

Application for Life Insurance

Genworth Life Insurance Company Genworth Life and Annuity Insurance Company

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.

LICENSED INSURANCE AGENT CHECKLIST

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

DO

- ▶ 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 1.
- ▶ Ask all questions and fully and accurately record all answers given — the application will be part of any policy issued.
- ▶ Enter each beneficiary's SSN — it will help us locate the beneficiary at claim time.
- ▶ Print in dark ink.
- ▶ Obtain all the necessary signatures.
- ▶ Complete and sign the Licensed Insurance Agent's Report.
- ▶ 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 1.
 - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered "No."
 - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
 - 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 1.
- ▶ 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 APRs are available and will be provided on request.

DO NOT

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

INSTRUCTIONS FOR APPLYING FOR RETURN OF PREMIUM (ROP) TERM PRODUCTS

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

So that we can provide the best possible service, please fully and accurately complete the Plan of Insurance and Riders sections when applying for an ROP Term Product:

- ▶ Enter the full product name and desired level premium period in the Plan of Insurance section on Page 1.
EXAMPLE - VantagePointSM 15 or VantagePointSM 20 or VantagePointSM 30 .

Do not enter names such as "Return of Premium Term," "ROP 20" or "Term 20." They will cause processing delays as we seek clarification of the proper product to issue.

- ▶ Two Cash Value Riders are available: Basic and Enhanced. Elect only one. To do so, complete the Riders section on Page 1 as follows:
 - Mark "Other," and in the space provided...
 - Write "Cash Value Rider Basic" or "CVR Basic" to elect the Basic rider, **or**
 - Write "Cash Value Rider Enhanced" or "CVR Enhanced" to elect the Enhanced rider.

Application for Life Insurance – Part I



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

700 Main Street • Lynchburg, VA 24504

1. Proposed Insured

Please print all answers.

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)		b. Sex <input type="radio"/> F <input type="radio"/> M	c. Date of Birth Mo. Day Yr.	d. State of Birth	e. Social Security Number
f. Home Address (Number, Street, City, State, and Zip Code.) e-mail: _____				How Long At Address?	g. Legal Residency <input type="radio"/> U.S. <input type="radio"/> Other (Specify):
h. Driver's License Number/State	i. Marital Status <input type="radio"/> M <input type="radio"/> S <input type="radio"/> W <input type="radio"/> D	j. Home Phone Number		k. Work Phone Number	
l. Occupation (Include duties.)	m. Employer Name and Address			How Long w/ Employer?	

2. Ownership (Complete if Owner is other than Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address) e-mail: _____	b. Rel. to Prop. Ins.	c. SSN or TIN	d. Date of Birth/Trust Mo. Day Yr.
e. Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			
f. Contingent Owner: (Full Name and Address) e-mail: _____	g. Rel. to Prop. Ins.	h. SSN or TIN	i. Date of Birth/Trust Mo. Day Yr.
j. Contingent Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			

3. Beneficiary (If percentage shares are not given, they will be equal. Use REMARKS to name additional Beneficiaries.)

a. Primary: (Full Name and Address)	b. % Share	c. Rel. to Prop. Ins.	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr.
f. Primary: (Full Name and Address)	g. % Share	h. Rel. to Prop. Ins.	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr.
k. Contingent: (Full Name and Address)	l. % Share	m. Rel. to Prop. Ins.	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr.
p. Contingent: (Full Name and Address)	q. % Share	r. Rel. to Prop. Ins.	s. SSN or TIN	t. Date of Birth/Trust Mo. Day Yr.

4. Insurer, Plan and Amount of Insurance

a. Insurer: (Select one) GLIC GLAIC

b. Plan of Insurance:

c. Amount of Insurance: \$

5. Death Benefit Option (Universal Life only)

Level (Specified Amount only)

Increasing (Specified Amount plus cash value)

Scheduled Increases (if available):
 Simple _____% Compound _____%

6. Riders (If available with Plan)

Waiver

Children's Term Ins.: Units

Other (Amount and Description):

7. Premiums

a. Payment Method: Pre-Arranged Withdrawal (PAW) Direct Bill Other (Specify):

b. Payment Mode: Monthly (PAW only) Quarterly Semiannual Annual Single

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

d. Send Premium Notices to: Insured (Section 1.f.) Owner (Section 2.a.) 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

- 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 **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 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 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? (Explain either answer in **REMARKS**.) Yes No
 5. Within the past 5 years, has the business filed for bankruptcy or had any lien or judgments filed against it? Yes No

10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in 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? Yes No
 (If "Yes," you may be required to review and sign additional forms.)
 c. If "Yes," to Question 10.a., list all existing life insurance policies and annuity contracts. For additional policies/contracts, use **REMARKS**.

Full Name of Company	To Be Replaced?	Amount	Year Issued	Beneficiary(ies)
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		

11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)

- | | | |
|--|-----------------------|-----------------------|
| | Yes | No |
| a. Do you have any other application or informal inquiry for life insurance pending in any company or society? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| c. Have you ever been convicted of a misdemeanor or felony? | <input type="radio"/> | <input type="radio"/> |
| d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment? | <input type="radio"/> | <input type="radio"/> |
| e. In the past 5 years, has your driver's license been suspended or revoked? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| g. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.) | <input type="radio"/> | <input type="radio"/> |
| h. In the past 2 years have you engaged in, or do you intend 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].) | <input type="radio"/> | <input type="radio"/> |
| 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.) | <input type="radio"/> | <input type="radio"/> |

12. REMARKS (For explanations and special requests. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

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. The following statements apply to Information being collected in the states named: **New Jersey** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. **Vermont** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. In Vermont, the Company will not forward the results of any new tests it requests to any other entity.

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 The Authorization is this 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.

In all states except Rhode Island and Vermont, this Authorization will be valid for thirty (30) months after the date this Application – Part I is signed. In Rhode Island and Vermont, this Authorization will be valid for twenty-four (24) 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.

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

Owner (if not Proposed Insured: Signature and any Title)

Signature of Licensed Insurance Agent

Signature of Licensed Insurance Agent

Licensed Insurance Agent’s Printed Name

Licensed Insurance Agent’s Printed Name

Social Security No. License No. Managing Agency/
Brokerage No.

Social Security No. License No. Managing Agency/
Brokerage No.

1. Licensed Insurance Agent's Report (Not part of the Application)

a. Full Name (Please print)	b. Agent's Company Code No.*	c. SSN or Tax ID No.	d. Phone and FAX Numbers Phone: FAX:
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e. 1. Does the proposed insured have any existing life insurance or annuity? Yes No

2. 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.

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

g. 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: _____

h. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: \$ _____ Reason: _____

i. 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.

Signature(s) of Licensed Insurance Agent(s)

Date

2. Managing Agency/Brokerage Report (Not part of the Application)

a. Managing Agency/Brokerage Name (Please print) e-mail: _____	b. Managing Agency/Brokerage No.	c. Date
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3. Licensed Insurance Agents to Receive Commission (Please print)

Complete for each licensed agent to receive commission.

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

a. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	b. Agent's Commission Share %	c. Agent's Company Code No.*
d. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	e. Agent's Commission Share %	f. Agent's Company Code No.*
g. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	h. Agent's Commission Share %	i. Agent's Company Code No.*
j. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	k. Agent's Commission Share %	l. Agent's Company Code No.*
m. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	n. Agent's Commission Share %	o. Agent's Company Code No.*

*The code number assigned by the Insurer selected in item 4.a. on Page 1 of the application.

Notice to Proposed Insured and Owner

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

700 Main Street • Lynchburg, VA 24504

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. For example, if you are considering purchasing term life insurance with a "return of premium" (ROP) feature, you should be aware that premiums for policies with the ROP feature are generally higher than those for policies without this feature.

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 give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate. For example, if you have ever used any kind of tobacco or other nicotine product, you may not be eligible for our lowest rate.

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 photo ID ready, e.g., driver's license, passport, or greencard

Other 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.

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, including information contained in investigative consumer reports. 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.

Premium Payments on Term and Excess Interest Whole Life

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.

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. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency will 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 P.O. Box 105, Essex Station, Boston, MA 02112; 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 or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. 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.

FRAUD WARNINGS

ARKANSAS and LOUISIANA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE and TENNESSEE and WASHINGTON

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

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notificación al Titular y al Asegurado Propuesto

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

700 Main Street • Lynchburg, VA 24504

Esta notificación le explica qué es lo que debe esperar después de completar la solicitud - Parte I. En caso de tener alguna duda, consulte al agente promotor de seguro autorizado (agente autorizado). El agente autorizado debe recabar información sobre su situación personal, necesidades asegurables y objetivos financieros, y explicar la manera en que se adecuan las recomendaciones del seguro para satisfacer dichas necesidades y alcanzar tales objetivos. Por ejemplo, si usted está considerando adquirir un seguro de vida temporal con una característica denominada "retorno de prima" (ROP), deberá tener en cuenta que las primas para pólizas con esta característica ROP son generalmente más altas que aquellas pólizas que no cuentan con la misma.

Las Pólizas se Encuentran Disponibles Sólo en Inglés

Las aplicaciones, ilustraciones, divulgaciones y pólizas de nuestro seguro están disponibles sólo en inglés. Además, toda la prestación de servicios para los titulares de póliza se encuentra disponible sólo en inglés. Es su responsabilidad entender por completo este material en inglés. No permitimos que nuestros agentes de seguro traduzcan este material a distintos idiomas y no debe basarse en ninguna traducción realizada por nuestro agente de seguro.

¿Qué sucede después?

Suscripción

Una vez que recibamos su solicitud, comenzaremos un proceso de evaluación llamado suscripción para determinar si usted es elegible para el seguro y, de serlo, la tasa que debe pagar por el mismo. Para ayudarnos en la evaluación, es posible que busquemos datos provenientes de otras fuentes. Durante la suscripción quizás descubramos que no somos capaces de otorgarle el seguro que usted solicitó o que somos capaces de otorgárselo sólo sobre una base modificada o a una tasa mayor que nuestra tasa más baja. Por ejemplo, si alguna vez ha consumido cualquier forma de tabaco u otra clase de productos con nicotina, quizás no sea elegible para recibir nuestra tasa más baja.

Examen Físico

Prácticamente todos los Asegurados Propuestos deben someterse a un examen físico. El examen es realizado por un profesional capacitado y dura aproximadamente 30 minutos. Durante el examen, debe prever lo siguiente: proporcionar su historia clínica, ser pesado y medido, realizarse un electrocardiograma (no siempre es necesario), proporcionar una muestra de sangre o saliva y una de orina, tomarse la presión arterial y el pulso.

A continuación encontrará algunas maneras de ayudar con el proceso de examinación:

- Programar su examen dentro de las 24 horas posteriores de haber completado la Solicitud para el Seguro de Vida Conjunto – Parte I
- Contar con una lista de los nombres y direcciones de todos los proveedores y los centros de atención médica certificados que haya visitado en los últimos 20 años y estar preparado para informar respecto de los motivos, las fechas y cualquier tratamiento recibido relacionados con dichas consultas médicas.
- No ingiera alimentos ni bebidas (excepto agua) durante las 12 horas previas al momento del examen programado.
- Tenga a mano alguna identificación con foto, por ejemplo, la licencia de conducir, el pasaporte o la tarjeta verde.

Más Información Importante

Disputabilidad

Debido a que su solicitud será nuestra principal fuente de información es necesario que sea precisa y para ello, lo instamos a revisar con atención la solicitud una vez completada. Debe informarnos sobre los cambios en cualquier respuesta, en cualquier parte de su solicitud, antes de aceptar la entrega de una póliza; de hecho, usted acuerda hacerlo cuando firma su solicitud. Se podrá denegar un reclamo o tomar medidas legales para disputar una cobertura si la solicitud está incompleta o si contiene declaraciones falsas o desfiguraciones de la verdad. En caso de que el resultado del juicio sea favorable, la póliza se anulará y se perderá la cobertura. Cualquier póliza que se le entregue indicará cuándo y en qué circunstancias podrá ser disputada. Además, si usted oculta a sabiendas hechos importantes o presenta una solicitud que contenga información fundamentalmente falsa, estará infringiendo la legislación estatal.

Reemplazo de Cobertura Existente

Si ya tiene cobertura, responda "sí" a esta pregunta en la solicitud. Si pretende reemplazar la cobertura existente, comuníquese a un agente autorizado y responda "sí" a la pregunta de reemplazo de la solicitud. La legislación estatal exige que el agente autorizado le brinde información que le ayudará a comparar la póliza que está solicitando con la póliza que pretende reemplazar. Si no está decidido respecto de mantener o no la cobertura existente, responda "sí" a la pregunta de reemplazo. De esa manera, quizás obtenga la información que necesita para tomar la decisión. En caso de que sí reemplace la cobertura, la nueva póliza podrá contener nuevos plazos de disputabilidad y de suicidio. Interrumpir los pagos de la prima, renunciar o tomar prestado de una póliza existente como resultado de solicitar esta póliza podría considerarse un reemplazo. Es posible que la legislación estatal defina el reemplazo de modo que incluya otras situaciones. Pregunte al agente autorizado si no está seguro sobre el reemplazo.

Prácticas Sobre Información del Seguro

Nos basaremos fundamentalmente en los datos que usted proporcione. Es posible que los complementemos con información proveniente de otras fuentes tales como profesionales médicos que lo hayan tratado. En algunos casos, solicitaremos que una agencia de información de crédito del consumidor recabe información y nos presente el informe investigativo del consumidor como se explica en esta Notificación conforme la Ley Federal de Informe Justo de Crédito (**Federal Fair Credit Reporting Act**). Puede solicitar ser entrevistado en relación con la preparación de este informe.

En ciertas situaciones limitadas, se nos permite legalmente divulgar a terceros determinados artículos de información personal sin su autorización expresa. Usted tiene derecho a que le informen respecto de artículos de información personal sobre usted que tengamos en archivo (incluso si se trata de datos incluidos en informes investigativos del consumidor), a consultarlos y copiarlos si lo desea. Además tiene derecho a solicitar la corrección de la información que usted crea incorrecta.

Le enviaremos una explicación más detallada sobre nuestras prácticas de información si usted nos envía la solicitud por escrito. Puede enviar su solicitud a P.O. Box 461, Lynchburg, Virginia 24505-0461.

Pagos de Prima a Término y Exceso de Interés de Seguro de Vida Entera

Para las primas que no se pagan sobre una base anual al principio del año de la póliza, ajustamos la prima anual según un factor modal para compensar las ganancias de inversiones, pérdidas, los costos administrativos adicionales y los vencimientos anticipados esperados. Estos factores modales y los APR (Porcentaje Anual de Tasas de Interés) asociados están disponibles y serán proporcionados. Solicite esta información al agente autorizado.

Ley Federal de Informe Justo de Crédito

Como parte de la suscripción, quizás solicitemos que se prepare un informe investigativo del consumidor. Una fuente independiente conocida como agencia de información de crédito del consumidor preparará el informe. Normalmente, el informe incluirá datos sobre su carácter, su reputación general, su modo de vida y sus características personales.

(El "Modo de vida" no incluye información directa o indirectamente relacionada con su orientación sexual.) La agencia llevará a cabo entrevistas personales con su familia, amigos, vecinos, socios comerciales, fuentes financieras u otras personas que lo conozcan a fin de obtener esta información. Si nos escribe en un plazo razonable, luego de recibir esta notificación, le informaremos si se solicitó o no un informe. En caso de que se haya solicitado, le comunicaremos el nombre, dirección y número de teléfono de la agencia a la cual se le solicitó. Si se lo solicita, la agencia facilitará la información sobre la naturaleza y el alcance de su investigación. Si usted desea analizar el informe y recibir una copia del mismo, podrá hacerlo comunicándose directamente con la agencia.

Divulgación de la Agencia de Información Médica (MIB – Medical Information Bureau)

La información con respecto a su asegurabilidad se tratará como confidencial. No obstante, es posible que nosotros y nuestros reaseguradores, presentemos un breve informe al MIB, Inc., una organización de membresía sin fines de lucro de compañías que ofrecen seguros de vida. La misma funciona como agencia de intercambio de información en nombre de sus miembros. Si usted solicita a otra compañía miembro un seguro de vida, de enfermedad o de incapacidad, o si presenta un reclamo por beneficios ante dicha compañía, MIB, Inc., mediante solicitud previa, proporcionará a dicha compañía toda información con la que cuente en sus archivos.

Previo recepción de la solicitud, MIB, Inc., dispondrá la divulgación de cualquier información que pueda tener en sus archivos. En caso de que usted cuestione la exactitud de la información en dicho archivo, podrá contactarse con MIB, Inc., y solicitar la corrección de acuerdo con los procedimientos establecidos en la Ley Federal de Informe Justo de Crédito. Para comunicarse con MIB, Inc., usted puede: escribir a P.O. Box 105, Essex Station, Boston, MA 02112; llamar al número gratuito (866) 692-6901 (TTY 866 346-3642 para personas con discapacidad auditiva); o a través de la página Web <http://www.mib.com>.

Nuestros reaseguradores y nosotros podemos divulgar información de nuestros archivos a compañías de seguro a quienes usted podrá solicitar un seguro de vida, de enfermedad o incapacidad o a quien podrá presentar un reclamo por beneficios.

Período de Observación Gratuito

Si le entregamos una póliza, tendrá un plazo breve para examinar la póliza y, si lo desea, devolverla para que se le reintegre la totalidad de cualquier prima que ya haya abonado. Usualmente, este período (conocido como el "período de observación gratuito") es de 20 días desde que le entregamos la póliza, pero puede ser un período algo más prolongado en algunos estados. Para devolver la póliza, simplemente envíela por correo o entréguela a la Compañía o a cualquiera de sus agentes antes de que cumpla el período de observación gratuito correspondiente a su estado. Entonces la póliza quedará anulada desde el comienzo.

Compensación del Productor

Cuando usted nos compra un seguro, nosotros pagamos una compensación al agente autorizado, y a cualquier intermediario con el que el agente trabaje, que nos represente para ciertas tareas limitadas como recibir su solicitud de seguro, cobrar las primas iniciales y entregar la póliza. Esta compensación puede incluir comisiones pagadas al momento de comprar o renovar una póliza y cargos por servicios administrativos y de marketing y oportunidades educativas. La compensación puede variar según el tipo de seguro adquirido o las características particulares recogidas en su póliza. A su vez, los agentes autorizados y/o sus intermediarios, podrán recibir descuentos sobre las primas y bonificaciones de sus pólizas personales o viajes y premios de incentivo a través de concursos de ventas basados en distintos criterios, como por ejemplo, el volumen general de ventas o el porcentaje de ventas consumadas de un agente o intermediario con nuestras empresas. Los intermediarios también podrán pagar la compensación directamente al agente autorizado. Si el agente autorizado vende pólizas de otras aseguradoras, las compensaciones de dichas aseguradoras pueden ser sean diferentes de las nuestras.

ADVERTENCIA DE FRAUDE

ARKANSAS y LOUISIANA

Cualquier persona que presente a sabiendas un reclamo de pago de una pérdida o beneficio falso o fraudulento, o incluya conscientemente datos falsos en una solicitud de seguro, será culpable de delito y estará sujeto a multas y encarcelación.

COLORADO

Es ilegal proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguro con el propósito de defraudar o intentar defraudar a la compañía. Las penalidades pueden incluir encarcelación, multa, denegación del seguro e indemnizaciones por daños civiles. Cualquier compañía de seguro o agente de seguro que, a sabiendas, proporcione información falsa, incompleta o engañosa con el propósito de defraudar o intentar defraudar a un titular de póliza o demandante con respecto a la liquidación del seguro, será informada a la División de Seguros de Colorado perteneciente al Departamento de Agencias Reguladoras.

DISTRITO DE COLUMBIA

Es ilegal proporcionar información falsa o engañosa a un asegurador con el propósito de defraudar al asegurador o a cualquier otra persona. Las penalidades incluyen encarcelación y/o multas. Además, un asegurador puede denegar los beneficios del seguro si el solicitante proporciona información fundamentalmente falsa en relación con un reclamo.

FLORIDA

Toda persona que, a sabiendas y con interés de perjudicar, defraudar o engañar a cualquier asegurador, presente una declaración de reclamo o una solicitud que contenga cualquier información falsa, incompleta o engañosa, se considerará culpable de delito en tercer grado.

KENTUCKY

Toda persona que, a sabiendas y con la intención de defraudar a cualquier compañía de seguro o a otra persona, presente una solicitud de seguro que contenga cualquier información fundamentalmente falsa u oculte datos relacionados con cualquier hecho esencial concerniente al mismo, está cometiendo un hecho delictivo en materia de seguros, lo cual constituye un delito.

MAINE y TENNESSEE y WASHINGTON

Es ilegal proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguro con el propósito de defraudarla. Las penalidades incluirán encarcelación, multas o denegación de los beneficios del seguro.

NUEVA JERSEY

Toda persona que incluya cualquier información falsa o engañosa en una solicitud de póliza de seguro estará sujeta a penalidades civiles y penales.

NUEVO MÉXICO

Cualquier persona que presente a sabiendas un reclamo de pago de una pérdida o beneficio falso o fraudulento, o incluya conscientemente datos falsos en una solicitud de seguro, es culpable de delito y estará sujeta a multas civiles y sanciones penales.

OHIO

Toda persona que, con la intención de defraudar o consciente de que está facilitando la comisión de fraude contra un asegurador, presente una solicitud o un reclamo que contenga una declaración falsa o falaz, es culpable de fraude en materia de seguro.

PENNSYLVANIA

Toda persona que, a sabiendas y con la intención de defraudar a cualquier compañía de seguro o a otra persona, presente una solicitud de seguro que contenga cualquier información fundamentalmente falsa u oculte datos relacionados con cualquier hecho esencial concerniente al mismo, está cometiendo un hecho delictivo en materia de seguros, lo cual constituye un delito.

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. Yes No

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

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

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

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

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)
Form No. GEFA-599 (TIAA)

Licensed Insurance Agent Number(s)

ORIGINAL Return with the application and the payment.

1/2007

Temporary Insurance Application and Agreement (TIAA)



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

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Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

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Licensed Insurance Agent's Statement

Amount Remitted \$

Person from Whom Received

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Signature(s) of Licensed Insurance Agent(s)

Licensed Insurance Agent Number(s)

Form No. GEFA-599 (TIAA)

COPY Give to the Owner only if payment is made at the time the Application – Part I is signed.

1/2007



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

Page 1 of 2

- 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.

John Henry Dough
PH. 000-000-0000
1234 Any Street
Mycity, VA 00000

Date _____

Pay to the
Order of _____ \$ _____ Dollars

★ Local Savings Bank
Mycity, VA

For _____

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊀ ㊁ ㊂ ㊃ ㊄ ㊅ ㊆ ㊇ ㊈ ㊉ ㊐ ㊑ ㊒ ㊓ ㊔ ㊕ ㊖ ㊗ ㊘ ㊙ ㊚ ㊛ ㊜ ㊝ ㊞ ㊟ ㊠ ㊡ ㊢ ㊣ ㊤ ㊥ ㊦ ㊧ ㊨ ㊩ ㊰ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺ ㊻ ㊼ ㊽ ㊾ ㊿

Electronic funds transfer (EFT) authorization
for Life Insurance new business

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

.



AUTHORIZATION FOR PAYMENT OF INITIAL PREMIUM BY CREDIT CARD

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

Instructions

- **Credit Card not available in AK, CA, MD, NC, NJ and PA. Only applicable for Colony and Sure Term® term life insurance.**
- **Select the appropriate Insurer and enter the name of the Proposed Insured.**
- **Indicate the amount of Initial Premium. It must at least equal the first modal premium or first two if paying monthly.**
- **Sign and date this Authorization and return it.**

Insurer (Select only one.) <input type="radio"/> GLAIC <input type="radio"/> GLIC	Name of Proposed Insured
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Amount of Initial Premium: \$ _____ (Must at least equal first modal premium or first two if paying monthly.)

Credit / Debit Card (Visa or MasterCard only. Select one: Visa MasterCard)

Name of Card Holder as Shown on Card _____

Card Number/Expiration Date - - / -

Billing Address of Card Holder (Street) _____ (City) _____ (State) _____ (Zip Code) _____

Authorization

I authorize the Insurer to collect the Initial Premium stated above by the Payment Method I have selected. I understand and agree that this Authorization is subject to the following conditions:

- **Signing this Authorization does not mean that insurance is effective. Insurance is effective only as stated in (1) the application for insurance; or (2) the Temporary Insurance Application and Agreement (TIAA) if one is properly issued in connection with the application.**
- Use of the selected Payment Method does not alter any provision of any policy issued by the Company.
- The Company will initiate payment of the Initial Premium only after (1) a completed and signed Application-Part 1 has been received by the Company and a TIAA or Conditional Receipt has been properly issued; or (2) all requirements requested during delivery to the Owner of any policy issued are received by the Company and reviewed for proper dates and signatures.
- If a policy is issued, it may be issued at a premium rate different from the rate applied for. If no TIAA is issued and the Initial Premium does not equal or exceed the first modal premium (first two if paying monthly) for the policy that is issued, the Company will not initiate payment, this authorization will be revoked, and no insurance will be effective.
- This Authorization pertains to payment of the initial premium only. No further premiums will be collected under this Authorization.
- Any refund of premium will be made directly to me or credited to my account.
- If the Payment Method selected is not honored upon presentation, this Authorization will not be effective as a premium payment; no insurance will be effective, and the Company will make no further attempts to use this Authorization to obtain payment of premium.
- This Authorization may be revoked by me upon written notice at any time prior to its use by the Company to obtain payment of the Initial Premium.

Signature of Premium Payer

Date

Signature of Policy Owner (if different)

Date

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 <input type="radio"/> F <input type="radio"/> M	c. Date of Birth MM/DD/CCYY	d. Social Security Number
e. Street Address	f. City	g. State	h. Zip Code
i. U.S. Citizen or Resident? <input type="radio"/> Yes <input type="radio"/> No	j. 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 Employer will be the Owner of any policy issued and a beneficiary of any proceeds payable upon the Employee's (Proposed Insured's) death.

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

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

Signature of Employee (Proposed Insured) _____
Date

Signature of Employer (Owner) _____
Date

Title



Authorization for Release of Health-Related Information

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

This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)

Date of birth

Authorization

This Authorization for Release of Health-Related Information to the Life Insurer

Life Insurer

Genworth Life and Annuity Insurance Company, or Genworth Life Insurance Company, as shown above

Protected Health Information

Protected Health Information is my entire medical record and other health information. It includes information such as: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, sexually transmitted diseases and mental illness; prescription drug use; other insurance coverage; hazardous activities; character; and the use of alcohol, drugs, and tobacco. It excludes psychotherapy notes.

My Providers

My Providers are: any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy database; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf.

I authorize My Providers to disclose my Protected Health Information to the Life Insurer and its agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I made that restrict my Protected Health Information do not apply to this Authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the Life Insurer may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the Life Insurer.

This Authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that: 1) I have the right to revoke this Authorization in writing, at any time, by sending a written notice to the Life Insurer at 3100 Albert Langford Drive, Lynchburg, VA 24501, Attention: Privacy Official; and 2) written revocation is not effective if any of My Providers has relied on this Authorization or if the Life Insurer has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any Protected Health Information disclosed pursuant to this Authorization may be redisclosed and no longer covered by the federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Protected Health Information, the Life Insurer may not be able to perform the underwriting necessary to process my life insurance application. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient
