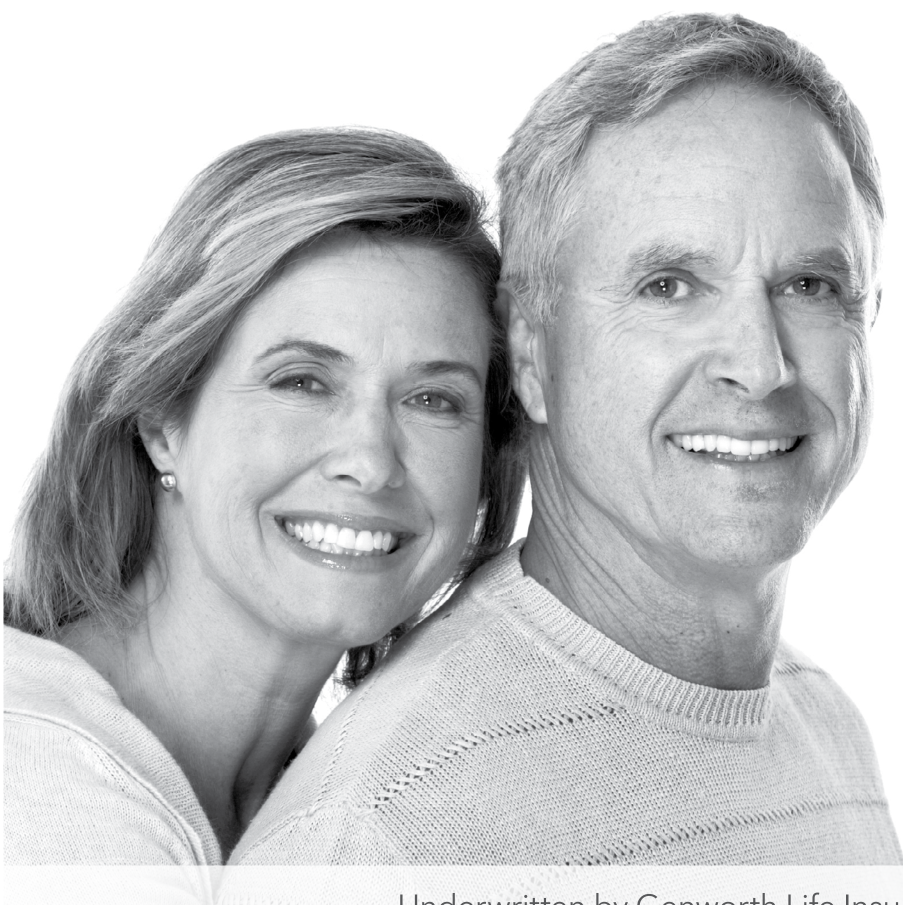
Application for Life Insurance

☐ Life Ready℠ UL II
☐ Colony℠ Term

Company Submission Materials Enclosed



Complete and return the following forms to Genworth:

- ☐ Part 1 Application
- ☐ Temporary Insurance Application and Agreement (TIAA)
- ☐ Health Information Authorization (HIPAA Form)
- ☐ Electronic Funds Transfer (EFT) Authorization
- ☐ HIV Notice and Consent
- ☐ Employer's Notice and Consent (If Required)
- ☐ Replacement Form (If Required)

Underwritten by Genworth Life Insurance Company, Richmond, VA and Genworth Life and Annuity Insurance Company, Richmond, VA

Licensed Insurance Agent Checklist for Life Application Part I

Please complete this application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. If special mailing envelopes have been provided, submitting the application in such an envelope will help avoid delays in processing your client's application. We sincerely appreciate your business.

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

Be sure to...

- ◯ Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- ◯ Make sure that the circle for the appropriate Insurer is marked in item 4.a. on Page 2.
- ◯ Ask all questions and fully and accurately record all answers given – the application will be part of any policy issued.
- ◯ Enter the Proposed Insured's SSN, date of birth, address and phone numbers.
- ◯ Enter each beneficiary's SSN, date of birth, address and phone numbers – it will help us locate the beneficiary at time of claim.
- ◯ Print in dark ink.
- ◯ Obtain all necessary signatures.
- ◯ Complete and sign the Licensed Insurance Agent's report, located after the application.
- ◯ Promptly schedule any required medical exam.
- ◯ Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- ◯ If you accept payment with the application:
  - Accept payment only in the form of a currently dated check or money order made payable to the selected Insurer.
  - Enter the full amount accepted in Section 7.f. on Page 3.
  - If the answer to any of the questions is "Yes," the Proposed Insured is not eligible for temporary coverage, and no TIAA form or premium should be accepted.
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it. Point out that the date of the policy will be the TIAA date and premiums will be due from that date.
  - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
  - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application – Part I, including the ORIGINAL of the TIAA to the Insurer marked in item 4.a. on Page 2.
- ◯ For Term and Excess Interest Whole Life plans – explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated Annual Percentage Rates (APRs) are available and will be provided on request.

DO NOT...

- ✕ **Use pencil or correction fluid.**
- ✕ **Attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.**
- ✕ **Promise or imply that we will provide insurance.**
- ✕ **Accept payment in the form of cash/currency or Traveler's checks.**
- ✕ **Accept a check or money order made payable to you or with the payee left blank.**
- ✕ **Accept payment when the amount applied for plus existing insurance with the Insurer exceeds $1,000,000.**
- ✕ **Accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.**
- ✕ **Accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.**

Genworth®

Genworth Life and Annuity Insurance Company, Richmond, VA
Genworth Life Insurance Company, Richmond, VA

Genworth®

3100 Albert Lankford Drive
Lynchburg, VA 24501

Application for Individual Life Insurance – Part I

○ Genworth Life Insurance Company (GLIC)
○ Genworth Life and Annuity Insurance Company (GLAIC)

Please print all answers clearly

1. Proposed Insured information

First name ▪ | Middle name ▪ | Last name *(include maiden name)* ▪

○ Male ○ Female | Date of birth ▪ | State/Country of birth ▪ | Social security number ▪

Home address ▪ | City ▪ | State ▪ | Zip code ▪

Email address ▪ | How long at home address? ▪

• **Is the Proposed Insured a United States citizen?** ○ Yes ○ No ***If "No,"*** *complete the Resident Alien Supplement form.*

Driver's license number/State ▪ | **Marital status** *Select one* ○ Single ○ Married ○ Divorced ○ Widowed

Home phone number ▪ | Work phone number ▪ | Cell phone number ▪

Occupation *(include duties)* ▪

Employer name and address ▪ | How long with employer? ▪

2. Owner information *Complete ONLY if Owner is someone other than the Proposed Insured. If Trust, give full name of trust and date of trust agreement.*

Owner (Full Name) ▪

Address ▪ | City ▪ | State ▪ | Zip code ▪

Relationship to Proposed Insured ▪ | Email address ▪

Social security/Tax ID number ▪ | Date of birth/Trust ▪

Home phone number ▪ | Work phone number ▪ | Cell phone number ▪

Owner Type *Select One* ○ Individual ○ Trust ○ Corporation ○ Limited liability company ○ Limited liability partnership ○ General partnership ○ Sole proprietor ○ Other *(Specify)*: ....

If Owner above is an individual, complete citizenship information below.
• Is the Owner a United States citizen? ○ Yes ○ No State/Country of birth ▪
If "No," complete the *Owner Resident Alien Supplement form.*
If Owner above is a business, complete the business questions below.

Purpose of business ▪ | State/country of incorporation/formation ▪ | Date of incorporation/formation ▪

Contingent Owner (Full Name) ▪

Address ▪ | City ▪ | State ▪ | Zip code ▪

Relationship to Proposed Insured ▪ | Email address ▪

Social security/Tax ID number ▪ | Date of birth/Trust ▪

Home phone number ▪ | Work phone number ▪ | Cell phone number ▪

Contingent Owner Type *Select One* ○ Individual ○ Trust ○ Corporation ○ Limited liability company ○ Limited liability partnership ○ General partnership ○ Sole proprietor ○ Other *(Specify)*: ....

2. Owner information *continued*

If Contingent Owner above is an individual, complete citizenship information below.
- Is the Contingent Owner a United States citizen? ○ Yes ○ No State/Country of birth

If "No," complete the *Owner Resident Alien Supplement form.*

If Contingent Owner above is a business, complete the business questions below.

Purpose of business | State/country of incorporation/formation | Date of incorporation/formation

3. Beneficiary information *If percentage shares are not given, they will be equal. Use section 12* ***REMARKS*** *to name additional beneficiaries.*

Primary Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Primary Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

Contingent Beneficiary (Full Name)

Address | City | State | Zip code

% Share | Relationship to Proposed Insured | Social security/Tax ID number | Date of birth/Trust

Home phone number | Work phone number | Cell phone number

4. Amount and plan of insurance

a. Insurer *Select one* ○ GLIC ○ GLAIC

b. Plan of insurance:

c. Amount of insurance:
$

5. Death benefit (Universal Life only)

○ Level (specified amount only)
○ Increasing (specified amount only)
○ Scheduled Increases (if available)
  ○ Simple %
  ○ Compound %

6. Riders (If available with Plan)

○ Waiver of Premium (Term)
○ Waiver of Monthly Deduction (UL)
○ Children's Term Insurance: units
○ Accelerated Benefit Rider (IUL)
○ Other (amount and description)

7. Premiums

a. Payment method: ○ Electronic Funds Transfer (EFT) ○ Direct Bill ○ Other *(Specify)*:

b. Payment mode: ○ Monthly (EFT only) ○ Quarterly ○ Semiannual ○ Annual ○ Single

c. Automatic Premium Loan (if available): ○ Yes ○ No

d. Send Premium Notices to: ○ Insured ○ Owner ○ Other *(Specify)*:

e. Premium source: ○ Salary ○ Investments ○ Savings ○ Gifts/Inheritance ○ Other *(Specify)*:

f. Amount remitted in exchange for Temporary Insurance: $

8. Proposed Insured's tobacco and nicotine use *Additional space for details is available in section 12* ***REMARKS****.*

a. Mark the **one** item that best describes your history of tobacco and other nicotine product use:
○ Never used ○ Totally stopped ○ Use now

b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in section 12 ***REMARKS***.
○ Less than 1 ○ 1 or more/less than 2 ○ 2 or more/less than 3 ○ 3 or more/less than 5 ○ 5 or more

9. Proposed Insured's Insurance Needs *Complete either the Personal or Business section. Explain "Yes" answers in section 12* ***REMARKS****.*

a. Personal: ○ Income replacement ○ Debt repayment ○ Estate conservation ○ Other

1. Personal Finances: Gross annual income $ Total assets $ Total liabilities $

2. Within the past 5 years, have you filed for bankruptcy or had any judgments, collections or liens filed against you? ○ Yes ○ No

b. Business: ○ Buy-Sell ○ Key employee ○ Secure credit ○ Other

1. Business Finances: Total assets $ Total liabilities $ Net worth $

2. What percentage of the business do you own? %

3. Your gross annual salary (include bonus) $

4. Is business insurance applied for or in force on other key members of the business? ○ Yes ○ No
(Explain either answer in section 12 ***REMARKS****.)*

5. Within the past 5 years, has the business filed for bankruptcy or had any judgments, collections or liens against it? ○ Yes ○ No

10. Proposed Insured's existing insurance/replacement *Additional space for details is available in section 12* ***REMARKS****.*

a. Do you have existing life insurance or annuities? ○ Yes ○ No

b. If "Yes," to Question 10.a. will the insurance applied for in this application replace, end or change any existing life insurance or annuities? *(If "Yes," you may be required to review and sign additional forms.)* ○ Yes ○ No

c. If "Yes," to Question 10.a. list all existing life insurance policies and annuity contracts. *For additional policies/contracts, use section 12* ***REMARKS****.*

Full name of company
To be replaced? ○ Yes ○ No

Amount $
Year issued
Beneficiary(ies)

Full name of company
To be replaced? ○ Yes ○ No

Amount $
Year issued
Beneficiary(ies)

Full name of company
To be replaced? ○ Yes ○ No

Amount $
Year issued
Beneficiary(ies)

11. Proposed Insured's History *Explain "Yes" answers in section 12* ***REMARKS***.

a. Do you have any other application or informal inquiry for life insurance pending in any company or society? ○ Yes ○ No

b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium? ○ Yes ○ No

c. Have you ever been convicted of a misdemeanor or felony? ○ Yes ○ No

d. In the past 5 years, have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy related payment? ○ Yes ○ No

e. In the past 5 years, has your driver's license been suspended or revoked? ○ Yes ○ No

f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? ○ Yes ○ No

g. In the past 5 years have you flown, or do you intend within the next 2 years to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (*If "Yes," complete Aviation Supplement*) ○ Yes ○ No

h. In the past 2 years have you engaged in, or do you intend within the next 2 years to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? ○ Yes ○ No
(*If "Yes," complete appropriate activities Supplement[s]*)

i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (*If "Yes," complete Foreign Residence/Travel Supplement*) ○ Yes ○ No

12. Remarks

Please use this section to provide full details to all "Yes" answers from previous sections. **Include question number and section/letter number.**

If beneficiaries are needed beyond those listed in section 3, please provide full details here.

Use application overflow form if additional space is needed.

13. Authorization to collect and disclose information

Information	Information means facts about the Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation.
Source	Medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; facilities or offices staffed or run by care providers; insurers; reinsurers; MIB; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.
Insurer	Genworth Life Insurance Company and Genworth Life and Annuity Insurance Company
Proposed Insured	The Proposed Insured is the person whose life is proposed to be insured.
Authorization	Authorization to Collect and Disclose Information.
MIB	MIB is the medical information bureau known as MIB, Inc.

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured's behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

This Authorization will be valid for the period of time permitted by applicable law, in the state where the policy was delivered or issued for delivery, after the date this Application - Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

14. Representations

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner's insurance needs.

I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

State in which owner signed application	State in which policy will be delivered	
Signature of Proposed Insured X	Date	Signature of Owner *If not Proposed Insured* X
Licensed Insurance agent signature X	Licensed Insurance agent name printed	
License No.	Managing agency/Brokerage No.	
Licensed Insurance agent signature X	Licensed Insurance agent name printed	
License No.	Managing agency/Brokerage No.	

Genworth
3100 Albert Lankford Drive
Lynchburg, VA 24501

Licensed Insurance Agent's Report

from Genworth Life Insurance Company and Genworth Life and Annuity Insurance Company

- **Submit with Application for Life Insurance - Part I**

1. Agent Information

First name | Middle initial | Last name | Agent's company code no.

Last four of social security no./tax ID no. | Phone number | Fax number

a. Does the proposed insured have any existing life insurance or annuity? ○ Yes ○ No
Is this insurance applied for intended to replace, end or change any existing insurance or annuity? ○ Yes ○ No
If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods may apply.

b. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? ○ Yes ○ No

c. Has a medical or paramedical exam been scheduled? *If "Yes," give date and Provider with whom scheduled.* ○ Yes ○ No
Date (Mo. Day Yr.) | Provider's name

d. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.
Amount $ | Reason

e. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.
Father | Mother
Siblings (name and amount)

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Licensed insurance agent signature
X
Date of signature

2. Managing Agency/Brokerage Report

Managing Agency/Brokerage name | Managing Agency/Brokerage No. | Email address | Date

3. Licensed Insurance Agents to Receive Commission *Complete for each licensed agent to receive commission.*

Total Commission Share(s) to equal 100%. Each licensed agent will share equally unless otherwise indicated.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.
Address | City | State | Zip code
Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.
Address | City | State | Zip code
Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.
Address | City | State | Zip code
Email address | Commission share | Company code no.

First name | Middle initial | Last name | **Last four** of social security no./tax ID no.
Address | City | State | Zip code
Email address | Commission share | Company code no.

INDIVIDUAL LIFE INSURANCE APPLICATION - OVERFLOW FORM

○ Genworth Life Insurance Company ○ Genworth Life and Annuity Insurance Company
3100 Albert Lankford Drive, Lynchburg, VA 24501

PROPOSED INSURED

a. Full Name (First)	(Middle)	(Last)	b. Date of Birth (Mo./Day/Yr.)	c. Social Security Number

DETAILS (Provide explanations and requested information. Identify applicable item number and letter.)

I represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and (2) **except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first premium is paid.**

Signature of Proposed Insured

Date signed

Signature of Owner (if other than Proposed Insured)

Signature of Licensed Insurance Agent or Examiner

Notice to Proposed Insured and Owner

Genworth Life Insurance Company • Genworth Life and Annuity Insurance Company
700 Main Street • Lynchburg, VA 24504

Thank you for your application. We greatly appreciate your completing each part truthfully and accurately. This notice tells you what to expect after completing the Application - Part I. If you have any questions, please ask the soliciting licensed insurance agent (licensed agent). The licensed agent should gather information about your personal situation, insurable needs and financial objectives and explain how the insurance recommendations are appropriate to fulfill those needs and objectives. When deciding insurance needs, consider the following: the losses you want to protect against; the kind of insurance; how long you will need the coverage; your future liquidity needs, e.g., college funding; your ability to pay the planned premium; taxes; and your other financial assets, e.g., Social Security, pension plans.

Policies Available Only in English

Our insurance applications, illustrations, disclosures and our insurance policies are available only in English. In addition, all of our servicing to our policyholders is only in English. You are responsible for fully understanding these English materials. We do not permit our insurance agents to translate these materials to a different language and you may not rely on any translation by our insurance agent.

What Happens Next

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may seek information from other sources to help us in our evaluation. During underwriting we may find that we are unable to insure you, to give you the amount of insurance you have applied for, or that we are only able to give insurance to you on a modified basis or at a rate that is greater than our lowest rate. Some of the factors we take into account in the underwriting process include medical history, driving history, history of tobacco use, activities such as aviation, any criminal history, and financial information. Available premium classifications are indicated below. Not all premium classifications are available with all products.

Preferred Best No Nicotine
Preferred No Nicotine
Select No Nicotine
Standard No Nicotine
Preferred Nicotine
Standard Nicotine
Substandard - Tables B – P (2 – 16)
(Table rated cases are issued as either No Nicotine or Nicotine, as appropriate. Flat extra premiums may also be applied.)

Physical Exam

Virtually all Proposed Insureds are required to take a physical exam. The exam is done by a qualified examiner and takes approximately 30 minutes. During the exam, you should expect the following: to provide your medical history; to be weighed and measured; to have an EKG (not always required); to provide a blood or saliva sample and a urine sample; to have your blood pressure and pulse taken.

Here are some of the ways you can help with the exam process:

- Schedule your exam within 24 hours after you complete the Application - Part I
- Have a list of the names and addresses of all licensed health care providers and facilities seen during the past 20 years and be prepared to provide reasons, dates and any treatments received as a result of those visits
- Do not eat or drink (except water) for 12 hours prior to your scheduled exam time
- Have a list of all medications taken in the past five years
- Have a photo ID ready, e.g., driver's license, passport, or greencard

Important Information

Contestability

Because your application will be our primary source of information, we strongly urge you to review the completed application closely for accuracy. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. In addition, you may be violating state law if you knowingly conceal material facts or submit an application that contains materially false information.

Replacement of Existing Coverage

If you have existing coverage, answer "yes" to this question in the application. If you intend to replace existing coverage, tell the licensed agent of your intention and answer "yes" to the replacement question in the application. State law may require the licensed agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, answer the replacement question "yes." Doing so may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. Stopping premium payments, surrendering, or borrowing from an existing policy as a result of applying for this policy could be considered replacement. State law may define replacement to include other situations. Ask the licensed agent if you are unsure about replacement.

Premium Payments on Term

For premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided. Ask the licensed agent for this information.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, and also the right to receive upon request a copy of any investigative consumer report. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to P.O. Box 461, Lynchburg, Virginia 24505-0461.

Federal Fair Credit Reporting Act

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics, as well as information obtained from other data sources. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) Disclosure

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc. MIB, Inc. is a non-profit membership organization of life insurance companies. It operates an information exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. To contact MIB, Inc., you may: write 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; phone toll free (866) 692-6901 (TTY 866 346-3642 for hearing impaired); or use the website http://www.mib.com.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Free Look Period

If we deliver a policy to you, you will have a brief period of time to examine the policy and, if you desire, to return the policy to us for a full refund of any premium you paid. This period – known as the "free look period"– is usually 20 days from our delivery of the policy to you, but it may be a slightly longer period in some states. To return the policy, simply mail or deliver the policy to the Company or any of its agents within the free look period for your state. The policy will then be made void from the beginning.

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, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased, renewed or when you exercise certain policy rights, such as increasing the premiums you pay, lengthening your coverage, increasing your death benefit or adding an optional rider. This compensation may also include 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. Additionally, licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, 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. Intermediaries may also pay compensation directly to the licensed agent. If the licensed agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Genworth

Temporary Insurance Application and Agreement (TIAA)

Genworth Life and Annuity
Genworth Life
3100 Albert Lankford Drive
Lynchburg, VA 24501

○ Genworth Life and Annuity Insurance Company
○ Genworth Life Insurance Company

ORIGINAL – Return with the application and the payment.
COPY – Give to the Owner only if payment is made at the time the Application – Part I is signed.

1. Notice to Proposed Insured and Owner

Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

2. Temporary Insurance Application *Answer all questions*

Insurer
The Insurer designated in Section 4.a. of the Application - Part I.

Temporary insurance cannot begin and you should make no payment if any question is answered "Yes" or left blank.

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? ○ Yes ○ No
2. Is the Policy applied for a joint life insurance policy? ○ Yes ○ No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed $1,000,000? ○ Yes ○ No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? ○ Yes ○ No
5. In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a professional health care provider for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? ○ Yes ○ No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? ○ Yes ○ No

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured	Date of this TIAA	**Signature of Owner** *If other than Proposed Insured*
X	▪	X

3. Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.
Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) $1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.
Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.
Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.
Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.
Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

4. Licensed Insurance Agent's Statement

Amount remitted	Person from whom received
$	▪

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

Signature(s) of Licensed Insurance Agent(s)	Licensed Insurance Agent Number(s)
X	▪

Genworth

Genworth Life and Annuity
Genworth Life
3100 Albert Lankford Drive
Lynchburg, VA 24501

Temporary Insurance Application and Agreement (TIAA)

○ Genworth Life and Annuity Insurance Company
○ Genworth Life Insurance Company

ORIGINAL – Return with the application and the payment.
COPY – Give to the Owner only if payment is made at the time the Application – Part I is signed.

1. Notice to Proposed Insured and Owner

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2. Temporary Insurance Application *Answer all questions*

Insurer
The Insurer designated in Section 4.a. of the Application - Part I.

Temporary insurance cannot begin and you should make no payment if any question is answered "Yes" or left blank.

1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? ○ Yes ○ No
2. Is the Policy applied for a joint life insurance policy? ○ Yes ○ No
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed $1,000,000? ○ Yes ○ No
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? ○ Yes ○ No
5. In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a professional health care provider for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? ○ Yes ○ No
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? ○ Yes ○ No

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured	Date of this TIAA	**Signature of Owner** *If other than Proposed Insured*
X	▪	X

3. Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.
Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) $1,000,000 minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.
Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.
Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 45 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date.
Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.
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Signature(s) of Licensed Insurance Agent(s)	Licensed Insurance Agent Number(s)
X	▪

Genworth Life & Annuity Insurance Company
Genworth Life Insurance Company
Genworth Life Insurance Company of New York
P.O. Box 461
Lynchburg, VA 24505-0461
Tel: 888 325.5433
genworth.com

Authorization to collect and disclose information

from Genworth Life and Annuity Insurance Company, Genworth Life Insurance Company and Genworth Life Insurance Company of New York†

This authorization complies with HIPAA.

Original to Insurer

Proposed Insured *Print* ▪

Birthdate *mm/dd/yyyy* ▪

Terms

Information

Facts about the Proposed Insured. It includes the Insured's entire medical record, including facts about mental and physical health; prescription drugs; and facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases. Information also includes facts about other insurance coverage; hazardous activities; character; finances; vocation; and other personal traits. It does not include facts about sexual orientation. Information does not include a mental health professional's Psychotherapy Notes (actual recorded notes of a counseling session that are separate from the rest of a medical record), but Information does include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress. For New Jersey and Maine, Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS.

Source

Medical Physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; care providers or evaluators; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; the Department of Veterans Affairs; facilities or offices staffed or run by care providers; other medical or medically related facilities; medical prescription drug databases; pharmacy or pharmacy benefit manager; insurers; reinsurers; health plans; MIB; consumer reporting agencies; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Genworth Life and Annuity Insurance Company, Genworth Life Insurance Company and Genworth Life Insurance Company of New York.

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

Understanding

1. The following parties may need to collect Information in connection with proposed insurance coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and these parties' representatives.
2. These parties may disclose collected Information to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them.
3. All parties may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization.
4. Some Information 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 information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.
5. The Insurer and its reinsurers will use Information to evaluate the application, obtain reinsurance, administer claims, administer coverage, and conduct other activities that are allowed or required by law and that relate to any insurance coverage or proposed insurance coverage with the Insurer.
6. Failing to sign, changing, or revoking the Authorization will impair processing of the application; as a result, the application may be denied.
7. This Authorization will be valid for twenty-four (24) months after the date signed.
8. The Proposed Insured or person authorized to act on the Proposed Insured's behalf; (a) may revoke this Authorization by sending written notice to the Insurer at 3100 Albert Lankford Drive, Lynchburg, VA 24501, Attention: Privacy Official, and (b) may ask to receive a copy of this Authorization.

Authorization and Acknowledgement

By signing below, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of a copy of the Authorization.

Signature of Proposed Insured or Personal Representative
X

Date *mm/dd/yyyy* ▪

Description of Personal Representative's Authority or Relationship to Proposed Insured ▪

†Only Genworth Life Insurance Company of New York is admitted in and conducts business in New York.

Genworth Life & Annuity Insurance Company
Genworth Life Insurance Company
Genworth Life Insurance Company of New York
P.O. Box 461
Lynchburg, VA 24505-0461
Tel: 888 325.5433
genworth.com

Authorization to collect and disclose information

from Genworth Life and Annuity Insurance Company, Genworth Life Insurance Company and Genworth Life Insurance Company of New York†

This authorization complies with HIPAA.

Copy to Applicant

Proposed Insured *Print* ▪ ....

Birthdate *mm/dd/yyyy* ▪ ....

Terms

Information

Facts about the Proposed Insured. It includes the Insured's entire medical record, including facts about mental and physical health; prescription drugs; and facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases. Information also includes facts about other insurance coverage; hazardous activities; character; finances; vocation; and other personal traits. It does not include facts about sexual orientation. Information does not include a mental health professional's Psychotherapy Notes (actual recorded notes of a counseling session that are separate from the rest of a medical record), but Information does include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress. For New Jersey and Maine, Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS.

Source

Medical Physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; care providers or evaluators; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; the Department of Veterans Affairs; facilities or offices staffed or run by care providers; other medical or medically related facilities; medical prescription drug databases; pharmacy or pharmacy benefit manager; insurers; reinsurers; health plans; MIB; consumer reporting agencies; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Genworth Life and Annuity Insurance Company, Genworth Life Insurance Company and Genworth Life Insurance Company of New York.

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

Understanding

1. The following parties may need to collect Information in connection with proposed insurance coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and these parties' representatives.
2. These parties may disclose collected Information to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them.
3. All parties may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization.
4. Some Information 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 information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.
5. The Insurer and its reinsurers will use Information to evaluate the application, obtain reinsurance, administer claims, administer coverage, and conduct other activities that are allowed or required by law and that relate to any insurance coverage or proposed insurance coverage with the Insurer.
6. Failing to sign, changing, or revoking the Authorization will impair processing of the application; as a result, the application may be denied.
7. This Authorization will be valid for twenty-four (24) months after the date signed.
8. The Proposed Insured or person authorized to act on the Proposed Insured's behalf; (a) may revoke this Authorization by sending written notice to the Insurer at 3100 Albert Lankford Drive, Lynchburg, VA 24501, Attention: Privacy Official, and (b) may ask to receive a copy of this Authorization.

Authorization and Acknowledgement

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Signature of Proposed Insured or Personal Representative
X ....

Date *mm/dd/yyyy* ▪ ....

Description of Personal Representative's Authority or Relationship to Proposed Insured
▪ ....

†Only Genworth Life Insurance Company of New York is admitted in and conducts business in New York.

Genworth Financial

Genworth Life Insurance Company
Genworth Life and Annuity Insurance Company
700 Main Street, Lynchburg, VA 24504
Phone: 888 325.5433

Electronic funds transfer (EFT) authorization

for Life Insurance new business

- Complete, sign, date and return this form to us with your application materials
- Keep a copy of the form for your records

Application information

Proposed Insured's name

▪ ....

File or application number(s) (if available)

▪ ....

Premium payment

For most products, frequencies other than annual include an additional cost. In those cases, the year's total premiums will be higher than if you paid one annual premium.

If you have a question about your product, contact your agent.

Select payment frequency:

◯ **Monthly*** ◯ **Quarterly** ◯ **Semi-Annually** ◯ **Annually**

We will withdraw the scheduled premium amount based on the frequency you select.

**If you choose monthly payment frequency, you need to authorize two months of premium payment. This amount will be drafted only for the initial premium payment.*

Payment amount authorized

▪ $ ....

Account information

If you do not check the initial payment selection, you must submit another form of payment to cover the initial premium payment, and we will use this electronic funds transfer for subsequent premiums only.

◯ I want my initial payment to be made via EFT.

Note: We will draft your account when we receive your application if the Temporary Insurance Application and Agreement (TIAA) is properly completed, signed and dated. If we do not receive the TIAA, or if the TIAA is not properly completed, signed and dated, we will draft your account when we receive all delivery requirements.

Account owner name *(if different from proposed insured above – see "A" below)*

▪ ....

Account owner street address *(see "A" below)*

▪ ....

Account owner City, State, ZIP *(see "A" below)*

▪ ....

Financial institution name *(see "B" below)*

▪ ....

Bank routing number *(see "C" below)*

▪ ....

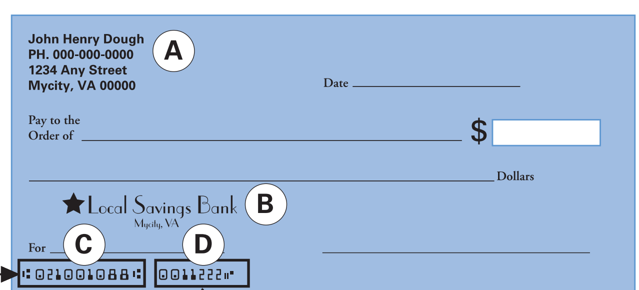
Checking account number *(see "D" below)*

▪ ....

This is an example of a personal check. A business check may be different. The circled letters show you where on the check to find the information required to process your electronic funds transfer.

The nine-character bank routing number appears between the ⑆ symbols, usually at the bottom left corner of the check.

The account number is 5-22 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.



Acknowledgement

By signing below, I (the policyowner) understand and accept these terms and conditions (if applicable):

- Signing the Electronic funds transfer authorization does not mean that insurance is effective. Insurance is effective only as stated in the Application for Life Insurance or in the Temporary Insurance Application Agreement (TIAA).
- We will not provide coverage if the financial institution does not honor the withdrawal, even if we receive all other requirements.
- We will initiate payment of the first premium only after:
  (1) we receive the completed and signed Application – Part I and a TIAA has been properly issued; or
  (2) we receive and review for proper dates and signatures the Policy Delivery and Acknowledgement form and all requirements we requested when we delivered the policy to you.
- We may issue the policy at a premium rate different from the rate for which you applied. In that case, we will give the payer advance notice of the new premium amount before we withdraw premiums, if there was a TIAA. After the first withdrawal, we will withdraw premiums on the day of the month that corresponds to the policy's effective date. The policy effective date is the date the policy owner signs the TIAA, or the Policy Delivery and Acknowledgement form.
- Coverage is effective under the TIAA only if the premium amount withdrawn equals one premium for the plan and payment frequency (two premium payments must be withdrawn if the premium frequency is monthly).
- If TIAA coverage ends as described in the TIAA's 'Stop Date,' we will return the amount withdrawn to the bank account shown on page 1.

Authorization

By signing below, I (the bank account owner) understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay your insurance premiums.
- If your financial institution does not honor a withdrawal request, we will NOT consider your premium paid.
- We have the right to end withdrawals at any time and bill you directly either quarterly or less frequently for premiums due.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.

Signatures

Signature of premium payer *(bank account owner)* Date

X .

Signature of policyowner *(if different from premium payer)* Date

X .

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, urine or oral fluid (saliva) for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw blood and/or to obtain a sample of your urine or oral fluid (saliva) and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and other physical conditions.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. If the test results are other than normal, the Insurer will report such test results to the Executive Officer of the State Board of Health or to other authorities required by the State Board of Health. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant test abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent For Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal from me of blood by needle, the test of that blood, and/or to provide a urine and/or oral fluid (saliva) sample, the test of that sample and the disclosure of the test results as described.

In the event of a positive HIV test result, I authorize the Insurer to send the test results to the following Physician for post-test counseling:

Name and address of designated Physician:

____

____

____

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Please Print)	Date of Birth

Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

Examiner's Name and Address:

____

____

____

○ **Genworth Life and Annuity Insurance Company**

New Business: P.O. Box 320
Lynchburg, VA 24505-0320

○ **Genworth Life Insurance Company**

New Business: P.O. Box 461
Lynchburg, VA 24505-0461

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, urine or oral fluid (saliva) for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw blood and/or to obtain a sample of your urine or oral fluid (saliva) and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and other physical conditions.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. If the test results are other than normal, the Insurer will report such test results to the Executive Officer of the State Board of Health or to other authorities required by the State Board of Health. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

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In the event of a positive HIV test result, I authorize the Insurer to send the test results to the following Physician for post-test counseling:

Name and address of designated Physician:

____

____

____

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Please Print)		Date of Birth
Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

Examiner's Name and Address:

____

____

____

○ **Genworth Life and Annuity Insurance Company**

New Business: P.O. Box 320
Lynchburg, VA 24505-0320

○ **Genworth Life Insurance Company**

New Business: P.O. Box 461
Lynchburg, VA 24505-0461

NOTICE AND CONSENT TO EMPLOYER'S APPLICATION FOR LIFE INSURANCE

◯ **Genworth Life Insurance Company**
P.O. Box 461, Lynchburg, VA 24505-0461
888 325.5433

◯ **Genworth Life and Annuity Insurance Company**
P.O. Box 320, Lynchburg, VA 24505-0320
888.325.5433

1. EMPLOYEE (PROPOSED INSURED) INFORMATION

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Gender ◯ F ◯ M	c. Date of Birth	d. Social Security Number
e. Street Address	f. City	g. State	h. Zip Code
i. Occupation			

2. EMPLOYER (OWNER) INFORMATION

a. Full Legal Name			
b. Street Address	c. City	d. State	e. Zip Code

3. NOTICE BY EMPLOYER (OWNER)

a. Employer intends to apply for insurance on the life of the Employee (Proposed Insured).

b. The maximum face amount the Employee (Proposed Insured) could be insured for at the time the contract is issued is $ ____________________.

c. The face amount of life insurance, either in dollars or as a multiple of salary, that the Employer reasonably expects to purchase with regard to the employee during the course of the employee's tenure is ______________________.

d. The Employer will be the Owner of any policy issued and a beneficiary of any proceeds payable upon the Employee's (Proposed Insured's) death.

e. State and federal law may limit the right of an Employer to buy life insurance on employees and former employees. Employer certifies that it has independently determined that the purchase of life insurance covered by this form complies with applicable laws and regulations.

4. CONSENT OF EMPLOYEE (PROPOSED INSURED)

a. I consent to being an insured under the life insurance policy for which my Employer intends to apply.

b. I consent to my Employer continuing coverage, after my employment ends, under any policy issued.

c. I understand that my Employer will own the policy. Unless provided in a separate agreement, my Employer will receive all of the death proceeds and my personal representative, next of kin, and heirs at law will have no beneficial interest in the policy or its death proceeds.

AGREEMENT AND AUTHORIZATION

This form is provided as a convenience to the employer and to obtain information that may be needed for information reporting services. By providing this form, the Company makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefits of certain employer-owned life insurance contracts will not be completely excluded from federal gross income of the employer unless notice-and-consent requirements and other requirements specified in the law are fulfilled.

The Genworth Financial companies and their representatives and distributors do not provide tax or legal advice. We did not create this form for use by any taxpayer to avoid any Internal Revenue Service penalty. You should ask your independent tax and legal advisors for advice based on your particular situation.

A photocopy of this form shall be as valid as the original.

______________________________ ______________

Signature of Employee (Proposed Insured) Date

______________________________ ______________

Signature of Employer (Owner) Date

____

Title

Genworth

Genworth Life & Annuity
Genworth Life
genworth.com

Important notice: replacement of life insurance or annuities

from Genworth Life and Annuity Insurance Company
and Genworth Life Insurance Company

Original to Insurer

This document must be signed by you and the producer, if there is one, and a copy left with you.

○ Genworth Life Insurance Company ○ Genworth Life and Annuity Insurance Company

Replacement information

The Genworth Financial insurance companies listed above are referred to as "we" in this document.

The owner is referred to as "you" and "your."

This document must be signed by you and the producer, if there is one, and a copy left with you.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the last page of this form.

Both questions to the right must be answered.

If either of the answers is "yes," provide the information noted below and complete the producer replacement sales certification on page 2.

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

○ Yes ○ No

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?

○ Yes ○ No

The existing policy or contract is being replaced because:

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer name	Contract/policy number
Insured/annuitant name	*Select one* ○ Replaced ○ Financing
Insurer name	Contract/policy number
Insured/annuitant name	*Select one* ○ Replaced ○ Financing
Insurer name	Contract/policy number
Insured/annuitant name	*Select one* ○ Replaced ○ Financing

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

Free Look Period

Upon issuance of your new policy or contract, the policy may be returned within 30 days from the date of delivery. **This return period may be different from what is reflected in your policy or contract; if so, the longer period will be applicable.**

If you return the policy, you will be entitled to receive:
- In Utah: an unconditional full refund of all premiums or considerations paid on the policy or contract
- All other states: an unconditional full refund of all premiums or considerations paid on the policy or contract, including any policy fees or charges or, in the case of a variable or market value adjustment contract, a payment of the cash surrender value provided under the contract plus the fees and other charges deducted from gross premiums or considerations or imposed under the contract.

Signature

I certify that the responses herein are, to the best of my knowledge, accurate:

Owner signature	Owner printed name	Date
X		

If you are a Trustee, Attorney-in-Fact, Guardian or other fiduciary, indicate the capacity in which you are acting.

○ Trustee ○ Attorney-in-fact POA
○ Guardian ○ Title/ Office
○ Other

Joint Owner signature	Joint Owner printed name	Date
X		

○ Trustee ○ Attorney-in-fact POA
○ Guardian ○ Title/ Office
○ Other

Producer signature	Producer printed name	Date
X		

I do not want this notice read aloud to me. *Applicants must initial only if they do not want the notice read aloud.*

*And copies of all sales material were left with the applicant.

I, the producer, certify that: (a) only company-approved sales materials were used in this transaction and they are appropriate for the policy or contract applied for*; (b) if used, any company-approved electronic sales materials will be printed and provided to the policy or contract owner prior to or at policy or contract delivery; (c) this sale conforms with the company's replacement policy (set forth below).

Producer must sign at right.

Producer signature	Date
X	

Replacement policy

We believe that replacement of an existing insurance or annuity policy must be appropriate for the customer and meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is also one that is justified from either an economic or personal standpoint. The provisions, features and benefits of both the current and proposed product should be considered in relation to the client's needs, circumstances and goals. Some examples of the types of provisions that should be considered are: premium rate differences, differences in suicide and incontestability provisions for individual life insurance and pre-existing conditions, waiting periods, elimination periods, and probationary periods for health insurance policies. In addition, factors such as the age and health of the customer must be considered. Distributors are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts to be provided to the customer when proposing a replacement. Distributors are expected to know and comply with these requirements.

Important notice

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts.

You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

Premiums
Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

Policy values
New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

Insurability
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

If you are keeping the old policy as well as the new policy
How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

If you are surrendering an annuity or interest sensitive life product
Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

Other issues to consider for all transactions
What are the tax consequences of buying the new policy? Is this a tax free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

Mailing instructions

Mail this form with the application.

Annuity New Business:
P.O. Box 40011 Lynchburg, VA 24506

Fixed Life New Business for Genworth Life and Annuity Insurance Company:
P.O. Box 320, Lynchburg, VA 24505-0320

Fixed Life and Linked Benefit New Business for Genworth Life Insurance Company:
P.O. Box 461, Lynchburg, VA 24505-0461

For questions call:
Variable Annuities: 800 352.9910
Fixed Annuities: 800 221.9501
Single Premium Immediate Annuities: 888 325.5433
Fixed or variable life: 888 325.5433

Genworth

Genworth Life & Annuity
Genworth Life
genworth.com

Important notice: replacement of life insurance or annuities

from Genworth Life and Annuity Insurance Company
and Genworth Life Insurance Company

 Copy to Applicant

This document must be signed by you and the producer, if there is one, and a copy left with you.

○ Genworth Life Insurance Company ○ Genworth Life and Annuity Insurance Company

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A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

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Both questions to the right must be answered.

If either of the answers is "yes," provide the information noted below and complete the producer replacement sales certification on page 2.

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

○ Yes ○ No

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?

○ Yes ○ No

The existing policy or contract is being replaced because:

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If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

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Signature

I certify that the responses herein are, to the best of my knowledge, accurate:

If you are a Trustee, Attorney-in-Fact, Guardian or other fiduciary, indicate the capacity in which you are acting.

Owner signature	Owner printed name	Date
X		

○ Trustee ○ Attorney-in-fact POA
○ Guardian ○ Title/ Office
○ Other

Joint Owner signature	Joint Owner printed name	Date
X		

○ Trustee ○ Attorney-in-fact POA
○ Guardian ○ Title/ Office
○ Other

Producer signature	Producer printed name	Date
X		

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For questions call:
Variable Annuities: 800 352.9910
Fixed Annuities: 800 221.9501
Single Premium Immediate Annuities: 888 325.5433
Fixed or variable life: 888 325.5433