applicant)

Billing information

Complete only if Account/ Cardholder is not an Applicant

Account/Cardholder Name *Print*
Address
City
State
Zip

Terms and conditions

I authorize Genworth Life Insurance Company to collect the initial and/or recurring premiums as stated in this form from the Bank or Credit Card Account described in this form. I understand and agree that this Authorization is subject to the following conditions:

- This Authorization form must be completed in its entirety in order to be valid.
- Signing this Authorization does not mean that coverage is effective. Coverage is effective only as specified in the application or in the Conditional Insurance Agreement (CIA).
- Payment by EFT or Credit Card does not alter any contract issued by the Company.
- Any refund for coverage not taken or declinations will be made directly via check, not as a credit to the Bank or Credit Card Account. Otherwise, refunds will be applied in accordance with applicable laws.
- If the EFT or Credit Charge request is not honored, no further attempt to use the EFT or Credit Card to collect the premium will be made and Conditional Insurance Agreement (CIA) will not apply.
- Any refund of the premium will NOT include reimbursements for interest, fees or other obligations that the Financial Institution Credit Card company may impose.

Signatures

Applicant A Signature

X _____

Date (mm/dd/yyyy)

. _____

Account/Cardholder Signature
(if not an Applicant)

X _____

Date (mm/dd/yyyy)

. _____

Applicant B Signature

X _____

Date (mm/dd/yyyy)

. _____

Account/Cardholder Signature
(if not an Applicant)

X _____

Date (mm/dd/yyyy)

. _____

APPLICATION FOR INSURANCE

Genworth Life Insurance Company

Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501

A. INSURABILITY PROFILE

Applicant **A** YES	Applicant **A** NO		Applicant **B** YES	Applicant **B** NO
○	○	**1**. Are you covered by Medicaid (<u>not</u> the same as Medicare)?	○	○
○	○	**2**A. Do you use a Walker, Wheelchair or Quad Cane; Hospital Bed; Oxygen, Respirator or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair, Bathing, Dressing, Eating, Toileting, Bowel/Bladder control, or Walking?	○	○
○	○	B. Have you been advised to: receive home care, use an adult day care facility, enter a nursing home, enter an assisted care facility, or enter any other long term care facility?	○	○
○	○	**3**. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following: • ALS (Lou Gehrig's disease) • Alzheimer's Disease • Congestive Heart Failure (CHF) *in combination* with any of the following: Heart Attack or Angina; Emphysema/ Chronic Obstructive Pulmonary Disease (COPD); Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis • Cirrhosis of the Liver • Cystic Fibrosis • Dementia • Diabetes under treatment with Insulin or with a history of TIA, Heart Disease, or Circulatory/ Vascular Disease • Frequent or persistent forgetfulness or memory loss • Huntington's Chorea • Metastatic Cancer (spread from original site/location) • Multiple Sclerosis (MS) • Muscular Dystrophy • Organic Brain Syndrome • Parkinson's Disease • Senility • Stroke • Transient Ischemic Attack (TIA) within the past 5 years • TIA *in combination* with Diabetes or Heart Surgery • TIA two or more times	○	○
○	○	**4**. In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, or Stomach?	○	○
○	○	**5**. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection or tested positive for HIV or exposure to the HIV infection?	○	○

<u>PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:</u> If you answered YES to any of the questions in Part A, we suggest that you do not submit this application. If you answered NO to every question, please continue.

B. PERSONAL PROFILE

Print Clearly - Use black ink.

APPLICANT A

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title: _____

Name _____
(As it should appear on your policy)

○ Married ○ Single ○ Widowed

Social Security Number _____

Birthdate _____ Age _____ Birthplace (state) _____

○ Male ○ Female Height: ft. _____ in. _____ Weight: lbs. _____

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ ○ a.m. ○ p.m.

APPLICANT B

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title: _____

Name _____
(As it should appear on your policy)

○ Married ○ Single ○ Widowed

Social Security Number _____

Birthdate _____ Age _____ Birthplace (state) _____

○ Male ○ Female Height: ft. _____ in. _____ Weight: lbs. _____

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ ○ a.m. ○ p.m.

Resident Address _____
(Street Address Only, No P.O. Boxes -- Your policy will be issued based on this address.)

City _____ State _____ Zip _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

Print Name of Applicant A _____ Print Name of Applicant B _____

C. MEDICAL PROFILE

Applicant **A** YES ○ NO ○

6. In the past 5 years (10 years for cancer) have you: received medical advice or treatment; been medically diagnosed; or consulted with a health professional for any of the following conditions? If 'YES,' please check appropriate circles for ***each applicant (A and B)*** and explain under the DETAILS section.

Applicant **B** YES ○ NO ○

A		B
○	Alcoholism	○
○	Amputation	○
○	Angioplasty or Heart Surgery	○
○	Asthma or Chronic Bronchitis	○
○	Brain Disorder	○
○	Cancer (excl. Basal Cell of the Skin)	○
○	Carotid or other Arterial Surgery	○
○	Congestive Heart Failure	○
○	CREST Syndrome	○
○	Depression	○
○	Diabetes not treated with Insulin	○
○	Disabling Back or Spine Condition	○
○	Drug Addiction	○
○	Emphysema/COPD	○

A		B
○	Epilepsy, Seizures, or Convulsions	○
○	Fainting Spells or Blacking Out	○
○	Fibromyalgia	○
○	Heart Attack, Angina or Atrial Fibrillation	○
○	Hodgkin's Disease	○
○	Immune System Disorders	○
○	Injury due to Falls or Imbalance	○
○	Joint Replacement Surgery	○
○	Kidney Failure	○
○	Leukemia	○
○	Lupus	○
○	Mental Illness	○
○	Mental Retardation	○
○	Multiple Myeloma	○

A		B
○	Myasthenia Gravis	○
○	Organ Transplant	○
○	Osteoporosis	○
○	Post-Polio Syndrome	○
○	Paralysis	○
○	Rheumatoid Arthritis	○
○	Scleroderma	○
○	Skin Ulcers	○
○	Tremor	○
○	Other Conditions Causing Crippling or Limited Motion, or Requiring Adaptive Devices	○

If you need more space to answer the following questions, please use the DETAILS *section.*

Applicant **A** YES ○ NO ○

7. Within the past 5 years, have you:

Applicant **B** YES ○ NO ○

A. Smoked or used other tobacco products? ○ ○ ○ ○

B. Required assistance with managing medications, shopping, using transportation, or housekeeping/cooking? ○ ○ ○ ○

If YES to any, please explain.

Applicant A	Applicant B	Type of assistance	Reason
○	○	_____	_____
○	○	_____	_____

C. Received home health care; used an adult day care facility; been confined to a nursing home, assisted care facility, or other long term care facility? *If YES* to any, please explain. ○ ○ ○ ○

Applicant A	Applicant B	Date	Reason
○	○	_____	_____
○	○	_____	_____

D. Been medically advised to have surgery which has not been performed? ○ ○ ○ ○

If YES, please explain (including dates of scheduled surgeries).

Applicant A	Applicant B	Date	Surgery Type	Reason
○	○	_____	_____	_____
○	○	_____	_____	_____

E. Received Social Security Disability Insurance benefits? ○ ○ ○ ○

F. Taken any prescription medications for High Blood Pressure and/or any form of Arthritis? ○ ○ ○ ○

If YES, list each medication *and why it's needed.*

Applicant A	Applicant B	Medication	Why needed?
○	○	_____	_____
○	○	_____	_____
○	○	_____	_____
○	○	_____	_____

Print Name of Applicant A _____ Print Name of Applicant B _____

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
		8. Within the past 2 years, have you:		
○	○	A. Received Disability Income, Worker's Compensation, or any state disability benefit?	○	○
○	○	B. Had another Long Term Care insurance application denied by us or any other company? *If YES*, by what company?	○	○

Applicant A Company: _____ Applicant B Company: _____

9. Within the past 3 years have you:

A. Taken *any* prescription medications (not previously listed in this application)? *If YES*, list each medication *and why it's needed*.

Applicant A	Applicant B	Medication	Why needed?
○	○		
○	○		
○	○		
○	○		
○	○		

B. Been medically advised to enter or been confined to a hospital or other health care facility? *If YES*, please explain (including dates and reasons).

Applicant A	Applicant B	Date	Facility	Reason
○	○			
○	○			
○	○			

10A. Who is your primary care physician with most of your medical records?

Applicant **A**

_____
Doctor's Name

_____
Address

_____
City, State, Zip

( ) _____ _____
Phone No. Date last seen (Mo/Day/Yr)

_____
Reason Last Seen

Applicant **B**

_____
Doctor's Name

_____
Address

_____
City, State, Zip

( ) _____ _____
Phone No. Date last seen (Mo/Day/Yr)

_____
Reason Last Seen

B. Within the past 3 years have you consulted with or been treated by a licensed health care provider, ***other than your primary care doctor*** for any reason excluding eye doctors, podiatrists, and dentists? *If YES*, please complete the following.

Applicant A	Applicant B	Physician's Name	City, State	Specialty	Reasons Consulted/Treated	Date(s)
○	○					
○	○					
○	○					
○	○					

Print Name of Applicant A _____ Print Name of Applicant B _____

D. DETAILS

Provide condition, reason consulted/treated, dates from/to, and name, address and phone # of Health Care Professional/Facility. For medications, please provide only the name and reason for taking. Include the question number for the details being provided.

Applicant A Ques.#		**Applicant B** Ques.#	

⚠ *If you need more room to write, use a separate signed and dated sheet, and check here:* ◯

Print Name of Applicant A _____ Print Name of Applicant B _____

E. FAMILY HISTORY PROFILE

Applicant A YES	Applicant A NO	Applicant A UNKNOWN		Applicant B YES	Applicant B NO	Applicant B UNKNOWN
○	○	○	**11**A. Is your mother living?	○	○	○
	_____		B. What is your mother's current age, or her age at death?		_____	
			C. Did/Does your mother have any of the following illnesses?			
○	○	○	• Diabetes	○	○	○
○	○	○	• Coronary Artery Disease or any other form of Vascular Disease	○	○	○
○	○	○	• Alzheimer's or any other form of Dementia	○	○	○
○	○	○	**12**A. Is your father living?	○	○	○
	_____		B. What is your father's current age, or his age at death?		_____	
			C. Did/Does your father have any of the following illnesses?			
○	○	○	• Diabetes	○	○	○
○	○	○	• Coronary Artery Disease or any other form of Vascular Disease	○	○	○
○	○	○	• Alzheimer's or any other form of Dementia	○	○	○

F. CLIENT PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
○	○	**13**A. Do you work 20 or more hours a week outside your home? *If YES*, list occupation. Applicant A: Occupation: _____ Applicant B: Occupation: _____	○	○
○	○	B. Do you perform volunteer work? *If YES,* list type of work and list hours worked per week. Applicant A: Type of work: _____ ____hrs/week Applicant B: Type of work: _____ ____hrs/week	○	○
○	○	C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? *If YES*, please describe. Applicant A: Activities: _____ Applicant B: Activities: _____	○	○
○	○	**14**. Do you drive an automobile? *If YES*, provide approximate annual mileage: Applicant A: Mileage: _____ Applicant B: Mileage: _____	○	○
○	○	**15**. Do you live in some form of a residential retirement community? *If YES*, list the specific services that are received (e.g., housekeeping, laundry, meals): Applicant A: Services: _____ Applicant B: Services: _____	○	○

Print Name of Applicant A _____ Print Name of Applicant B _____

G. OTHER COVERAGE AND REPLACEMENT

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
○	○	**16**A. Do you have any accident and sickness or Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate (including health care service contract, health maintenance organization contract, or life insurance with Long Term Care coverage) in force or applied for? *If YES*, provide DETAILS below. Applicant A Company: _____ Long Term Care? ○ No ○ Yes Daily Benefit: $ _____ Applicant B Company: _____ Long Term Care? ○ No ○ Yes Daily Benefit: $ _____	○	○
○	○	B. If you have Long Term Care Insurance coverage with us, please list policy/certificate number(s): Applicant A Policy/certificate number(s): _____ Applicant B Policy/certificate number(s): _____	○	○
○	○	C. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy/certificate in force during the last 12 months? *If YES*, with which company? Applicant A Company: _____ Applicant B Company: _____ If that insurance lapsed, when did it lapse? Applicant A Lapse Date: _____ Applicant B Lapse Date: _____	○	○
○	○	D. Do you intend to replace ***any*** of your long term care, medical, or health insurance coverage with this policy? *If YES*, name company being replaced: Applicant A Company: _____ Applicant B Company: _____ **Agent:** *If YES*, be sure to fill out the Replacement Notice. Leave one copy with applicant; send one copy with application.	○	○

H. PROTECTION AGAINST UNINTENTIONAL LAPSE

*One of the circles **must be** checked.*

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A (Use for Individual and Shared Applications)

○ I elect NOT to designate any person to receive such notice.

○ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

If selecting this option, we recommend designating someone other than a spouse or agent.

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title:

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Relationship _____

Applicant B (Complete whenever there is a second applicant)

○ Same as applicant A.

○ I elect NOT to designate any person to receive such notice.

○ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

If selecting this option, we recommend designating someone other than a spouse or agent.

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title:

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Relationship _____

Print Name of Applicant A _____ Print Name of Applicant B _____

I. DECLARATIONS

No agent is authorized to: change, waive, or alter the terms and conditions of this application; accept risks; pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

REJECTION OF 5% COMPOUND INFLATION PROTECTION:

Check circle only if you have selected a benefit increase option other than 5% Compound.

Applicant **A**

◯ I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans with and without inflation protection, and I reject inflation protection of at least 5% Compound.

Applicant **B**

◯ I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans with and without inflation protection, and I reject inflation protection of at least 5% Compound.

AUTHORIZATION: I authorize Genworth Life Insurance Company, its insurance support organizations (such as EMSI), affiliates, and any reinsurers, to obtain information as to the diagnosis, treatment or prognosis of my physical and mental condition, other coverage and any other information needed to evaluate my application for insurance. Upon presentation of this authorization, or copy of it, they may obtain such information or records thereof from any physician, health professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, consumer reporting agency or insurance support organization or other person or organization which has such information. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This authorization includes information about drugs, alcoholism, and mental illness. I understand and agree that the Company or its representatives may conduct a phone or in-person interview as part of the underwriting process. I agree that this authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

RECEIPT: I have received and read the Privacy Notice. When I applied for insurance under this policy to be issued by Genworth Life Insurance Company, I also received the Outline of Coverage and the applicable Shopper's or Buyer's Guide.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

AGREEMENT: I agree that:

1) the answers contained herein are full, complete and true to the best of my knowledge and belief; and
2) this application will be part of the insurance policy for which I am applying; and
3) if I qualify, and an Initial Premium is paid, the policy will take effect on the date I sign the application, or on a date set by the Company if I request a later policy effective date.

REQUEST FOR A LATER POLICY EFFECTIVE DATE:

*Check circle **only** to request your policy become effective at a date later than the date you sign this application.*

INDIVIDUAL PLANS:	◯* Applicant **A**	◯* Applicant **B**
SHARED PLANS:	◯*	

* By checking this circle I acknowledge that, if my application is approved, the effective date of my coverage will be a later date to be set by the Company. I understand that the Company will consider any changes to my health *after* the Date of this Application in their underwriting decision, and that the Initial Premium will begin as of the Effective Date set by the Company.

CAUTION: If your answers on this application are incorrect or untrue, Genworth Life Insurance Company may have the right to deny benefits or rescind your insurance, subject to the Time Limit on Certain Defenses provision in the Policy.

X _____ Signature of Applicant **A**	X _____ Signature of Applicant **B**	X _____ Signature of Licensed and Appointed Insurance Producer/Agent/Representative
_____ Date Signed	_____ Date Signed	

Print Name of Applicant A _____ Print Name of Applicant B _____

J. AGENT INFORMATION

Name of Licensed and Appointed Agent (Please print)

Street Address

Producer Code # or Soc. Sec. #/Tax ID

E-mail Address

City, State, Zip

X
Signature of Soliciting Agent

( ) Phone No.

( ) Fax No.

Name of Licensed and Appointed Brokerage General Agency (if applicable)

Producer Code # of Brokerage General Agency

If more than one agent worked on this sale, please provide the following:

Name of Licensed and Appointed Agent

Percentage

Producer Code # or Soc. Sec. #/Tax ID

E-mail Address

Name of Licensed and Appointed Agent

Percentage

Producer Code # or Soc. Sec. #/Tax ID

E-mail Address

K. AGENT'S REPORT

To ensure against delays in processing please provide complete details.

Applicant **A** YES	Applicant **A** NO		Applicant **B** YES	Applicant **B** NO
○	○	**1**. Did you personally interview the applicant face to face and witness his or her signature? *If NO*, give details. Applicant **A**: _____ Applicant **B**: _____	○	○
○	○	**2**. Did you observe any physical or mental impairments with walking or talking, or any form of tremor? *If YES*, please explain. Applicant **A**: _____ Applicant **B**: _____	○	○
		3. List other health insurance policies sold by you to the applicant. Applicant **A**: _____ Applicant **B**: _____		
		4. List health insurance policies sold by you to the applicant in the last five years that are no longer in force. Applicant **A**: _____ Applicant **B**: _____		

61074 02/08/05

Genworth Life Insurance Company
Long Term Care Insurance Division
Administrative Office:
3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

This is a HIPAA Compliant Authorization

HEALTH INFORMATION AUTHORIZATION

I authorize the use and disclosure of health information about me as described herein.

Purpose: My health information may be disclosed under this Authorization so that Genworth Life Insurance Company may (1) underwrite my application for coverage, make eligibility, risk rating, policy/certificate issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or provide coverage and benefits; (4) administer coverage; and (5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with Genworth Life Insurance Company.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, Human Immunodeficiency Virus (HIV) antibodies, Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC).

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company; its vendors including but not limited to, ReleasePoint, Examination Management Services, Incorporated (EMSI) and APS Workflow, Inc.; its insurance support organizations; its affiliates and reinsurers. A copy of my application may also be attached to any policy/certificate of a co-applicant who is issued coverage as a result of the same application.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; Pharmacy Benefits Manager; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Statements of Understanding: I understand that:

- I will receive a copy of this Authorization; and that a copy of it is as valid as the original.
- If I do not sign this Authorization, or revoke it by writing to Genworth Life Insurance Company at its Administrative Office, the company may decline my application.
- If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization.
- Some health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if health information is disclosed to persons or organizations that are not subject to health information privacy laws, such persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of the information.
- This Authorization will be valid for 24 months from the date signed.

Printed Name of Applicant A	Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN
Signature of Applicant A		Date Signed
Printed Name of Applicant B	Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN
Signature of Applicant B		Date Signed

Other Important Information

Producer Compensation: When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy/certificate, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy/certificate is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy/certificate. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy/certificate premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed agent can sell insurance polices from other insurance carriers, those carriers may pay compensation that differs from ours.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and *ask* you to fill out the rest to help you and the company decide if you should buy this policy.

SECTION A

Premium Information

Policy Form #: 7052 or state equivalent

The premium for the coverage you are considering will be: (Complete *only* the premium for the desired payment frequency.)

$ annually $ semi-annually $ quarterly $ monthly

Type of Policy Guaranteed renewable.

The Company's Right to Increase Premiums The company has the right to increase premiums based on premium class; provided it raises premiums for all similar policies issued in the same state and on the same policy form.

Rate Increase History The company has sold long term care insurance since 1974 and has sold this policy since 2011. The company has not raised its rates on this policy form in this or any other state, but in the past 10 years it has raised its rates on similar policy forms that are no longer available for sale. *Following is a summary of the rate increases:*

Policy Form Series	Years Available for sale	Percentage of Increase[1]	Effective Year[2]
6465, 6026, 6318, 6322, 6328, 6394, 6395	1974-1989	0-8%	2007-2013
6484, 6667, 7003, 7012, 7021, 50000, 50001, 50003, 50004, 50013, 50018, 50020, 50021, 50022, 50023, 50024, 50029, 50100, 50107, 51000	1988-1998	0-9%	2007-2013
7000, 7002, 7011, 7020, 7022, 50024, 50027, 50109, 50110, 51001, 51002	1993-1999	0-12%	2007-2013
		0-18%	2011-2013
7011, 7012, 7030, 7031, 7032, 7033, 7034, 50024, 51005, 51006, 51007	1997-2003	0-11%	2007-2013
		0-18%	2011-2013

[1] Varies by state

[2] Future effective date reflects increases requested but not yet implemented.

Questions Related to Your Income

How will you pay each year's premium? ◯ From my Income ◯ From my Savings/Investments ◯ My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

◯ Yes ◯ No — *If you have not considered this possibility, please do not proceed with the application until doing so.*

SECTION B

What is your annual income? (check one)

◯ Under $10,000 ◯ $10,000-$20,000 ◯ $20,001-$30,000 ◯ $30,001-$50,000 ◯ Over $50,000

How do you expect your income to change in the next 10 years? (check one)

◯ No change ◯ Increase ◯ Decrease

If you will be paying with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ◯ Yes ◯ No

If not, how will you pay for the difference between future costs and your daily benefit amount?

◯ From my Income ◯ From my Savings/Investments ◯ My Family will Pay

The national median annual cost of care in 2010 was $75,190 ($206 per day), but this figure varies across the country. In 10 years the national median annual cost would be about $122,477, if costs increase 5% annually.

Select Elimination Period you are considering. The approximate cost of care for that period (based on a national median cost of $206/day) is shown for each elimination period choice.

◯ 30 Days ($6,180) ◯ 90 Days ($18,540) ◯ 180 Days ($37,080) ◯ 365 Days ($75,190)

How are you planning to pay for your care during the Elimination Period? (check one)

◯ From my Income ◯ From my Savings/Investments ◯ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

◯ Under $20,000 ◯ $20,000-$30,000 ◯ $30,001-$50,000 ◯ Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

◯ Stay about the same ◯ Increase ◯ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET *continued*

DISCLOSURE STATEMENT

Check one: ○ The answers to the preceding questions accurately describe my financial situation.
○ I choose not to complete this information (in section B on the prior page), and I have signed the Verification of Financial Non-Disclosure.
NOTE: Section A of this worksheet must be completed even if you do not disclose your financial information.

YOU MUST CHECK THE CIRCLE BELOW TO ACKNOWLEDGE THAT YOU HAVE READ THE FOLLOWING STATEMENT. PLEASE SIGN BELOW.

○ **(THIS CIRCLE MUST BE CHECKED)** I acknowledge that the carrier and/or its Agent/Producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures.
I understand that the rates for this policy may increase in the future.

Applicant A Signature	Printed Name	Date *mm/dd/yyyy*
X		| |
Applicant B Signature	Printed Name	Date *mm/dd/yyyy*
X		| |

I explained to the applicant the importance of completing this information.

Agent/Producer's Signature	Agent/Producer's Printed Name	Date *mm/dd/yyyy*
X		| |

Complete this section ONLY if your Agent/Producer has advised you that this policy may not be suitable for you.
My Agent/Producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Applicant A Signature	Date *mm/dd/yyyy*	Applicant B Signature	Date *mm/dd/yyyy*
X	| |	**X**	| |

In order for us to process your application, please return this signed statement to Genworth Life Insurance Company, along with your application. The company may contact you to verify your answers.

VERIFICATION OF FINANCIAL NON-DISCLOSURE

Please check below and return this form with your signed Personal Worksheet.

○ Yes, I wish to purchase this coverage. I still choose not to complete the financial information required in the **Long Term Care Insurance Personal Worksheet**. Please resume your review of my application.

○ No, I have decided not to buy long term care insurance at this time.

Applicant A Signature **X**	Printed Name	Date *mm/dd/yyyy* | |
Applicant B Signature **X**	Printed Name	Date *mm/dd/yyyy* | |

An approved policy WILL NOT BE ISSUED until the Long Term Care Insurance Personal Worksheet (and if applicable, the Verification of Financial Non-Disclosure) has been fully completed and received by the company.

Complete and submit this form with the application to:
Genworth Life Insurance Company
Long Term Care Insurance Division
3100 Albert Lankford Drive
Lynchburg, Virginia 24501-4948

LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

1. The **annual premium rate** that is applicable to you and that will be in effect until a request is made and approved for an increase is $ _____.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective on the next policy anniversary date.

4. **Potential Rate Revisions:** *This policy is Guaranteed Renewable.* This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:
   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

I have read the above information concerning "Potential Rate Increases."

Applicant A Signature	Date
Applicant B Signature	Date

CONTINGENT NONFORFEITURE

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care insurance coverage, if:
- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose the Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:
- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500, for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

(over)

Company Copy – Complete and return a signed copy with your application to Genworth Life Insurance Company.

CONTINGENT NONFORFEITURE

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the following chart:

   Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days after the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will also change in the following ways:

a. The total lifetime amount of benefits your reduced paid-up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

Genworth Financial

Genworth Life Insurance Company

Please print using black ink.

ACKNOWLEDGMENT OF RELEASE OF CERTAIN HEALTH RELATED INFORMATION

By signing below, I hereby acknowledge that Genworth Life Insurance Company ("Company") may release, and/or make available, certain information regarding my health or medical records to the Company Sales Representative/Agent ("Representative") referenced below. I understand that the purpose of providing this information to my Representative is to better assist my Representative in the processing of my application for Long Term Care Insurance[1], including certain premium pricing and underwriting considerations.

In the event that coverage is declined, I understand that information related to the declination of coverage will be provided to my Representative, including certain medical information. I further understand that information regarding Sensitive Medical Histories will not be released or made available to my Representative. This includes, but is not limited to, HIV, alcohol or drug abuse, mental and psychiatric disorders, cognitive impairments or medical information that may be restricted by state law.

All Medical information provided to your Representative will also be provided to you, as the applicant(s) for coverage.

I hereby acknowledge that the Company may release the information described above to the Representative identified below:

Representative Name	Phone Number
Address of Representative	

In addition, I understand that:

- At any time prior to the disclosure of my health or medical records to my Representative, I may send a written notice to the Company, at the address shown below, requesting that the Company not disclose my health or medical records to my Representative.

Printed Name of Applicant	Application Date
Applicant's Signature	Today's Date

Printed Name of Applicant	Application Date
Applicant's Signature	Today's Date

Return completed form to:
Medical Records – NB
Long Term Care Insurance Division
P. O. Box 40004
Lynchburg, Virginia 24506
or fax to 800 456.8329.

[1]Products underwritten by Genworth Life Insurance Company

REQUIREMENTS TO ACCESS SPECIAL (COUPLES) BENEFITS

Married couples are eligible to apply for our Shared Benefit policy or our Shared Coverage Rider or to receive a couples discount on our Individual plans. If you are not married but meet the criteria below, you may be eligible for a Shared Benefit policy or Shared Coverage Rider or to receive a couples discount on an Individual plan.

Criteria to Qualify for Couples Benefits: Two people who, at the time of application

- are named in a valid Certificate or License of Civil Union issued by your state; or
- are and have been living together for the past three consecutive years in a committed relationship as partners or family members; and
  - are committed to sharing basic living expenses; and
  - are not married to each other, or to anyone else; and
  - if related, must belong to the same generation of the same family, (e.g., brothers, sisters, cousins)

If you meet the criteria listed above, both applicant signatures are required below.

Applicant's Signature	Printed Name of Applicant	Date *mm/dd/yyyy*
X		
Applicant's Signature	Printed Name of Applicant	Date *mm/dd/yyyy*
X		
Agent's Signature	Printed Name of Agent	Date *mm/dd/yyyy*
X		

This form MUST be submitted with the application(s) for couples discount or Shared Benefit policy or Shared Coverage Rider eligibility consideration.

Submit completed form, along with application to:
Long Term Care Insurance Division
3100 Albert Lankford Drive
Lynchburg, Virginia 24501-4948

Genworth Financial Genworth Life Insurance Company

BENEFICIARY DESIGNATION FOR LONG TERM CARE INSURANCE

Complete only if you have selected a Refund of Premium on Death Benefit.

Payment will default to the estate of the deceased if no beneficiary is named, or if form is submitted incomplete. Please complete all fields for a Primary and Contingent Beneficiary.

Beneficiaries may be changed at any time, unless made irrevocable by checking here: ◯ **Irrevocable**

Primary Beneficiary for Applicant A

Name (Last, First, MI - or - Name of Trust) | Trustee Name

DOB or Trust Date (mm/dd/yyyy) | Address | City | State | Zip

SSN/Tax ID | Gender ◯ Male ◯ Female | Allocated Percentage _____% | (Proceeds will be split evenly among named beneficiaries if no allocation provided)

Additional Beneficiary for Applicant A (Optional) ◯ Primary ◯ Contingent

Name (Last, First, MI - or - Name of Trust) | Trustee Name

DOB or Trust Date (mm/dd/yyyy) | Address | City | State | Zip

SSN/Tax ID | Gender ◯ Male ◯ Female | Allocated Percentage _____% | (Proceeds will be split evenly among named beneficiaries if no allocation provided)

Primary Beneficiary for Applicant B

Name (Last, First, MI - or - Name of Trust) | Trustee Name

DOB or Trust Date (mm/dd/yyyy) | Address | City | State | Zip

SSN/Tax ID | Gender ◯ Male ◯ Female | Allocated Percentage _____% | (Proceeds will be split evenly among named beneficiaries if no allocation provided)

Additional Beneficiary for Applicant B (Optional) ◯ Primary ◯ Contingent

Name (Last, First, MI - or - Name of Trust) | Trustee Name

DOB or Trust Date (mm/dd/yyyy) | Address | City | State | Zip

SSN/Tax ID | Gender ◯ Male ◯ Female | Allocated Percentage _____% | (Proceeds will be split evenly among named beneficiaries if no allocation provided)

Signatures

Signature of Applicant A | Printed Name of Applicant A | Date (mm/dd/yyyy)

X

Signature of Applicant B | Printed Name of Applicant B | Date (mm/dd/yyyy)

X

Signature of Witness | Printed Name of Witness | Date (mm/dd/yyyy)

X

Submit completed form, along with application, to:
Long Term Care Insurance Division, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

37749 06/01/11

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

Genworth Life Insurance Company
Administrative Office: 3100 Albert Lankford Drive Lynchburg, Virginia 24501-4948

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance or long term care insurance coverage and replace it with an individual long term care insurance policy issued by Genworth Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care insurance coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT/PRODUCER: (Use additional sheets as necessary) I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy.
2. State law provides that your replacement policy may not contain new pre-existing conditions or probationary periods. The policy you are applying for has no such pre-existing conditions or probationary periods.
3. If you are replacing existing long term care insurance, you may wish to secure the advice of your present insurer or its agent/producer regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Insurance Producer, Agent, Broker, or other Representative Agent	Print Name and Address of Insurance Producer or other Representative of Agent or Broker
X _____	

Signature of Applicant **A**	The above "Notice to Applicant" was delivered to me on:	Date
X _____		/ /

Signature of Applicant **B**	The above "Notice to Applicant" was delivered to me on:	Date
X _____		/ /

Company Copy – Complete and return a signed copy with your application to Genworth Life Insurance Company

Insurance and annuity products:	• **Are not** deposits. • **May** decrease in value.	• **Are not** insured by the FDIC or any other federal government agency. • **Are not** guaranteed by a bank or its affiliates.