Privileged Choice® **Flex 3** Application and Forms

Company Submission Materials Enclosed

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

- Coverage Selection for Privileged Choice Flex 3
- Payment Authorization (If Required)
- Application Part I for Long Term Care Insurance
- Long Term Care Insurance Application Overflow Form (If Required)
- Health Information Authorization
- Notice and Consent for Testing
- Long Term Care Insurance Personal Worksheet
- Verification of Financial Non-Disclosure
- Potential Rate Increase Disclosure Form
- Requirements to Access Couples Benefits (If Required)
- Notice to Applicant Regarding Replacement of Accident and Sickness or Long Term Care Insurance

Genworth®

B107152C ICC 07/07/14

Underwritten by Genworth Life Insurance Company, Richmond, VA

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Important Instructions for Agents/Producers

from Genworth Life Insurance Company

Prior to soliciting new business, verify that your producer license is in good standing, you have completed all required CE, and you are in compliance with all applicable licensure requirements. Applications will be returned if all such requirements have not been met as of the date of the Application.

To avoid delays in processing your new business submission, carefully follow the instructions below.

Eligibility Requirements

Review the Insurability Profile with the Applicant(s). The Applicant(s) may be uninsurable if:

- The Applicant(s) answers "Yes" to any question in this section; or
- The Applicant(s) falls over or under the build limits.

You may want to contact the Pre-qualification hotline at 800 354.6892 before submitting an Application.

Instructions

1. Complete the entire Application to avoid returned Applications and processing delays. Do NOT use correction fluid. Corrections should be crossed out and initialed by the Applicant(s). Ensure all handwriting is legible.
2. 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.)
3. Write the quoted class in the margin of the agent report or send in the illustration summary page with the Application.
4. If an initial premium check 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 per Applicant in order to be eligible for the Conditional Insurance Agreement (CIA) (only one (1) month of premium in the states of NH (clients age 65 and older) and CA). If using Electronic Funds Transfer (EFT) or Credit Card payments (Credit card payment not available in AK, CA, MD, NJ, NC and PA), be sure to complete the Payment Authorization form. If you have questions, call 800 309.0047.
5. Review and/or complete the forms in the Applicant Materials Booklet and leave it with the Applicant(s).
6. Confirm that the Application and all required forms have been signed where required and dated in all appropriate sections.
7. Prepare the Applicant(s) for the next steps by providing the "What to Expect Next" brochure, which explains the health interviews and other medical requirements that will be needed to process the Application. Let the Applicant(s) know that all costs associated with paramed exams and interviews are paid for by Genworth.

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 (Credit card payment not available in AK, CA, MD, NJ, NC and PA), be sure to complete and include the Payment Authorization Form.
- ◯ Include any other forms needed (e.g., Requirements to Access Couples Benefits, replacement form or any state required forms.)
- ◯ Health Information Authorization (HIPAA)
- ◯ Notice of Consent for Testing
- ◯ Long Term Care Insurance Personal Worksheet
- ◯ Potential Rate Increase Disclosure Notice

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

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

Provide the Applicant(s) with the Applicant Materials Booklet, which includes the Applicant's copies of any state required forms, as well as the Outline of Coverage.

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Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Coverage Selection for Privileged Choice® Flex 3 Individual Long Term Care Insurance from Genworth Life Insurance Company

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.

Applicant A *Print name*

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Applicant B *Print name*

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Coverage selection

	Applicant A		Applicant B	
Shared Benefit Rider	◯ Yes	◯ No		
	If Shared Benefit Rider is chosen, both Applicants must make identical selections below.			
Benefit Multiplier Months/Days Choose a Monthly or Daily benefit multiplier.	◯ 60/1825 ◯ 48/1460	◯ 36/1095 ◯ 24/730	◯ 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 $9,000; or choose a Daily Maximum between $50 and $300.			
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			
Waiver of 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	◯ 5% Compound ◯ 4% Compound ◯ 3% Compound ◯ 2% Compound	◯ 5% Simple ◯ Future Purchase Option** ◯ None	◯ 5% Compound ◯ 4% Compound ◯ 3% Compound ◯ 2% Compound	◯ 5% Simple ◯ Future Purchase Option** ◯ None
	**Future Purchase Option not available with Shared			
Nonforfeiture Benefit	◯ Yes (Accept)	◯ No (Decline)	◯ Yes (Accept)	◯ No (Decline)

Applicant A *Print name*

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Applicant B *Print name*

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Eligibility for couples benefits

Applicant B, if provided on this form or the individual designated here will be the named individual for any couples premium or Shared Benefit Rider, as applicable.

Criteria to qualify for couples benefits: Two people who, at the time of Application

- are joined by marriage; or
- are joined by a relationship legally recognized under state law as entitled to the same rights and benefits of married persons; or
- are and have been living together for the past three consecutive years in a committed domestic relationship as partners. You and such person cannot be joined to anyone else by: (a) marriage; or (b) a domestic relationship legally recognized under State law.

Do you qualify for couples benefits? ◯ 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:

Print spouse/partner name

.

Social Security Number

.

Date of Birth

.

Existing coverage number

.

MODAL PREMIUM DISCLOSURE

Although premiums are calculated on an annual basis, premiums may be shown on a monthly, quarterly or semi-annual basis. Annual premiums may be paid in advance at the beginning of each coverage year. However, your premiums may be paid on a more frequent basis throughout your coverage year. If you pay your premiums more frequently than annually (e.g. monthly, quarterly or semi-annually), there will be additional charges that apply. The more frequent the premium payment mode, the more charges you will incur. Please refer to the Modal Premium Disclosure in your policy.

Premium information

Full modal premium

$

Premium Payment mode

◯ Annual (1.0)
◯ Semi-annual (.51)
◯ Quarterly (.26)
◯ Monthly*** (.09)

Full modal premium

$

Premium Payment mode

◯ Annual (1.0)
◯ Semi-annual (.51)
◯ Quarterly (.26)
◯ Monthly*** (.09)

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

Quoted Underwriting Category

Please check the underwriting category quoted to you. If any insurance is issued, the underwriting category may be different.

◯ Preferred Best
◯ Preferred
◯ Select
◯ Standard

◯ Preferred Best
◯ Preferred
◯ Select
◯ Standard

List Bill

List bill ◯ Yes ◯ No

List Bill Number

.

List bill ◯ Yes ◯ No

List Bill Number

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Payment Authorization

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

Include a voided check to ensure accurate processing.

○ Use same bank information for both applicants (optional)

Bank Name	Bank Name
Bank Account #	Bank Account #
Bank Routing #	Bank Routing #
Account Holder Name (if different from Applicant)	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	○ Visa ○ MasterCard
Card Number	Card Number
Exp (mm/yy)	Exp (mm/yy)
Cardholder Name (if different from Applicant)	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)

. .....

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Lynchburg, VA 24501

Application Part I for Individual Long Term Care Insurance from Genworth Life Insurance Company

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.
A separate Application Part II Medical History - Long Term Care Insurance must be completed by each Applicant listed below.

Applicant A *Print name*

Applicant B *Print name*

Personal profile

Applicant A

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

Name (as it should appear on your policy)

○ Married/Legal Partner ○ Single ○ Widowed

Social Security/Tax ID Number

Email address

Date of birth (mm/dd/yyyy) Age Birthplace (state/country)

○ Male ○ Female

Height: ft. in. Weight: lbs.

Daytime phone

Evening phone

Best time to call

○ AM ○ PM

Applicant B

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

Name (as it should appear on your policy)

○ Married/Legal Partner ○ Single ○ Widowed

Social Security/Tax ID Number

Email address

Date of birth (mm/dd/yyyy) Age Birthplace (state/country)

○ Male ○ Female

Height: ft. in. Weight: lbs.

Daytime phone

Evening phone

Best time to call

○ AM ○ PM

Resident Address (street address; your policy form will be determined by the state below.)

City State Zip

Mailing Address (if different from Resident Address)

City State Zip

Applicant A *Print name*

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Applicant B *Print name*

.

Insurability profile

Genworth Life Insurance Company is referred to as "we," "us," and "the Company" in this Application.

"You" and "your" refers to each Applicant in this Application.

1. Are you covered by Medicaid (not the same as Medicare)?

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

2. Are you currently receiving, or have you received, Social Security Disability Insurance benefits within the past 3 years?

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

3a. Do you use a Walker, Motorized Scooter, Stair Lift, 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?

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

3b. Do you currently reside in, have you been advised by a licensed healthcare provider, or are you planning to: receive home care, use an adult day care facility, or enter a nursing home, assisted care facility, or any other custodial or long term care facility?

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

4. Are you currently diagnosed, or have you ever been diagnosed or advised by a member of the medical profession as having, or in the last 5 years been treated for any of the following conditions:

- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's Disease)
- Bipolar Disorder (Manic Depression)
- Cirrhosis of the Liver
- Congestive Heart Failure (CHF) in combination with any of the following: Heart Attack or Angina; Angioplasty or Heart Surgery
- Cystic Fibrosis
- Dementia
- Diabetes under treatment with Insulin or with a history of TIA, Heart Disease, or Circulatory/Vascular Disease
- Ehlers-Danlos Syndrome
- Frequent or persistent forgetfulness or memory loss
- Huntington's Disease
- Marfan's Syndrome
- Metastatic Cancer (spread from original site/location)
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Myelofibrosis
- Organ Transplant (other than Kidney or Cornea)
- Parkinson's Disease
- Schizophrenia or other forms of Psychosis
- Senility
- Stroke
- Transient Ischemic Attack (TIA) within the past 5 years
- TIA in combination with Heart Disease or Heart Surgery
- TIA two or more times

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

BEFORE YOU CONTINUE WITH THIS APPLICATION: If you answered YES to any of the questions in the Insurability profile, we suggest that you do not submit this Application. If you answered NO to every question, please continue.

5. In the past 4 years have you had treatment for, been diagnosed or advised by a member of the medical profession as having Cancer of the: Brain, Esophagus, Liver, Ovary, Pancreas, or Stomach?

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

6. Have you ever been diagnosed by a licensed healthcare provider 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?

Applicant A ○ Yes ○ No **Applicant B** ○ Yes ○ No

Applicant A *Print name*

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Applicant B *Print name*

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Client profile

7. Have you ever used tobacco or any other product that contains nicotine?

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
Type of Product	Type of Product
Frequency	Frequency
Date last used (MM/YY)	Date last used (MM/YY)

8a. Do you work 20 or more hours a week outside your home?

If YES, list occupation.

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
Occupation:	Occupation:

8b. Do you perform volunteer work?

If YES, list type of work and list hours worked per week.

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
Type of work:	Type of work:
Hours per week:	Hours per week:

8c. Do you have any hobbies, interests, or participate in any outside activities on a regular basis?

If YES, please describe.

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
Activities:	Activities:

9. Do you drive an automobile?

If YES, provide approximate annual mileage.

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
Mileage:	Mileage:

10. 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 ○ Yes ○ No	**Applicant B** ○ Yes ○ No
Services:	Services:

Applicant A *Print name*

.....

Applicant B *Print name*

.....

Other coverage and replacement

11a. Do you have any Accident and Sickness, Long Term Care, Nursing Home, or Home Health Care insurance policy/certificate in force or applied for? (Including any health care service contract, health maintenance organization contract or life insurance with Long Term Care coverage.)

	Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
If YES, provide details for Applicant.	Company:.....	Company:.....
	Long Term Care? ○ Yes ○ No	Long Term Care? ○ Yes ○ No
	Daily Benefit: $.....	Daily Benefit: $.....
	Monthly Benefit: $.....	Monthly Benefit: $.....

11b. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy/certificate in force during the last 12 months?

	Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
If YES, with which company?	Company:.....	Company:.....
If that insurance lapsed, when did it lapse?	Lapse Date :.....	Lapse Date :.....

11c. Do you intend to replace any of your Long Term Care coverage with this policy?

	Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
If YES, name company being replaced.	Company:.....	Company: .....
	Policy/Certificate #:	Policy/Certificate #: .....

11d. Within the past 2 years, have you had another application or reinstatement request for long term care or life insurance declined, postponed, or have you been rated substandard by any other company?

	Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
If YES, with which company?	Company:	Company: .....
	Product:	Product: .....
	Reason:	Reason: .....

Applicant A *Print name*

Applicant B *Print name*

Protection against unintentional lapse

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 non-payment of premium.
I understand that notice will not be given until 30 days after a premium is due and unpaid.

One of the circles must be checked.

Applicant A Select one	**Applicant B** Select one (Complete whenever there is a second Applicant)
◯ I elect NOT to designate any person to receive such notice.	◯ Same as Applicant A.
◯ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:	◯ 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 non-payment of premium:
◯ Mr. ◯ Mrs. ◯ Miss	◯ Mr. ◯ Mrs. ◯ Miss
◯ Ms. ◯ Other Title	◯ Ms. ◯ Other Title
Name	Name
Address	Address
City	City
State Zip	State Zip
Phone	Phone
Relationship	Relationship

Declarations

By providing your Signature below, you hereby acknowledge and agree that you have read, understand and agree to the following provisions of this Declarations section:

- **Application for Coverage;**
- **Authorization;**
- **Receipt;**
- **Agreement;**
- **Conditional Insurance Agreement (if applicable);**
- **Request for a Later Policy Effective Date (if applicable);**
- **Rejection of 5% Compound Inflation Protection (if applicable);**
- **Caution; and**
- **Fraud Notice**

You further acknowledge and agree that these provisions shall apply to the entire Application, as outlined below.

Application for Coverage. The Application Part I for Individual Long Term Care Insurance and Application Part II Medical History – Long Term Care Insurance together form your Application for coverage with the Company (hereinafter collectively referred to as the "Application" and individually referred to as "Application Part I for Individual Long Term Care Insurance" and "Application Part II Medical History – Long Term Care Insurance"). In the case of two Applicants, each Application Part II Medical History – Long Term Care Insurance shall be considered part of the Application.

Authorization. You authorize Genworth Life Insurance Company, its third party service organizations (such as EMSI), affiliates, and any reinsurers (our "representatives") to obtain information as to the diagnosis, treatment or prognosis of your physical and mental condition, other coverage and any other information requested by us to evaluate your Application for coverage. Upon presentation of this Authorization and these Declarations, or a copy thereof, the Company, or its representatives, may obtain

Applicant A *Print name*

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Applicant B *Print name*

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Declarations *(Continued)*

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, prescription drug database provider, insurance company, consumer reporting agency or insurance support organization or any other person or organization which may have such information. Genworth Life Insurance Company, or its designees, may also obtain and/or provide/exchange such information from, or with, the MIB, Inc. This Authorization includes information about drugs, alcoholism, and mental illness. The Company, or its representatives, may conduct a phone or in-person interview as part of the application and underwriting process, the results of which will become part of this Application and form a basis for a decision to issue coverage. You agree that this Authorization will be valid for 24 months from the date signed. You, or your authorized representative, may request a photocopy of your Application. You hereby authorize any physician, health professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, prescription drug database provider, insurance company, consumer reporting agency or insurance support organization, or any other person or organization which may have information, knowledge or records related to your diagnosis, treatment or prognosis of your physical and mental condition, other coverage or any other information requested by us, to provide such information, knowledge or records to Genworth Life Insurance Company, or its representatives. You hereby agree that a photographic copy of this Authorization shall be as valid as the original.

Receipt. You have received and read the Privacy Notice. When you applied for coverage under this policy to be issued by Genworth Life Insurance Company, you also received the Outline of Coverage, Long Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long Term Care Insurance, Potential Rate Increase Disclosure Form, and the Shopper's Guide for Long Term Care Insurance.

Agreement. You have reviewed the Application in its entirety and you agree to all of the following:

a. The answers contained herein are full, complete and true to the best of your knowledge and belief;
b. The Application will be part of policy for which you are applying;
c. If you qualify for coverage, and an Initial Premium is paid, the coverage will take effect on either: the date you sign this Application Part I for Individual Long Term Care Insurance, or on a date set by the Company, if you request a later policy effective date, as provided for in the Policy Effective Date provision below;
d. Neither an agent, broker nor medical examiner has the Company's authorization to accept risk, pass on insurability, or make, void or change any questions, conditions or provisions of the Application, policy or receipt, as applicable;
e. The Company may require an attending physician statement, medical records, an underwriting assessment, a medical exam, a Department of Motor Vehicles report or other similar questionnaire, test, MIB report, financial information, or a prescription drug medication report; and
f. The information obtained by the Company may be used to evaluate insurance fraud or abuse, or for other compliance-related activities, all, or some of which, may be reported to the MIB.

Conditional Insurance Agreement - Individual Applicants

This Conditional Insurance Agreement applies to individual applicants where the following requirements have been satisfied:

a. You submitted your Initial Premium payment to the Company at the time your Application Part I for Individual Long Term Care Insurance was submitted;
b. You did not make a Request for a Later Policy Effective Date, as provided for below;
c. You answered "No" to all parts of questions #1 through #6 in the Insurability profile of this Application Part I for Individual Long Term Care Insurance and the Company was able to verify the accuracy of your answers during underwriting of your Application; and
d. No misrepresentation or misstatement was made in the Application.

When all of the requirements set forth above are satisfied, as determined by the Company, we agree:

a. That we will not decline your Application based on any change in your health status that occurs after the date you signed this Application Part I for Individual Long Term Care Insurance, although the Company may decline your Application based on: information we obtain after the date you signed this Application Part I for Individual Long Term Care Insurance that does not indicate a change in Your health status; or information we learn as part of our underwriting process so long as that information does not indicate a change in Your health status.

Applicant A *Print name*

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Applicant B *Print name*

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Conditional Insurance Agreement - Individual Applicants *(Continued)*

b. If we approve your Application, we will provide coverage under the policy for which your Application was made, and that policy will be effective as of the date you signed this Application Part I for Individual Long Term Care Insurance; and

c. If we decline your Application, we will provide limited coverage for Covered Expenses incurred on or after the date you signed this Application Part I for Individual Long Term Care Insurance through the date your Application is declined. For purposes of this Conditional Insurance Agreement only, your Application shall be deemed declined, if not otherwise declined sooner by us, if we do not approve it within 120 days of the date you signed this Application Part I for Individual Long Term Care Insurance, although we reserve the right to approve your Application at a later date. This limited coverage will be provided under the same provisions, conditions, limitations and exclusions as set forth in the policy for which this Application is being made; **except that in no event will the total payment of Covered Expenses exceed the lesser of (a) $10,000; or (b) the actual Covered Expenses incurred. This Conditional Insurance Agreement will only pay benefits for Covered Expenses that are incurred within 150 days following the date you signed this Application Part I for Individual Long Term Care Insurance, or the date that your Application is declined, whichever occurs first.**

If all of the requirements set forth above are not satisfied, as determined by the Company, you understand and agree:

a. That there will be no Conditional Insurance Agreement; and

b. The Company will determine the Effective Date of the policy, if your Application is approved.

Conditional Insurance Agreement - Applicants Requesting Shared Benefits

This Conditional Insurance Agreement applies to applicants requesting Shared Benefits where the following requirements have been satisfied:

a. The Initial Premium payment was submitted to the Company by both applicants requesting Shared Benefits at the time their respective Application Part I for Individual Long Term Care Insurance was submitted;

b. Neither applicant requesting Shared Benefits made a Request for a Later Policy Effective Date, as provided below;

c. Both applicants requesting Shared Benefits answered "No" to all parts of questions #1 through #6 in the Insurability profile of their respective Application Part I for Individual Long Term Care Insurance and the Company was able to verify the accuracy of each applicant's answers during underwriting of the Application; and

d. No misrepresentation or misstatement was made in either Application.

When all of the requirements set forth above are satisfied, as determined by the Company, we agree:

a. That we will not decline the Application based on any change in your health status or the status of your Spouse or Partner that occurs after the latest date upon which the Application Part I for Individual Long Term Care Insurance was signed by you or your Spouse or Partner and a request for Shared Benefits was made, although the Company may decline the Application based on: information we obtain after the latest date upon which the Application Part I for Individual Long Term Care Insurance was signed by you or your Spouse or Partner that does not indicate a change in your health status or the status of your Spouse or Partner, or information we learn as part of our underwriting process so long as that information does not indicate a change in your health status or the status of your Spouse or Partner.

b. If we approve the Application, we will provide coverage under the policy for which the Application was made as of the latest date upon which the Application Part I for Individual Long Term Care Insurance was signed by you or your Spouse or Partner and a request for Shared Benefits was made.

c. If we decline the Application, we will provide limited coverage for Covered Expenses incurred on or after the latest date upon which the Application Part I for Individual Long Term Care Insurance was signed by you or your Spouse or Partner and a request for Shared Benefits was made through the date the Application is declined. For purposes of this Conditional Insurance Agreement only, the Application shall be deemed declined, if not otherwise declined sooner by us, if we do not approve it within 120 days of the latest date upon which the Application Part I for Individual Long Term Care Insurance was signed by you or your Spouse or Partner and a request for Shared Benefits was made, although we reserve the right to approve the Application at a later date. This limited coverage will be provided under the same provisions, conditions, limitations and exclusions as set forth in the policy for which this

Applicant A *Print name*

Applicant B *Print name*

Conditional Insurance Agreement - Applicants Requesting Shared Benefits *(Continued)*

Application is being made; **except that in no event will the total payment of Covered Expenses exceed the lesser of (a) $10,000; or (b) the actual Covered Expenses incurred. This Conditional Insurance Agreement will only pay benefits for Covered Expenses that are incurred within 150 days following the date both applicants signed this Application Part I for Individual Long Term Care Insurance, or the date that the Application is declined, whichever occurs first.**

If all of the requirements set forth above are not satisfied, as determined by the Company, you and your Spouse or Partner understand and agree:

a. That there will be no Conditional Insurance Agreement; and

b. The Company will determine the Effective Date of the policy, if the Application is approved.

Policy effective date

Request for a Later Policy Effective Date.

By checking the circle below, you acknowledge that, if your Application is approved, the effective date of your coverage will be a later date, as set forth by the Company. You further understand and agree that:

a. The Company will consider any changes in your health status after the date you sign this Part I for Individual Long Term Care Insurance Application up through the approval of your Application, if applicable, in determining whether to issue coverage;

b. If any answer to the questions contained in this Application changes prior to the Effective Date set forth by the Company, you are required to notify the Company of any such change. You further understand that any failure to notify the Company will be deemed a misrepresentation in the Application and may result in the denial of benefits or rescission of your coverage, subject to the Time Limit on Certain Defenses provision in the Policy; and

c. In no circumstance will the policy take effect until (a) the Initial Premium is received by the Company; and (b) the Company determines the Effective Date of the policy.

Check circle only to request that your policy takes effect at a date later than the date you signed this Application.

Applicant A ○ **Applicant B** ○

Rejection of 5% Compound Inflation Protection

Initial only if you have selected a benefit increase option other than 5% Compound

I have reviewed the outline of coverage (or disclosure form) 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. Initial below (if rejecting 5% Compound Inflation Protection).

Applicant A _____ Applicant B _____

Caution and Fraud Notice

Caution: If your answers on this Application are incorrect or untrue, Genworth Life Insurance Company may deny benefits or rescind your Policy.

FRAUD NOTICE: 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.

Signature

Signature of Applicant A

X

Date Signed

Signature of Applicant B

X

Date Signed

Signature of Licensed and Appointed Insurance Producer/Agent/Representative

X

Date Signed

State in which application is signed

Insurance Producer / Agent / Representative Information

Name of Licensed and Appointed Insurance Producer/Agent/Representative (Please print)

Street Address

City | State | Zip

Insurance Producer/Agent/Representative Code # or Soc. Sec. #/Tax ID | Email Address

Phone Number | Fax Number

⚠ Signature of Soliciting Insurance Producer/Agent/Representative

X

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

Producer Code # of Brokerage General Agency

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

Name of Licensed and Appointed Insurance Producer/Agent/Representative | Percentage

Insurance Producer/Agent/Representative Code # or Soc. Sec. #/Tax ID | Email Address

Name of Licensed and Appointed Insurance Producer/Agent/Representative | Percentage

Insurance Producer/Agent/Representative Code # or Soc. Sec. #/Tax ID | Email Address

Insurance Producer / Agent / Representative Report

1. Did you personally interview the Applicant face to face and witness his or her signature?

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
If NO, give details.	

2. Did you observe any physical or mental impairments related to walking or talking, or any form of tremor?

Applicant A ○ Yes ○ No	**Applicant B** ○ Yes ○ No
If YES, please explain.	

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**

Genworth

Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Long Term Care Insurance Application Overflow Form

from Genworth Life Insurance Company

APPLICANT

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

REMARKS (Provide explanations and requested information. Identify applicable item number and letter if any.)

This Long Term Care Insurance Application Overflow Form is part of the Application for coverage with the Company. By signing below, you acknowledge and agree that the provisions set forth in the Declarations Section of the Application shall apply to this Long Term Care Insurance Application Overflow Form, as part of the Application. You further agree that you have reviewed this Long Term Care Insurance Application Overflow Form and that the answers contained here in are full, complete and true to the best of your knowledge and belief.

Signature of Applicant _____ Date signed _____

Signature of Licensed and Appointed Insurance Producer/Agent/ Representative or Examiner _____

Genworth

Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Long Term Care Insurance Application Overflow Form

from Genworth Life Insurance Company

APPLICANT

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

REMARKS (Provide explanations and requested information. Identify applicable item number and letter if any.)

This Long Term Care Insurance Application Overflow Form is part of the Application for coverage with the Company. By signing below, you acknowledge and agree that the provisions set forth in the Declarations Section of the Application shall apply to this Long Term Care Insurance Application Overflow Form, as part of the Application. You further agree that you have reviewed this Long Term Care Insurance Application Overflow Form and that the answers contained here in are full, complete and true to the best of your knowledge and belief.

Signature of Applicant _____ Date signed _____

Signature of Licensed and Appointed Insurance Producer/Agent/ Representative or Examiner _____

Genworth

Health Information Authorization

from Genworth Life Insurance Company

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

This is a HIPAA Compliant Authorization

Who is Authorized to Disclose Information

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical prescription drug databases, medical facility, Veterans Administration, care providers or evaluators, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, or consumer reporting agency, to disclose my Health Information to Genworth.

Health Information to be Used or Disclosed

"Health Information" includes any information about me, my entire medical record and any other health information concerning me, without restriction. This includes medical records, prescription drugs and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any of My Providers and other entities or persons referred to above to release and disclose my entire medical record without restriction to Genworth.

Who May Request Information

My Health Information may be disclosed to Genworth Life Insurance Company and its agents, employees and representatives ("Genworth"), including, but not limited to, Release Point, Examination Management Services, Incorporated (EMSI) and APS Workflow, Inc.; its insurance support organizations; its affiliates and reinsurers; and MIB, Inc. ("MIB"). A copy of my application may be attached to any policy/certificate of a co-applicant who is issued coverage as a result of the same application.

Purpose

Health Information is to be disclosed under this authorization so that Genworth may do any of the following: 1) underwrite any insurance I am or will be applying for or a co-applicant is or will be applying for and 2) administer claims related to any coverage I have. I further authorize Genworth to disclose my Health Information to any consumer reporting agency such as the Medical Information Bureau (MIB, Inc.).

- This authorization shall remain in force for 24 months following the date of my signature below, unless state law imposes a shorter duration.
- I understand that I have the right to withdraw this authorization in writing, at any time, by sending a written request to: 3100 Albert Lankford Drive, Lynchburg, VA 24501, Attention: Privacy Official.
- I understand that a withdrawal is not effective if any of My Providers has relied on this authorization or to the extent that Genworth has a legal right to contest a claim under an insurance policy or to contest the policy itself.
- I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.
- A copy of this authorization is as valid as the original.
- I understand that if I refuse to sign this authorization, Genworth may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments.
- I understand that Genworth will provide me with a copy of this authorization.

Signature

Printed Name of Applicant A	Date of Birth	Last 4 Digits of SSN
Signature of Applicant A **X**		Date Signed
Printed Name of Applicant B	Date of Birth	Last 4 Digits of SSN
Signature of Applicant B **X**		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 is authorized to sell insurance polices from other insurance carriers, those carriers may pay compensation that differs from ours.

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

from Genworth Life Insurance Company

Insurability

To determine your insurability, the Insurer indicated on this form has requested that you provide a sample of your blood, oral fluid or urine 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 a blood sample, collect oral fluid or urine samples, and order laboratory tests only in regard to your present application for insurance. In order to perform all testing procedures, it may be necessary for you to provide more than one of these body fluid samples.

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, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. 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 result 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.

Signatures

I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

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.

Printed Name of Applicant	Date of Birth
	.

Name and address of designated Physician:

Signature of Applicant or Parent/Guardian	Date Signed	State of Residence
X	.	.

Examiner's Name and Address:

Genworth Life Insurance Company

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

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

from Genworth Life Insurance Company

Insurability

To determine your insurability, the Insurer indicated on this form has requested that you provide a sample of your blood, oral fluid or urine 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 a blood sample, collect oral fluid or urine samples, and order laboratory tests only in regard to your present application for insurance. In order to perform all testing procedures, it may be necessary for you to provide more than one of these body fluid samples.

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, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. 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 result 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.

Signatures

I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

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.

Printed Name of Applicant	Date of Birth
	.

Name and address of designated Physician:

Signature of Applicant or Parent/Guardian	Date Signed	State of Residence
X	.	.

Examiner's Name and Address:

Genworth Life Insurance Company

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

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Long Term Care Insurance Personal Worksheet

from Genworth Life Insurance Company

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 # ICC13-8000R1 or ICC13-8001R1

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 form as this policy.

Rate Increase History The company has sold long term care insurance since 1974 and has sold this policy since 2014. 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 - Not every series was available in every state	**Years Available for Sale**	**Percentage of Increase**[1]	**Effective Year**[2]
6465, 6026, 6318, 6322, 6328, 6394, 6395	1974-1989	0-10%	2007-2015
6484, 6667, 7003, 7012, 7021, 50000, 50001, 50003, 50004, 50013, 50018, 50020, 50021, 50022, 50023, 50024, 50029, 50100, 50107, 51000	1988-2003	0-14%	2007-2015
		0-88%	2012-2015
7000, 7002, 7011, 7020, 7022, 50024, 50027, 50109, 50110, 51001, 51002	1993-2005	0-12%	2007-2010
		0-25%	2011-2015
		0-118%	2012-2015
7011, 7012, 7030, 7031, 7032, 7033, 7034, 51005, 51006, 51007	1997-2004	0-11%	2007-2010
		0-25%	2011-2015
		0-97%	2012-2015
7025, 7035, 7037, 51010, 51001	2001-2006	0-60%	2012-2015
7040	1999-2012	0-35%	2013-2015
7044, 7042, 7044REV, 7042REV	2003-2012	0-12.8%	2014-2016

[1] The amount of the rate increase may vary by state; policy form series; or policy type. The Percentage of increase shown reflects the aggregate effect of more than one rate increase request.

[2] Future effective dates reflect rate increases requested, but not yet implemented. Each date range represents a separate rate increase request.

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? (check one)

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

The national median annual cost of care in 2014 was $87,600 ($240 per day), but this figure varies across the country. In ten years the national median annual cost would be about $142,700, 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 $240/day) is shown for each elimination period choice.

◯ 30 Days ($7,200) ◯ 90 Days ($21,600) ◯ 180 Days ($43,200) ◯ 365 Days ($87,600)

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 ten 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.

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

X

Printed Name | Date mm/dd/yy

Applicant B Signature

X

Printed Name | Date mm/dd/yy

I explained to the applicant(s) the importance of completing this information.

Agent/Producer's Signature

X

Agent/Producer's Printed Name | Date mm/dd/yy

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 may not be suitable for me. However, I still want the company to consider my application.

Applicant A Signature | Date mm/dd/yy

X

Applicant B Signature | Date mm/dd/yy

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.

Genworth

Verification of Financial Non-Disclosure

from Genworth Life Insurance Company

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Signatures

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 proceed with your review of my application.

◯ No, I have decided not to buy a policy at this time.

Applicant A Signature

X

Printed Name | Date *mm/dd/yy*

Applicant B Signature

X

Printed Name | Date *mm/dd/yy*

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, VA 24501-4948

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Long Term Care Insurance
Potential Rate Increase Disclosure Form

from Genworth Life Insurance Company

Potential Rate Increases

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 Signed
X	
Applicant B Signature	Date Signed
X	

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).

Contingent Nonforfeiture *(continued)*

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

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Requirements To Access Couples Benefits

from Genworth Life Insurance Company

Spouses and Partners, whether married or not, may be eligible to apply for Couples Benefits (the Shared Benefit Rider or the couples premiums) if they meet the criteria below.

Criteria to qualify for Couples Benefits:

Two people who, at the time of application:

- are joined by a relationship legally recognized under State law as entitled to the same rights and benefits of married persons; or
- are and have been living together for the past three consecutive years in a committed domestic relationship as partners. You and Your partner cannot be joined to anyone else by: (a) marriage; or (b) a domestic relationship legally recognized under State law.

Spouse or Partner excludes:

- anyone who is related to You as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece. This includes adopted, in-law and step-relatives.

You may only have one Spouse or Partner for purposes of the Policy.

Signatures

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

Applicant's Signature

X

Printed Name of Applicant	Date *mm/dd/yy*

Applicant's Signature

X

Printed Name of Applicant	Date *mm/dd/yy*

Agent/Producer Signature

X

Printed Name of Agent/Producer	Date *mm/dd/yy*

This form MUST be submitted with the application(s) for Couples Benefits eligibility consideration.

Submit completed form, along with application(s), to:
Genworth Life Insurance Company
Long Term Care Insurance Division
3100 Albert Lankford Drive
Lynchburg, VA 24501-4948

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Notice to applicant regarding replacement of accident and sickness or long term care insurance

from Genworth Financial Insurance Company

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

Signature of Insurance Producer, Agent, Broker, or other Representative — Date Signed

X ▪

Print Name and Address of Insurance Producer or other Representative of Agent or Broker

X

Signature of Applicant A

X

The above "Notice to Applicant" was delivered to me on:

▪ Date

Signature of Applicant B

X

The above "Notice to Applicant" was delivered to me on:

▪ Date

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