Genworth

IGO App Quickcheck Guide

Receive a faster response with an "In Good Order" (IGO) Application

Before submitting the application:
Check it for these most often missed minimum requirements for smooth IGO processing.

Prior to soliciting the application:
Check that you are licensed (and appointed, if applicable) in the appropriate state. Be sure you are using the appropriate state-specific version of the application based on the policy's state of delivery.

Page 1

1. Proposed Insured

- Full Name
- Gender
- Date of Birth
- State/Country of Birth
- Social Security Number
- Complete Home Address (No abbreviations in city, state and zip code.) If home address is different from mailing address, include mailing address.
- Is the Proposed Insured a United States citizen **(If no, complete the Resident Alien Supplement, including all Visa information.)**
- Driver's License # and State (If no driver's license, state "None.")
- Phone Numbers (with area codes)

2. Ownership

- Owner's Full Name (If trust, give full name(s) of trustee(s) and trust, and date of trust agreement.)
- Complete Address
- Relationship to Proposed Insured
- Social Security Number or TIN
- Date of Birth/Trust Date (required prior to issue in CA and MN)
- Phone Numbers (with area codes)
- If owner is an individual, complete citizenship information and State/Country of birth. **(If not a United States citizen, complete the Owner Resident Alien Supplement form.)** If owner is a business, complete the business questions.

Page 2

3. Beneficiary

If percentage shares are not given, they will be equal.

- Full Name (If trust, give full name(s) of the trustee(s) and trust, and date of trust agreement.)
- Complete Address
- % Share
- Relationship to Proposed Insured
- Social Security Number or TIN
- Date of Birth/Trust Date
- Phone Numbers (with area codes)

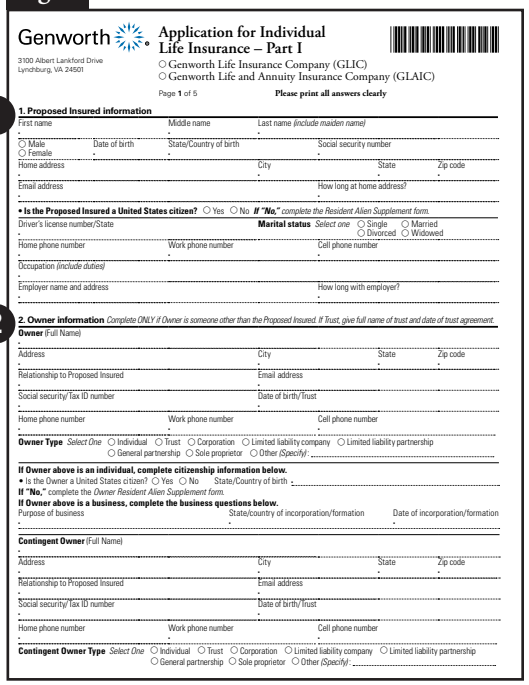
4. Insurer, Plan and Amount of Insurance

- Insurer (select one): Genworth Life Insurance Company (GLIC) or Genworth Life and Annuity Insurance Company (GLAIC)
- Plan of Insurance (Use complete plan name; i.e., use "Colony[SM] Term 10," not "Colony[SM] Term," or use "GenGuard® UL," not "UL."

5. Death Benefit Option

If left blank, "Level" will be given for applicable plans.

Page 1



Genworth

Application for Individual Life Insurance – Part I

3100 Albert Lankford Drive
Lynchburg, VA 24501

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

Page 1 of 5 — Please print all answers clearly

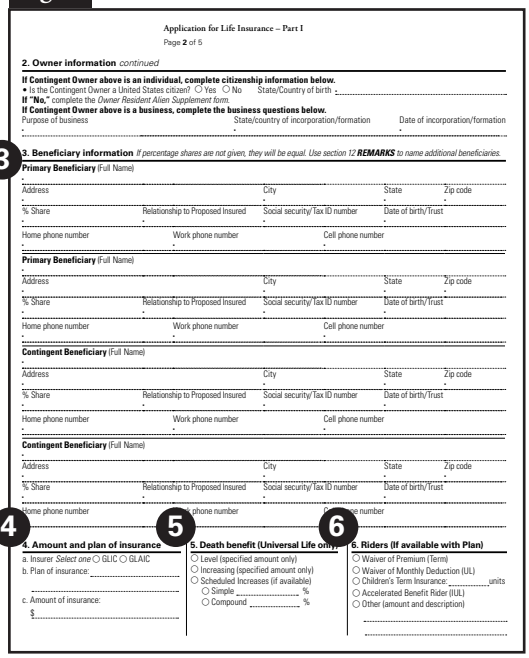
1

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

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):

Page 2



Application for Life Insurance – Part I

Page 2 of 5

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

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

4. Amount and plan of insurance
a. Insurer Select one ○ GLIC ○ GLAIC
b. Plan of insurance:
c. Amount of insurance:
$

5

5. Death benefit (Universal Life only)
○ Level (specified amount only)
○ Increasing (specified amount only)
○ Scheduled Increases (if available)
○ Simple ____ %
○ Compound ____ %

6

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)

6. Riders (if available with plan)

- Waiver of Premium (Term)
- Waiver of Monthly deduction (UL) (For Waiver of Specified Premium, include amount of monthly waiver benefit; amount cannot exceed the planned premium.)
- Children's Term Ins.: Units ____ (Complete CIR application. If "Units" is blank, 10 units will be given.)
- Accelerated Benefit Rider (IUL)
- Other (amount and description)

Are all questions answered?
Omission of any of these answers could result in amendments at the time of delivery.

Did everyone sign?

Money
All checks must be payable to the insurer selected on the application. Neither Third Party Checks nor cash will be accepted. The TIAA date, application date and check date must all match.

Another company's exam
A completed Part II Medical History form is required if another company's exam is accepted. Be sure that you are using the appropriate state-specific version based on the policy's state of delivery.

Minors
A completed Part II Medical History form is required for all minors. Be sure you are using the appropriate state-specific version based on the policy's state of delivery.

HIV consent
All HIV consent forms should be obtained for the Proposed Insured's resident state.
Exception: if policy is to be delivered in CA or TX, use a CA or TX form, respectively.

Page 3

7. Premiums

- Payment Method (If blank and other than monthly, will be "Direct Bill.")
- Payment Mode (If blank, will be "Annual.") Direct Monthly is not available.
- Premium source

A complete illustration, projection or premium verification will be required on all UL cases in order to issue in a timely manner.

8. Proposed Insured's Tobacco, Nicotine and Nicotine Substitute Use

- Mark One: Never Used, Totally Stopped, Use Now
- Totally Stopped (Complete "b" and give date and reason in remarks.)

9. Proposed Insured's Insurance Needs – Required for All Applications

Must select Business or Personal and answer all questions.

10. Proposed Insured's Existing Insurance/ Replacement

- **This must be fully completed in accordance with the state in which the policy will be delivered.**
  If NAIC state and "yes" to existing insurance (10a), complete appropriate replacement form(s); if non-NAIC state and "yes" to replacement (10b), complete appropriate replacement form(s).
- All existing coverage, whether being replaced or not, must be listed.

Page 4

11. Proposed Insured's History – Supplemental Forms May be Required

- If any answers are "yes," provide details and complete supplement.

Page 5

A. Representations

- State in Which Owner Signed Application
- State in Which Policy Will Be Delivered
- Proposed Insured Signature (Parent or legal guardian must sign for child on Part I and non-med form.)
- Date
- Owner Signature and Title
- All Trustee Signatures (if applicable)
- Agent Signature

Agent's Report

B. Licensed Insurance Agent's Report

- Must answer Existing Insurance and Replacement question #1a.
- If Proposed Insured is married, complete #1d.
- If Proposed Insured is a Minor, complete #1e.
- Agent must sign.

C. Managing Agency/Brokerage Report

- Managing Agency/Brokerage Name
- Managing Agency/Brokerage No.

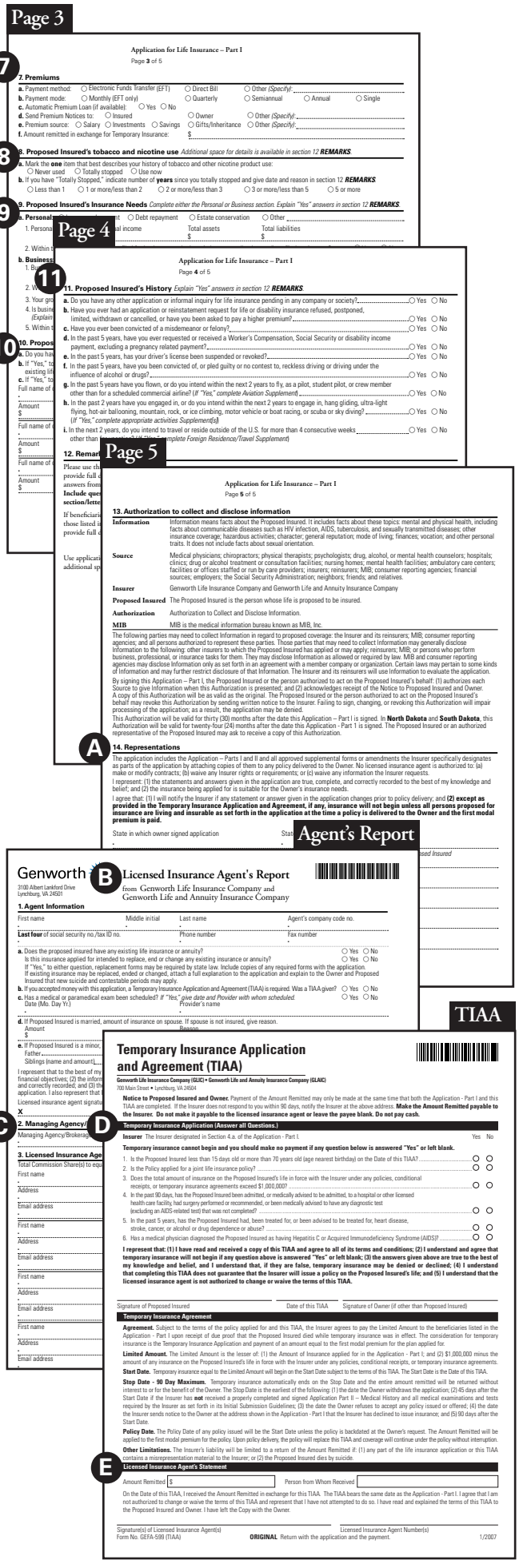
TIAA

D. Temporary Insurance Application

- TIAA - All questions answered
- TIAA - Money cannot be accepted if any questions are answered "yes" or left blank (If collected, money will be returned).
- Insured and Owner's Signature and date

E. Licensed Insurance Agent's Statement

- Agent Signature



BULLETIN:

Colony Term LQR Minimum Face Amount Requirement Reduced

genworth.com | September 14, 2015

Effective – 09/14/15

States – All states except New York.

Contact – For more information, contact your Genworth Sales Representative.

Genworth, a long-time leader in life insurance, is announcing added submission flexibility for your Colony Term cases.

Effective Monday, September 14, 2015, all Colony Term applications with face amounts over $100,000 are now commission eligible when submitted through paper applications in addition to the Life Quick Request® (LQR) fulfillment platform*.

This change increases your submission choices, enabling you to select which best fits your practice. Colony Term has been and continues to be a market leading product, especially for face amounts under $500,000.

Transition Rules

As of **Monday, September 14**, all Colony Term applications with face amounts over $100,000 may be submitted via paper applications or through LQR or iLQR (iPipeline® platform).

Pending Inventory

All LQR and iLQR tickets submitted prior to Monday, September 14, will continue through the fulfillment process.

Reminder

Colony Term applications with face amounts of $100,000 and below must continue to be submitted using LQR or iLQR for commissions to be paid.

continued –

159540 09/02/15

In situations where LQR or iLQR is unavailable, paper applications will be accepted and eligible for commissions. Please include the applicable situation listed below on your cover letter to ensure proper handling. LQR and iLQR are unavailable in the following situations:

- Arkansas, Rhode Island and Wyoming replacement policies
- Bermuda cases
- New Jersey cases with a Temporary Insurance Application and Agreement (TIAA)
- Business-owned
- Applicant requires translator (for language other than Spanish or English)

* As of February 1, 2015, cases processed through Life Quick Request had a median cycle time of 13 days for term life insurance from the day New Business receives the case to the day the policy is mailed. Term cases with face amounts greater than $100,000 have an 8% increase in placement ratio over paper applications (rolling 12-month average).

Colony Term has guaranteed level premiums for the selected periods of 10, 15 and 20 years. After the level premium period, premiums are not guaranteed and increase annually subject to maximums stated in the policies. Benefits for all policies cease at the policy anniversary nearest the insured’s 98th birthday (in MD, the insured’s 95th birthday).

Colony Term is subject to Policy Form No. 1420 (96) et al. or 1421 et al. (Genworth Life & Annuity) or Policy Form No. GE-1420 et al. (Genworth Life).

All products, their riders and benefits are subject to the terms and conditions of their policy forms and to state availability and issue limitations. Colony Term is not available in New York.

Refer to the insurance policy for definitions and more details regarding coverage and its features. This bulletin provides a summary of coverage. Policy terms and provisions will prevail.

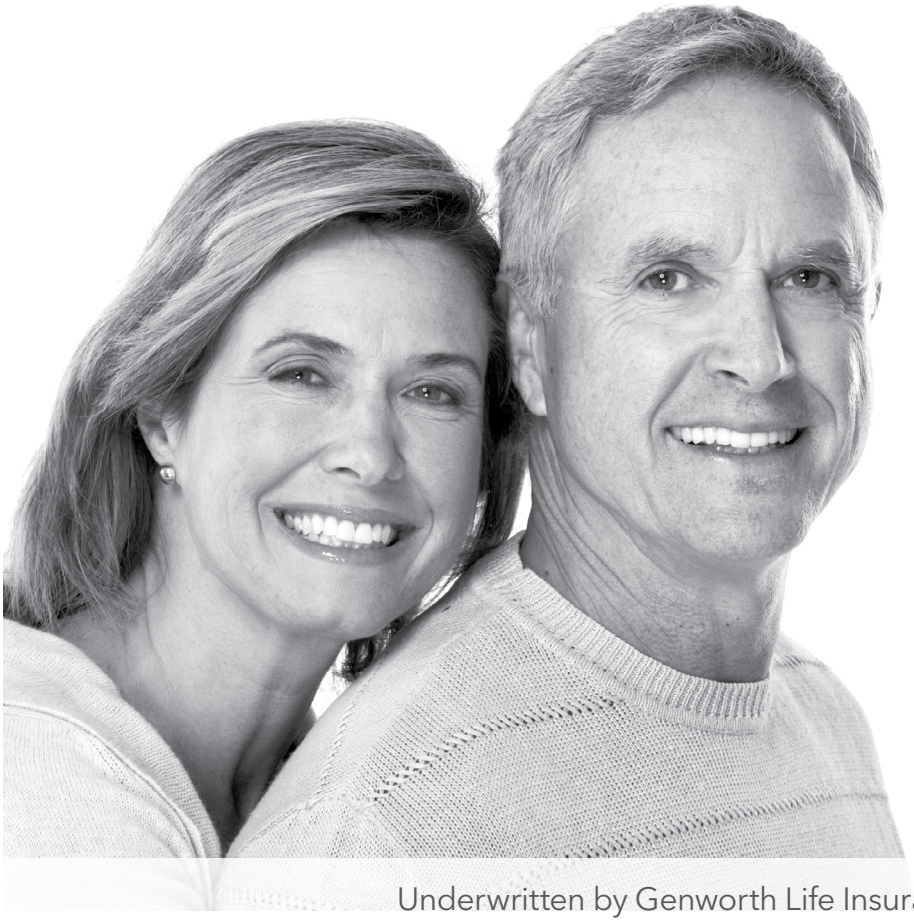
All guarantees are based on the claims-paying ability of the issuing insurance company.

Application for Life Insurance

☐ Life Ready℠ UL II
☐ Colony℠ Term

Company Submission Materials Enclosed

Genworth®



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)
- ☐ Verification of Disclosures Form (CA Residents 65 and Older)
- ☐ Notice Regarding Standards for Medi-Cal Eligibility and Recovery Form

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

B129897CA 02/16/15

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. Are you employed by a business that, within the past 5 years, has filed for bankruptcy or had any judgments, liens or collection actions filed against it? ◯ Yes ◯ No
i. If "Yes" for bankruptcy, under what Chapter of the Bankruptcy Code did your bankruptcy proceed?
Chapter ◯ 7 ◯ 11 ◯ 12 ◯ 13
ii. Has the bankruptcy been discharged? ◯ Yes ◯ No
If "Yes," provide date of discharge ..... ***(If "No,"*** *provide details in section 12* ***REMARKS****.)*

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? (*If "Yes," complete appropriate activities Supplement[s]*) ○ Yes ○ No

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 thirty (30) months 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.**

State in which owner signed application

State in which policy will be delivered

Signature of Proposed Insured

Date

Signature of Owner *If not Proposed Insured*

X

X

Licensed Insurance agent signature

Licensed Insurance agent name printed

X

License No.

Managing agency/Brokerage No.

Licensed Insurance agent signature

Licensed Insurance agent name printed

X

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.	

Genworth

3100 Albert Lankford Drive
Lynchburg, VA 24501

Application for Individual Life Insurance Part I - Overflow Form

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

Proposed Insured
.

Social security number
.

Remarks *Use this section for explanations and special requests. Identify applicable item number and letter.*

Signature of Proposed Insured
X

Date
.

Owner (*If not Proposed Insured: Signature and Title)*
X

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.

Temporary Insurance Application and Agreement (TIAA)

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

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.**

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 below is answered "Yes" or left blank.

	Yes	No
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?	◯	◯
2. Is the Policy applied for a joint life insurance policy?	◯	◯
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?	◯	◯
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?	◯	◯
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse?	◯	◯
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)?	◯	◯

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)

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.

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)

Temporary Insurance Application and Agreement (TIAA)

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

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.**

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 below is answered "Yes" or left blank.

	Yes	No
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?	◯	◯
2. Is the Policy applied for a joint life insurance policy?	◯	◯
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?	◯	◯
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?	◯	◯
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse?	◯	◯
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)?	◯	◯

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)

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.

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)

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

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® 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)*

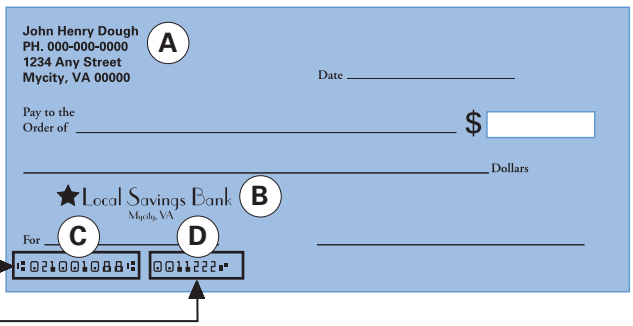
Bank routing number *(see "C" below)*

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 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, 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 test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
   (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or 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.

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 a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result 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. Test results may be maintained in a file or a data bank.

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.

I have read and I understand this Notice and 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.

Proposed Insured (Please Print) _____ Date of Birth _____

Name and address of designated Physician:

_____

_____

_____

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

◯ **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 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, 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 test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
   (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or 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.

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 a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result 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. Test results may be maintained in a file or a data bank.

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.

I have read and I understand this Notice and 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.

Proposed Insured (Please Print) _____ Date of Birth _____

Name and address of designated Physician:

_____

_____

_____

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

○ **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

LISTING OF CALIFORNIA AIDS COUNSELING RESOURCES
EARLY INTERVENTION PROJECTS/CENTERS

Following is a list of counseling resources where you can obtain assistance in understanding the meaning of the HIV antibody/antigen testing and the test results.

ALAMEDA COUNTY
Fairmont Hospital
15400 Foothill Boulevard
San Leandro, CA 94578
(510) 667-3937
FAX (510) 667-4400

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Raygenia Stewart-Budd
(510) 271-4229

ALAMEDA/CONTRA COSTA COUNTIES
SisterCare
Women's Early Intervention Center
3000 Colby Street, #206
Berkeley, CA 94705
(510) 204-2700
FAX (510) 549-2673

Operating Hours: M/Tu/W/Th/F – 9am to 5pm
Contact Person: Project Director – Gay Calhoun
(510) 204-2700

BUTTE/GLENN/SHASTA/TEHAMA/TRINITY COUNTIES
Butte County Department of Public Health
695 Oleander Avenue
Chico, CA 95926
(530) 895-6562
FAX (530) 891-2873

Operating Hours: M/Tu/W/Th – 8am to 5:30pm
Contact Person: Project Director – Carmen Ochoa
(530) 895-6545

FRESNO COUNTY
Fresno County Health Services Agency
1221 Fulton Mall
Fresno, CA 93775
(209) 445-3434
FAX (209) 445-3535

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Alan Gilmore
(209) 445-3434

HUMBOLDT/DEL NORTE COUNTIES
Humboldt County Department of Public Health
North Coast AIDS Project
529 "I" Street
Eureka, CA 95501
(707) 268-2132
FAX (707) 445-6097

Operating Hours: M/Tu/W/Th/F – 8:30am to 5pm
Contact Person: Project Director – Peggy Falk
(707) 268-2142

KERN COUNTY
Kern County Department of Public Health
1700 Flower Street — (805) 868-0327
Bakersfield, CA 93305 — FAX (805) 868-0263

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Veva Islas — (805) 868-0331

KINGS COUNTY
Kings County Department of Public Health
AIDS Care Program
330 Campus Drive — (209) 584-1401
Hanford, CA 93230 — FAX (209) 582-0927

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Barbara Van Baren — (209) 584-1401, Ext. 4531

LONG BEACH CITY
Long Beach Department of Health & Human Services
2525 Grand Avenue, Room 204 — (562) 570-4317
Long Beach, CA 90815 — FAX (562) 570-4033

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Patrick Burkhardt — (562) 570-4328

LOS ANGELES COUNTY
Los Angeles County Health Department
3209 North Alameda, Suite K — (310) 761-8444
Compton, CA 90222 — FAX (310) 761-8448

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Deloris Pace — (310) 761-8444

WomensCare
Women's Early Intervention Center
1300 North Vermont, #401 — (213) 662-7420
Los Angeles, CA 90027 — FAX (213) 662-3910

Operating Hours: M/Tu/W/Th/F – 9am to 5:30pm
Contact Person: Project Director – Lupe Carreon — (213) 662-7420

MADERA/MARIPOSA/MERCED COUNTIES
Madera County Department of Public Health
14215 Road 28 — (209) 675-7627
Madera, CA 93638 — FAX (209) 674-7262

Operating Hours: By Appointment
Contact Person: Project Director – Anne Harris — (209) 675-7627

ORANGE COUNTY
Orange County Health Care Agency
1725 West 17th Street, Building 50 — (714) 834-7991
Santa Ana, CA 92706 — FAX (714) 834-7958

Operating Hours: M/W/Th/F – 8am to 4pm, Tu – 10am to 5:30pm
Contact Person: Project Director – Karen Schneider — (714) 834-8406

PLUMAS/LASSEN/MODOC/SIERRA/SISKIYOU COUNTIES
Plumas County Department of Health Services
P.O. Box 3140
586 Jackson Street (530) 283-6113
Qunicy, CA 95971 FAX (530) 283-6156

Operating Hours: Flexible, by appointment
Contact Person: Project Director – Karla Burnworth (530) 283-6257

RIVERSIDE COUNTY
Riverside Neighborhood Health Center
7140 Indiana Avenue (909) 358-6005
Riverside, CA 92507 FAX (909) 358-6007

Operating Hours: M/Th/F – 8am to 5pm, Tu/W – 8am to 9pm
Contact Person: Project Director – Victoria Jauregui (909) 358-5307

SACRAMENTO COUNTY
Center for AIDS Research, Education and Service (CARES)
1500 21st Street (916) 443-3299
Sacramento, CA 95814 FAX (916) 443-2438

Operating Hours: M/Tu/W/Th/F – 9am to 5pm
Contact Person: Project Director – Robert Caulk (916) 443-3299

SAN BERNARDINO COUNTY
San Bernardino County Department of Public Health
799 East Rialto Avenue (909) 383-3060
San Bernardino, CA 92415 FAX (909) 387-6228

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Chino EIP Clinic: F – 8am to 10:45am (Call (909) 383-3060 for appointment)
Hesperia EIP Clinic: W/F – 8am to 10:45am (Call (909) 383-3060 for appointment)
Contact Person: Project Director – Alex Taylor (909) 387-6206

SAN DIEGO COUNTY
Department of Health Services
1700 Pacific Highway, Room 110 (619) 515-6655
San Diego, CA 92101 FAX (619) 515-6646

Operating Hours: M/Tu/W/Th/F – 8am to 4:30pm
Contact Person: Project Director – Michelle Ginsberg, M.D. (619) 515-6638

SAN FRANCISCO CITY/COUNTY
La Clinica Esperanza
Mission Neighborhood Health Center
240 Shotwell Street (at 16th Street) (415) 431-3212
San Francisco, CA 94110 FAX (415) 863-6384

Operating Hours: Office: M/Tu/W/Th/F – 9am to 6pm
Clinic: M/Tu/W/Th – 12pm to 9pm, F – 9am to 6pm
Contact Person: Project Director – Brenda Storey (415) 552-1013, Ext. 203

SAN LUIS OBISPO COUNTY
San Luis Obispo County Health Agency
2191 Johnson Avenue (805) 781-5540
San Luis Obispo, CA 93401 FAX (805) 781-1154

Operating Hours: Flexible, call for appointment
Contact Person: Project Director – Marsha Bollinger (805) 781-4200

SAN MATEO COUNTY
San Mateo County AIDS Program
3700 Edison Street (650) 573-2385
San Mateo, CA 94403 FAX (650) 573-2474

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Jonathan Mesinger (650) 573-2587

SANTA BARBARA COUNTY
AIDS Project Central Coast
126 East Haley Street, Suite A-17 (805) 681-5488
Santa Barbara, CA 93101 FAX (805) 681-4782

Operating Hours: M/Tu/W/Th/F – 9am to 5pm, some evenings
Contact Person: Project Director – Angela Antenore (805) 681-5365

SANTA CLARA COUNTY
Santa Clara County Health Department
PACE Clinic
2400 Moorpark Avenue, Suite 316 (408) 885-5935
San Jose, CA 95128 FAX (408) 885-4699

Operating Hours: Clinic – M – 8am to 8pm, Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Pat Cox (408) 885-4693

SONOMA COUNTY
Sonoma County Public Health Department
499 Humboldt Street (707) 524-7400
Santa Rosa, CA 95404 FAX (707) 524-7346

Operating Hours: Clinic – M/Tu/W/Th/F – 8:30am to 5pm
Contact Person: Project Director – Pat Kuta (707) 524-7379

TULARE COUNTY
Tulare County Health & Human Services Agency
1062 South "K" Street (209) 685-2535
Tulare, CA 93274 FAX (209) 685-2661

Operating Hours: M/Tu/W/Th/F – 8am to 5pm
Contact Person: Project Director – Kathleen Farrell (209) 685-2535

VENTURA COUNTY
Ventura County Public Health
3147 Loma Vista Road (805) 652-6162
Ventura, CA 93003 FAX (805) 652-3320

Operating Hours: M/Tu/W/Th/F – 8am to 4:30pm
Client Contact Person: Case Manager – Craig Webb (805) 652-6162
Contact Person: Project Director – Diane Seyl (805) 652-6152

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.

f. The Employer certifies that the Employee (Proposed Insured) is either 1) not a California resident or 2) is a California resident and is a current or former employee and is an exempt employee as defined by California Labor Code §515 and any adopted 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

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY
REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing its policy.

List below the identification of policies you intend to replace.

Name of Existing Insurer	Contract or ID* Number	Generic Name of Policy	Name of Insured

*If the existing insurer has not assigned a policy number, list alternative identification such as an application or receipt number.

Name of Proposed Insured _____ Date of Birth _____

Applicant (if different) _____

Address _____

Application Number _____

_____
Replacing Agent – print name

_____ _____ _____
Applicant (signature) Date Replacing Agent (Signature)

ATTENTION CONSUMER: THIS NOTICE IS REQUIRED BY THE INSURANCE COMMISSIONER.
PLEASE READ IT CAREFULLY BEFORE SIGNING.

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

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022

◯ **Genworth Life Insurance Company**
Fixed Life: P.O. Box 461 • Lynchburg, VA 24505-0461

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022

Comparative Information Form

Genworth Life and Annuity Insurance Company • Genworth Life Insurance Company

AGENTS – Complete the following information and provide a copy to the applicant. Do not send a copy to the existing or proposed insurer.

Name of Proposed Insured	Address
City & State	Date of Birth

	Existing insurance	**Proposed insurance**
Name of company		
Policy number		
Basic policy generic name		
Name of basic policy		
Rider 1; generic name		
Rider 2; generic name		
Rider 3; generic name		
Issue age		
Date of issue		
Contestable period expires		
Suicide clauses expires		

	Prem. mode: Amount	**Age payable to**	**Death benefit**	**Age Benefit ceases**	**Prem. mode: Amount**	**Age payable to**	**Death benefit**	**Age benefit ceases**
Basic policy	$		$		$		$	
Rider 1	$		$		$		$	
Rider 2	$		$		$		$	
Rider 3	$		$		$		$	
Accidental death benefit	$		$		$		$	
Option to purchase additional insurance	$		$ Option Ages:_____		$		$ Option Ages: _____	
Waiver of premium benefit	$		$xxx		$		$xxx	
Disability income benefit	$		$xxx Monthly Income:		$		$xxx Monthly Income:	
Total current premium	$		$		$		$	

	*Guaranteed cash value	*Dividends	*Guaranteed cash value	*Dividends
Currently (last Policy anniversary)	$	$	$	$
1 year hence	$	$	$	$
5 years hence	$	$	$	$
10 years hence	$	$	$	$
At Age 65	$	$	$	$

*Current Death Benefit of Dividend Additions	$		
*Current Cash Value of Dividend Additions	$		
*Current Accumulated Dividends	$		
*Current Policy Loan	$		
Existing Maximum Policy Loan Interest Rate	%	Proposed Maximum Policy Loan Interest Rate	%
*Existing Dividends are based on the (_____ Year) scale.		*Proposed Dividends are based on the current (_____ Year) scale.	

Dividends, policy loan and certain guaranteed cash value information concerning your existing insurance may not be known to our agent. Dividends are not guaranteed. However, they may materially reduce the cost of insurance and are an important factor to consider. Thus, if dividends or other figures have been omitted from this Comparative Information Form, you should not reach a final decision to replace your existing insurance until you have them. You may obtain the omitted figures from the company that issued your existing policy. We will notify that company of your intent to replace your existing policy.

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY
REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing its policy.

List below the identification of policies you intend to replace.

Name of Existing Insurer	Contract or ID* Number	Generic Name of Policy	Name of Insured

*If the existing insurer has not assigned a policy number, list alternative identification such as an application or receipt number.

Name of Proposed Insured _____ Date of Birth _____

Applicant (if different) _____

Address _____

Application Number _____

_____
Replacing Agent – print name

_____ _____ _____
Applicant (signature) Date Replacing Agent (Signature)

ATTENTION CONSUMER: THIS NOTICE IS REQUIRED BY THE INSURANCE COMMISSIONER.
PLEASE READ IT CAREFULLY BEFORE SIGNING.

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

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022

◯ **Genworth Life Insurance Company**
Fixed Life: P.O. Box 461 • Lynchburg, VA 24505-0461

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022

Comparative Information Form

Genworth Life and Annuity Insurance Company • Genworth Life Insurance Company

AGENTS – Complete the following information and provide a copy to the applicant. Do not send a copy to the existing or proposed insurer.

Name of Proposed Insured	Address
City & State	Date of Birth

	Existing insurance	**Proposed insurance**
Name of company		
Policy number		
Basic policy generic name		
Name of basic policy		
Rider 1; generic name		
Rider 2; generic name		
Rider 3; generic name		
Issue age		
Date of issue		
Contestable period expires		
Suicide clauses expires		

	Prem. mode: Amount	**Age payable to**	**Death benefit**	**Age Benefit ceases**	**Prem. mode: Amount**	**Age payable to**	**Death benefit**	**Age benefit ceases**
Basic policy	$		$		$		$	
Rider 1	$		$		$		$	
Rider 2	$		$		$		$	
Rider 3	$		$		$		$	
Accidental death benefit	$		$		$		$	
Option to purchase additional insurance	$		$ Option Ages:_____		$		$ Option Ages: _____	
Waiver of premium benefit	$		$xxx		$		$xxx	
Disability income benefit	$		$xxx Monthly Income:		$		$xxx Monthly Income:	
Total current premium	$		$		$		$	

	*Guaranteed cash value	*Dividends	*Guaranteed cash value	*Dividends
Currently (last Policy anniversary)	$	$	$	$
1 year hence	$	$	$	$
5 years hence	$	$	$	$
10 years hence	$	$	$	$
At Age 65	$	$	$	$

*Current Death Benefit of Dividend Additions	$		
*Current Cash Value of Dividend Additions	$		
*Current Accumulated Dividends	$		
*Current Policy Loan	$		
Existing Maximum Policy Loan Interest Rate	%	Proposed Maximum Policy Loan Interest Rate	%
*Existing Dividends are based on the (_____ Year) scale.		*Proposed Dividends are based on the current (_____ Year) scale.	

Dividends, policy loan and certain guaranteed cash value information concerning your existing insurance may not be known to our agent. Dividends are not guaranteed. However, they may materially reduce the cost of insurance and are an important factor to consider. Thus, if dividends or other figures have been omitted from this Comparative Information Form, you should not reach a final decision to replace your existing insurance until you have them. You may obtain the omitted figures from the company that issued your existing policy. We will notify that company of your intent to replace your existing policy.

Genworth

VERIFICATION OF DISCLOSURES TO CALIFORNIA RESIDENTS 65 AND OLDER

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

○ Genworth Life Insurance Company
P.O. Box 461, Lynchburg, VA 24505-0461

Advisement of Consequences in the Sale or Liquidation of Assets: I have advised the applicant that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other assets used to fund the purchase of a life or annuity product may involve tax consequences, early withdrawal penalties, or other costs or penalties associated with the sale or liquidation of the assets. I have also advised the applicant to obtain the advice of independent legal or financial counsel before selling any assets and before purchasing the life or annuity product.

Medi-Cal Notice: If this purchase of a financial product is based on the treatment under the Medi-Cal program I have given the applicant the *'Notice Regarding Standards for Medi-Cal Eligibility and Recovery'* form*, Form No. DISCLCA2.

At Home Pre-Solicitation Notice: If the sale of this financial product was conducted in the applicant's home, I acknowledge that a Pre-Solicitation Notice* was provided. The notice was a stand-alone document with the following information: 1) the applicant's right to contact the Department of Insurance for information or 2) the applicant's right to contact the Department of Insurance to file a complaint, and 3) the names, title and insurance licenses of all individual presenting or attending the solicitation meeting. This notice was provided in writing to the applicant:

- If an initial meeting, no less than 24 hours and no more than 14 days prior to the meeting, or
- If an existing relationship and applicant requested a same day meeting, just prior to the meeting.

*A sample of these notices are provided on Genworth.com

Date _____ Signature of Agent _____

My signature attests to the fact that I provided the above notices and/or disclosures, if applicable.

Genworth

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

If you, or your spouse, are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You, or your spouse, do not have to use up all of your savings before applying for Medical.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than (insert amount of individual's resource allowance _____) in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of (insert amount of personal needs allowance _____) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of community countable assets _____).

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or (insert amount of the minimum monthly maintenance needs allowance _____), whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than (insert amount of community spouse resource allowance plus individual's resource allowance _____) in countable resources. The order also may allow the at-home spouse to retain more than (insert amount of the monthly maintenance needs allowance _____) in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

ONE PRINCIPAL RESIDENCE: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.
The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL PROPERTY USED IN A BUSINESS OR TRADE: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.

ONE MOTOR VEHICLE.

IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.

THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I have read the above notice and have received a copy.

Date	Prospective Purchaser's Signature
Date	Spouse's Signature (if Applicable)
Date	Legal Representative (if Applicable)

Disclosure Statement

◯ **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

DISCLOSURE STATEMENT FOR UNIVERSAL LIFE POLICIES WITH NO-LAPSE GUARANTEES OR ANY SIMILAR CONFIGURATION

This policy is guaranteed to stay in force for a number of years as long as you have paid at least as much as the required premiums. This is called a no-lapse guarantee.

Even though it contains a no-lapse guarantee, this policy may provide nonforfeiture benefits (such as cash surrender values) which are less than those that would be provided if the no-lapse guarantee were issued as a separate policy (for example, as a term policy). However, the premiums for the term policy might be higher than those for the no-lapse guarantee in this policy.

When considering the purchase of this policy, you should consider the value to you of higher nonforfeiture benefits versus the level of the premiums required to keep your insurance coverage in force.

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

NOTICE AND CONSENT FOR 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, 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 test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
   (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or 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.

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 a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result 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. Test results may be maintained in a file or a data bank.

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.

I have read and I understand this Notice and 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.

Proposed Insured (Please Print) _____ Date of Birth _____

Name and address of designated Physician:

_____

_____

_____

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

○ **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

Genworth

VERIFICATION OF DISCLOSURES TO CALIFORNIA RESIDENTS 65 AND OLDER

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

○ Genworth Life Insurance Company
P.O. Box 461, Lynchburg, VA 24505-0461

Advisement of Consequences in the Sale or Liquidation of Assets: I have advised the applicant that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other assets used to fund the purchase of a life or annuity product may involve tax consequences, early withdrawal penalties, or other costs or penalties associated with the sale or liquidation of the assets. I have also advised the applicant to obtain the advice of independent legal or financial counsel before selling any assets and before purchasing the life or annuity product.

Medi-Cal Notice: If this purchase of a financial product is based on the treatment under the Medi-Cal program I have given the applicant the *'Notice Regarding Standards for Medi-Cal Eligibility and Recovery'* form*, Form No. DISCLCA2.

At Home Pre-Solicitation Notice: If the sale of this financial product was conducted in the applicant's home, I acknowledge that a Pre-Solicitation Notice* was provided. The notice was a stand-alone document with the following information: 1) the applicant's right to contact the Department of Insurance for information or 2) the applicant's right to contact the Department of Insurance to file a complaint, and 3) the names, title and insurance licenses of all individual presenting or attending the solicitation meeting. This notice was provided in writing to the applicant:

- If an initial meeting, no less than 24 hours and no more than 14 days prior to the meeting, or
- If an existing relationship and applicant requested a same day meeting, just prior to the meeting.

*A sample of these notices are provided on Genworth.com

Date _____ Signature of Agent _____

My signature attests to the fact that I provided the above notices and/or disclosures, if applicable.

Genworth

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

If you, or your spouse, are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You, or your spouse, do not have to use up all of your savings before applying for Medical.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than (insert amount of individual's resource allowance _____) in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of (insert amount of personal needs allowance _____) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of community countable assets _____).

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or (insert amount of the minimum monthly maintenance needs allowance _____), whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than (insert amount of community spouse resource allowance plus individual's resource allowance _____) in countable resources. The order also may allow the at-home spouse to retain more than (insert amount of the monthly maintenance needs allowance _____) in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

ONE PRINCIPAL RESIDENCE: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.
The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL PROPERTY USED IN A BUSINESS OR TRADE: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.

ONE MOTOR VEHICLE.

IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.

THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I have read the above notice and have received a copy.

Date	Prospective Purchaser's Signature
Date	Spouse's Signature (if Applicable)
Date	Legal Representative (if Applicable)

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.

f. The Employer certifies that the Employee (Proposed Insured) is either 1) not a California resident or 2) is a California resident and is a current or former employee and is an exempt employee as defined by California Labor Code §515 and any adopted 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 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

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.

Secondary Addressee Designation Form

○ **Genworth Life and Annuity Insurance Company (GLAIC)** ○ **Genworth Life Insurance Company (GLIC)**
700 Main Street • Lynchburg, VA 24504

Right to Name a Second Addressee

The law in your state permits you to name a secondary addressee. We will process any secondary addressee you list in the space below. The person you designate below will receive duplicate copies of the policy's billing correspondence. You may revoke your designation or update it by providing written notice to the Company at any time.

Second Addressee

a. Full Name

b. Home Address (Give Number, Street, City, State and Zip Code.)

Telephone Number

Applicant's signature

Date

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)*

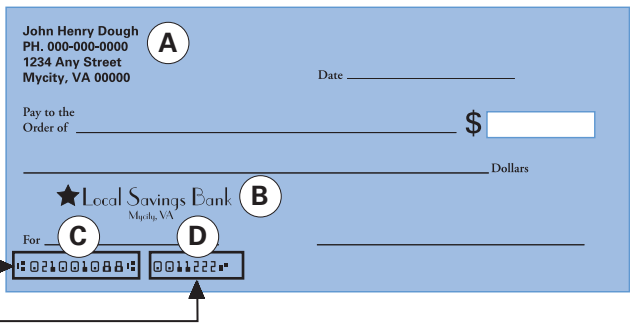
Bank routing number *(see "C" below)*

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 REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY
REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing its policy.

List below the identification of policies you intend to replace.

Name of Existing Insurer	Contract or ID* Number	Generic Name of Policy	Name of Insured

*If the existing insurer has not assigned a policy number, list alternative identification such as an application or receipt number.

Name of Proposed Insured _____ Date of Birth _____

Applicant (if different) _____

Address _____

Application Number _____

_____
Replacing Agent – print name

_____ _____ _____
Applicant (signature) Date Replacing Agent (Signature)

ATTENTION CONSUMER: THIS NOTICE IS REQUIRED BY THE INSURANCE COMMISSIONER.
PLEASE READ IT CAREFULLY BEFORE SIGNING.

○ **Genworth Life and Annuity Insurance Company**
Fixed Life: P.O. Box 320 • Lynchburg, VA 24505-0320

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022

○ **Genworth Life Insurance Company**
Fixed Life: P.O. Box 461 • Lynchburg, VA 24505-0461

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022