Genworth[SM]
Financial

APPLICATION & OUTLINE OF COVERAGE

Privileged Choice®
Classic Select[SM]

LONG TERM CARE INSURANCE

Underwritten by
Genworth Life Insurance Company

37122NE 01/01/06

Nebraska

APPLICATION INSTRUCTIONS

Step #1.) Ensure basic underwriting eligibility.

a.) Check applicants height and weight to see if they meet the Basic Eligibility Requirements in the table below.

b.) Complete the Insurability Profile section on page A-1.

Step #2.) Complete the *entire* application to avoid returned applications and processing delays.

BASIC ELIGIBILITY REQUIREMENTS

***If over or under limits below, do not take the application*.**

Height	Weight		
	MIN.	MAX. FEMALE	MAX. MALE
4' 6"	71	149	157
4' 7"	73	155	163
4' 8"	76	160	169
4' 9"	79	166	175
4'10"	82	172	182
4'11"	84	178	188
5' 0"	87	184	194
5' 1"	90	190	201
5' 2"	93	197	208

Height	Weight		
	MIN.	MAX. FEMALE	MAX. MALE
5' 3"	96	203	214
5' 4"	99	210	221
5' 5"	102	216	228
5' 6"	106	223	235
5' 7"	109	230	243
5' 8"	112	237	250
5' 9"	115	244	257
5'10"	119	251	265
5'11"	122	258	272

Height	Weight		
	MIN.	MAX. FEMALE	MAX. MALE
6' 0"	126	265	280
6' 1"	129	273	288
6' 2"	133	280	296
6' 3"	136	288	304
6' 4"	140	296	312
6' 5"	144	304	321
6' 6"	147	312	329

DISCOUNTS

Discounts are given to applicants who accurately answer NO to all parts of questions 1 through 7. See the chart below for the discount amount(s) based on eligibility, coverage selection, and discount combinations. (The Shared Coverage rates for couples already include built-in discounts.)

	POLICY TYPE	COUPLES DISCOUNT	PREFERRED HEALTH DISCOUNT APPLICANT #1	PREFERRED HEALTH DISCOUNT APPLICANT #2	TOTAL DISCOUNT APPLICANT #1	TOTAL DISCOUNT APPLICANT #2
1 APPLICANT With Preferred Health	Individual	n/a	20%		**20%**	
2 APPLICANTS Both Approved / Both Preferred	Individual	40%	10%	10%	**50%**	**50%**
2 APPLICANTS Both Approved / One Preferred	Individual	40%	10%		**50%**	**40%**
2 APPLICANTS Both Approved / No Preferred	Individual	40%			**40%**	**40%**
2 APPLICANTS One Approved / With Preferred	Individual	25%	10%		**35%**	
2 APPLICANTS One Approved / No Preferred	Individual	25%			**25%**	
2 APPLICANTS Both Approved / Both Preferred	**Shared**	Built-in	10%	10%	**10%**	**10%**
2 APPLICANTS Both Approved / One Preferred	**Shared**	Built-in	10%		**10%**	

COUPLES

Submit applications together (or within 12 months of each other).
In addition to married couples, family members or partners who: live together and share basic living expenses (for at least the past 3 years); are not married to anyone else; and if related, belong to the same generation of the same family (e.g. brothers, sister, cousins), are also eligible. These couples must complete and submit the "Requirements to Access Special (Couples) Benefits" form.

PREMIUM

Full premium for the Premium Payment Mode selected must be submitted with application, or both application and premium will be returned (if EFT is chosen, a minimum of 3 months premium must be submitted). For EFT and/or credit card payments, use the EFT/Credit Card Authorization form.

AGENT'S REPORT

Used for processing only, this does not become part of the issued policy.

CONDITIONAL INSURANCE AGREEMENT

If eligible, coverage begins on the date the application is signed, unless a later effective date is requested on page A-7.

OUTLINES OF COVERAGE

Leave applicants the Outline of Coverage for which they are applying.

MINIMUM UNDERWRITING REQUIREMENTS

		AGE:	18-64	65-71	72-79
Preferred Health		Application	×	×	×
		MRR		×	×
		In-Person Health Interview			×
		Phone Health Interview	×		
Non-Preferred	Doctor visit in last 2 years	Application	×	×	×
		MRR	×	×	×
		In-Person Health Interview			×
	No doctor visit in last 2 years	Application	×	×	×
		In-Person Health Interview	×	×	×

Additional requirements may be requested at the underwriter's discretion.

MEDICAL RECORDS REQUEST (MRR)

Always complete and have the applicant sign the MRR form.
Medical records aren't always needed, but this allows us to obtain them when necessary. ***Use chart above to determine if you need to request records or advise applicant of underwriting requirements.***

Only fax the MRR form (request records) as indicated in the chart above.

Do not order MRRs for: specialists, dentists, optometrists, chiropractors, ophthamologists, dermatologists, podiatrists, or allergists.

Make sure all information is complete and legible.

Fax immediately to: **1-800-876-8329** (☑Check 'fax box' on MRR).

Submit original with application.

PHONE AND IN-PERSON HEALTH INTERVIEW REQUESTS

For applicants who require an in-person health interview, complete and submit the Health Interview Request with the application. When needed, phone interviews will be ordered by the Home Office.

Please provide applicants with the Health Interview brochure (available online or by ordering form #81707), which explains both interviews. Let applicants know all costs associated with the interviews are paid for by us.

The interviews include questions about daily activities and a brief cognitive exercise. The in-person health interview takes approximately 1 hour, and the phone health interview takes about 15 minutes.

SUBMIT TO HOME OFFICE CHECKLIST

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

- ☐ Application (fully completed)
- ☐ EFT/Credit Card Authorization (if paying by either method)
- ☐ A check for Full Modal Premium
- ☐ Medical Records Request (original)
- ☐ Health Information Authorization
- ☐ Health Interview Request (when required)
- ☐ Replacement Notice (when required)
- ☐ Suitability form (when required)
- ☐ Potential Rate Disclosure (when required)
- ☐ State specific forms (when required)
- ☐ Requirements to Access Special (Couples) Benefits form (for Individual Coverage only; when required)

1. COVERAGE SELECTION Privileged Choice INDIVIDUAL Coverage

Use reverse for SHARED coverage.

Complete and submit only one Coverage Selection page.

Applicant A Age

Print Name: _____

BASIC BENEFIT SELECTIONS

Monthly Maximum

$ _____

Benefit Multiplier

☐ Unlimited ☐ 120 ☐ 96 ☐ 72
☐ 60 ☐ 48 ☐ 36 ☐ 24

Elimination Period

☐ 30 days ☐ 90 days ☐ 180 days

Inflation Protection / Benefit Increases

☐ 5% Compound Increases ☐ 5% Equal Increases ☐ No Increases

Applicant B Age

Print Name: _____

Monthly Maximum

$ _____

Benefit Multiplier

☐ Unlimited ☐ 120 ☐ 96 ☐ 72
☐ 60 ☐ 48 ☐ 36 ☐ 24

Elimination Period

☐ 30 days ☐ 90 days ☐ 180 days

Inflation Protection / Benefit Increases

☐ 5% Compound Increases ☐ 5% Equal Increases ☐ No Increases

OPTIONS/RIDERS

Enhanced Survivorship Benefit - The 10-Year Benefit is included with coverage.
☐ Yes ☐ No This Enhanced option is only available if a couple both apply for and are issued policies.

Restoration of Benefits

☐ Yes* ☐ No *Not available with Unlimited Benefit Multiplier.

Nonforfeiture Benefit

☐ Yes ☐ No

Restoration of Benefits

☐ Yes* ☐ No *Not available with Unlimited Benefit Multiplier.

Nonforfeiture Benefit

☐ Yes ☐ No

DISCOUNTS

Eligible for Preferred Health Discount

☐ Yes* ☐ No

Eligible for Preferred Health Discount

☐ Yes* ☐ No

* Must accurately answer No to all parts of questions 1-7.
If medical history is found inconsistent with your answers, premium will be adjusted accordingly.

Eligible for Couples Discount

☐ Yes ☐ No

Criteria must be met. See "Application Instructions." If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.

Second Applicant Social Security Number | Second Applicant Name | Second Applicant Existing Policy Number

PREMIUM INFORMATION

Premium Payments

☐ Standard ☐ 10-Pay ☐ Pay-to-65 (only available for ages 55 and younger)

Premium Payment Mode

☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26) ☐ Monthly* (.09)
* Automatic draft of checking account required. Must complete EFT form.

Submitted Full Modal Premium

$ _____

Replacement

Is this to replace an existing policy with us?
☐ Yes ☐ No

Premium Payments

☐ Standard ☐ 10-Pay ☐ Pay-to-65 (only available for ages 55 and younger)

Premium Payment Mode

☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26) ☐ Monthly* (.09)
* Automatic draft of checking account required. Must complete EFT form.

Submitted Full Modal Premium

$ _____

Replacement

Is this to replace an existing policy with us?
☐ Yes ☐ No

Agent Name:

Agent Producer Code:

State in which application is signed:

For Internal Use
Cell Code: PCI-65000

List Bill

☐ Yes ☐ No

Group Number

2. COVERAGE SELECTION Privileged Choice SHARED Coverage

Use reverse for INDIVIDUAL coverage.

Complete and submit only one Coverage Selection page.

Applicant A Age
Print Name: _____

Applicant B Age
Print Name: _____

BASIC BENEFIT SELECTIONS

Monthly Maximum
$ _____

Benefit Multiplier
☐ 240 ☐ 192 ☐ 144 ☐ 120
☐ 96 ☐ 72 ☐ 48

Elimination Period
☐ 30 days ☐ 90 days ☐ 180 days

Inflation Protection / Benefit Increases
☐ 5% Compound Increases ☐ 5% Equal Increases ☐ No Increases

OPTIONS/RIDERS

Restoration of Benefits
☐ Yes ☐ No

Nonforfeiture Benefit
☐ Yes ☐ No

Enhanced 7-Year Survivorship Benefit -
☐ Yes ☐ No

The 10-Year Benefit is included with coverage.
This Enhanced 7-Year option is only available if a couple both apply for and are issued policies.

CONTINGENT SELECTIONS

If one applicant for this Shared Coverage is found uninsurable by the Underwriting Department, the insurable person will receive an Individual plan with the selections above (except that only 50% of the Benefit Multiplier will be used, but not less than 24), unless Contingent Selections are chosen. **Complete these Contingent Selections ONLY if the selections above are not desired.**

Monthly Maximum
$ _____

Benefit Multiplier
☐ Unlimited ☐ 120 ☐ 96 ☐ 72
☐ 60 ☐ 48 ☐ 36 ☐ 24

Elimination Period
☐ 30 days ☐ 90 days ☐ 180 days

Inflation Protection / Benefit Increases
☐ 5% Compound Increases ☐ 5% Equal Increases ☐ No Increases

Restoration of Benefits
☐ Yes ☐ No

Nonforfeiture Benefit
☐ Yes ☐ No

DISCOUNTS

Eligible for Preferred Health Discount
Applicant **A:** ☐ Yes* ☐ No

Eligible for Preferred Health Discount
Applicant **B:** ☐ Yes* ☐ No

* Must accurately answer No to all parts of questions 1-7.
If medical history is found inconsistent with your answers, premium will be adjusted accordingly.

PREMIUM INFORMATION

Premium Payment Mode
☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26) ☐ Monthly* (.09)
* Automatic draft of checking account required. Must complete EFT form.

Submitted Full Modal Premium
$ _____

Replacement
Is this to replace an existing policy with us?
Applicant **A:** ☐ Yes ☐ No
Applicant **B:** ☐ Yes ☐ No

Agent Name:

Agent Producer Code: | | | | | | | | | | |

State in which application is signed:

For Internal Use
Cell Code: PCS-65001

List Bill
☐ Yes ☐ No

Group Number | | | | | | |

3. COVERAGE SELECTION Classic Select INDIVIDUAL Coverage

Use reverse for SHARED coverage.

Complete and submit only one Coverage Selection page.

Applicant A Age
Print Name: _____

Applicant B Age
Print Name: _____

BASIC BENEFIT SELECTIONS

Daily Maximum
$ _____

Benefit Multiplier
☐ Unlimited ☐ 3650 ☐ 2920 ☐ 2190
☐ 1825 ☐ 1460 ☐ 1095 ☐ 730

Elimination Period
☐ 30 days ☐ 90 days
☐ 180 days ☐ 365 days*
*Not available with Waiver of Home Care Elimination Period.

Home Care Benefits
☐ 100% ☐ 50%

Inflation Protection / Benefit Increases
☐ 5% Compound Increases ☐ 5% Equal Increases ☐ No Increases

Daily Maximum
$ _____

Benefit Multiplier
☐ Unlimited ☐ 3650 ☐ 2920 ☐ 2190
☐ 1825 ☐ 1460 ☐ 1095 ☐ 730

Elimination Period
☐ 30 days ☐ 90 days
☐ 180 days ☐ 365 days*
*Not available with Waiver of Home Care Elimination Period.

Home Care Benefits
☐ 100% ☐ 50%

Inflation Protection / Benefit Increases
☐ 5% Compound Increases ☐ 5% Equal Increases ☐ No Increases

OPTIONS/RIDERS

Monthly Maximum*
☐ Yes ☐ No *Not available with 50% Home Care Benefits option.

Waiver of Home Care Elimination Period*
☐ Yes ☐ No *Not available with 50% Home Care Benefits option.

Monthly Maximum*
☐ Yes ☐ No *Not available with 50% Home Care Benefits option.

Waiver of Home Care Elimination Period*
☐ Yes ☐ No *Not available with 50% Home Care Benefits option.

Survivorship Benefit - 7-Year and 10-Year options are only available if a couple both apply for and are issued policies. Check only one box.
☐ 7-Year (optional) ☐ 10-Year (optional) ☐ None

Restoration of Benefits
☐ Yes* ☐ No *Not available with Unlimited Benefit Multiplier.

Nonforfeiture Benefit
☐ Yes ☐ No

Restoration of Benefits
☐ Yes* ☐ No *Not available with Unlimited Benefit Multiplier.

Nonforfeiture Benefit
☐ Yes ☐ No

DISCOUNTS

Eligible for Preferred Health Discount
☐ Yes* ☐ No

Eligible for Preferred Health Discount
☐ Yes* ☐ No

* Must accurately answer No to all parts of questions 1-7.
If medical history is found inconsistent with your answers, premium will be adjusted accordingly.

Eligible for Couples Discount
☐ Yes ☐ No

Criteria must be met. See "Application Instructions." If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.

Second Applicant Social Security Number | Second Applicant Name | Second Applicant Existing Policy Number

PREMIUM INFORMATION

Premium Payments
☐ Standard ☐ 10-Pay ☐ Pay-to-65 (only available for ages 55 and younger)

Premium Payment Mode
☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26) ☐ Monthly* (.09)
* Automatic draft of checking account required. Must complete EFT form.

Submitted Full Modal Premium
$ _____

Replacement
Is this to replace an existing policy with us?
☐ Yes ☐ No

Premium Payments
☐ Standard ☐ 10-Pay ☐ Pay-to-65 (only available for ages 55 and younger)

Premium Payment Mode
☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26) ☐ Monthly* (.09)
* Automatic draft of checking account required. Must complete EFT form.

Submitted Full Modal Premium
$ _____

Replacement
Is this to replace an existing policy with us?
☐ Yes ☐ No

Agent Name:

Agent Producer Code:

State in which application is signed:

For Internal Use
Cell Code: CSI-65200

List Bill
☐ Yes ☐ No

Group Number

4. COVERAGE SELECTION Classic Select SHARED Coverage

Use reverse for INDIVIDUAL coverage.

Complete and submit only one Coverage Selection page.

Applicant A Age
Print Name: _____

Applicant B Age
Print Name: _____

BASIC BENEFIT SELECTIONS

Daily Maximum
$_____

Benefit Multiplier
☐7300 ☐5840 ☐4380 ☐3650
☐2920 ☐2190 ☐1460

Elimination Period
☐30 days ☐90 days ☐180 days ☐365 days*
*Not available with Waiver of Home Care Elimination Period.

Inflation Protection / Benefit Increases
☐5% Compound Increases ☐5% Equal Increases ☐No Increases

OPTIONS/RIDERS

Monthly Maximum
☐Yes ☐No

Waiver of Home Care Elimination Period
☐Yes ☐No

Survivorship Benefit - 7-Year and 10-Year options only available if a Shared Coverage policy is issued. Check only one box.
☐7-Year (optional) ☐10-Year (optional) ☐None

Restoration of Benefits
☐Yes ☐No

Nonforfeiture Benefit
☐Yes ☐No

CONTINGENT SELECTIONS

If one applicant for this Shared Coverage is found uninsurable by the Underwriting Department, the insurable person will receive an Individual plan with the selections above (except that only 50% of the Benefit Multiplier will be used, but not less than 730), unless Contingent Selections are chosen. **Complete these Contingent Selections ONLY if the selections above are not desired.**

Daily Maximum
$_____

Benefit Multiplier
☐Unlimited ☐3650 ☐2920 ☐2190
☐1825 ☐1460 ☐1095 ☐730

Inflation Protection / Benefit Increases
☐5% Compound Increases ☐5% Equal Increases ☐No Increases

Elimination Period
☐30 days ☐90 days ☐180 days ☐365 days*
*Not available with Waiver of Home Care Elimination Period.

Waiver of Home Care Elimination Period*
☐Yes ☐No
*Not available with 50% Home Care Benefits option.

Home Care Benefits
☐100% ☐50%

Monthly Maximum*
☐Yes ☐No
*Not available with 50% Home Care Benefits option.

Restoration of Benefits
☐Yes* ☐No
*Not available with Unlimited Benefit Multiplier.

Nonforfeiture Benefit
☐Yes ☐No

DISCOUNTS

Eligible for Preferred Health Discount
Applicant **A:** ☐Yes* ☐No

Eligible for Preferred Health Discount
Applicant **B:** ☐Yes* ☐No

* Must accurately answer No to all parts of questions 1-7.
If medical history is found inconsistent with your answers, premium will be adjusted accordingly.

PREMIUM INFORMATION

Premium Payment Mode
☐Annual (1.0) ☐Semi-annual (.51) ☐Quarterly (.26) ☐Monthly* (.09)
* Automatic draft of checking account required. Must complete EFT form.

Submitted Full Modal Premium
$_____

Replacement
Is this to replace an existing policy with us?
Applicant **A:** ☐Yes ☐No
Applicant **B:** ☐Yes ☐No

Agent Name:

Agent Producer Code: | | | | | | | | | | | |

State in which application is signed:

For Internal Use
Cell Code: CSS-65201

List Bill
☐Yes ☐No

Group Number
| | | | | | |

APPLICATION
*** For Insurance ***

Genworth Life Insurance Company *Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501*

A. INSURABILITY PROFILE

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

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

B. PERSONAL PROFILE

Print clearly - Use black ink

APPLICANT A

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

Name _____
(As it should appear on your policy)

☐Married ☐Single ☐Widowed

Social Security Number _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ ☐a.m. ☐p.m.

APPLICANT B

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

Name _____
(As it should appear on your policy)

☐Married ☐Single ☐Widowed

Social Security Number _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ ☐a.m. ☐p.m.

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

City _____ State _____ Zip _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

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

C. MEDICAL PROFILE

Applicant **A** YES ☐ NO ☐ | Applicant **B** YES ☐ NO ☐

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

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

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

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

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

Applicant **A** YES ☐ NO ☐ | Applicant **B** YES ☐ NO ☐

7. Within the past 5 years, have you:

A. Smoked or used other tobacco products? ☐ ☐ | ☐ ☐

B. Required assistance with managing medications, shopping, using transportation, or housekeeping/cooking? ☐ ☐ | ☐ ☐
If YES to any, please explain.

Applicant A	Applicant B	Type of assistance	Reason
☐	☐		
☐	☐		

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

Applicant A	Applicant B	Date	Reason
☐	☐		
☐	☐		

D. Been medically advised to have surgery which has not been performed? ☐ ☐ | ☐ ☐
If YES, please explain (including dates of scheduled surgeries).

Applicant A	Applicant B	Date	Surgery Type	Reason
☐	☐			
☐	☐			

E. Received Social Security Disability Insurance benefits? ☐ ☐ | ☐ ☐

F. Taken any prescription medications for High Blood Pressure and/or any form of Arthritis? ☐ ☐ | ☐ ☐
If YES, list each medication *and why it's needed.*

Applicant A	Applicant B	Medication	Why needed?
☐	☐		
☐	☐		
☐	☐		
☐	☐		

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

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

Applicant A Company: _____ Applicant B Company: _____

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
		9. Within the past 3 years have you:		
☐	☐	A. Taken *any* prescription medications (not previously listed in this application)? *If YES*, list each medication *and why it's needed*.	☐	☐

Applicant A	Applicant B	Medication	Why needed?
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	B. Been medically advised to enter or been confined to a hospital or other health care facility? *If YES*, please explain (including dates and reasons).	☐	☐

Applicant A	Applicant B	Date	Facility	Reason
☐	☐			
☐	☐			
☐	☐			

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

Applicant **A**

_____
Doctor's Name

_____
Address

_____
City, State, Zip

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

_____
Reason Last Seen

Applicant **B**

_____
Doctor's Name

_____
Address

_____
City, State, Zip

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

_____
Reason Last Seen

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	B. Within the past 3 years have you consulted with or been treated by a licensed health care provider, ***other than your primary care doctor*** for any reason excluding eye doctors, podiatrists, and dentists? *If YES*, please complete the following.	☐	☐

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

Print Name of Applicant A ______________________ Print Name of Applicant B ______________________

D. DETAILS

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

Applicant A

Ques.#

Applicant B

Ques.#

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

36156

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

E. FAMILY HISTORY PROFILE

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

F. CLIENT PROFILE

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

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

G. OTHER COVERAGE AND REPLACEMENT

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

H. PROTECTION AGAINST UNINTENTIONAL LAPSE

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

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

Applicant A (Use for Individual and Shared Applications)

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

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

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

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title:

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Relationship _____

Applicant B (Complete whenever there is a second applicant)

☐ Same as applicant A.

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

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

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

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title:

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Relationship _____

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

I. DECLARATIONS

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

REJECTION OF 5% COMPOUND INFLATION PROTECTION:

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

Applicant **A**

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

Applicant **B**

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

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

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

AGREEMENT: I agree that:

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

REQUEST FOR A LATER POLICY EFFECTIVE DATE:

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

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

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

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

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

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

J. AGENT INFORMATION

Name of Licensed and Appointed Agent (Please print) | Street Address

Producer Code # or Soc. Sec. #/Tax ID | E-mail Address | City, State, Zip

X _____ ( ) _____ ( ) _____

Signature of Soliciting Agent | Phone No. | Fax No.

Name of Licensed and Appointed Brokerage General Agency (if applicable) | **Producer Code #** of Brokerage General Agency

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

Name of Licensed and Appointed Agent | Percentage | **Name** of Licensed and Appointed Agent | Percentage

Producer Code # or Soc. Sec. #/Tax ID | E-mail Address | **Producer Code #** or Soc. Sec. #/Tax ID | E-mail Address

K. AGENT'S REPORT

To ensure against delays in processing please provide complete details.

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

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– APPLICANT COPY –

L. PREMIUM RECEIPT

Genworth Life Insurance Company (Herein called "We," "Us," and "Our")
Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501

Make check payable to: Genworth Life.
Do not pay cash or leave the payee blank.

RECEIPT FOR INITIAL PREMIUM: This acknowledges receipt of the Initial Premium to be applied in connection with your application to Us for long term care insurance. We will return your premium payment if we do not approve your application. This receipt will be void and of no effect if your check is not payable to Genworth Life or is not paid upon presentation.

Print Name of **Applicant A** | Application Date

$ Initial Premium (minimum 3 months premium)

Print Name of **Applicant B** | Application Date

$ Initial Premium (minimum 3 months premium)

Printed Name of Agent

Agent's Business Address (please print)

X Signature of Agent | Date Signed

( ) Phone Number

M. CONDITIONAL INSURANCE AGREEMENT

Your coverage can begin as soon as you sign the application.

If you requested an Effective Date that is later than your Application Date, the following Agreement will not apply and Our underwriting will consider any changes in your health status which occur after the Application Date.

AGREEMENT: This Agreement applies only if all of the following requirements have been satisfied:

1. You submit your check payable to Genworth Life for the Initial Premium set forth above; and
2. You did not request in writing, an Effective Date that is later than your Application Date; and
3. You accurately answered NO to all parts of questions #1 through #5 in the application; and
4. The answers in the application accurately indicate that within the past 5 years you HAVE NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Epilepsy, Convulsions, Seizures, Fainting Spells, Black Outs, Mental Illness, or Paralysis; or been medically advised to have surgery that has not been performed; or received home health care; used an adult day care facility; been confined to a nursing home, assisted care facility, or other long term care facility.
5. NO material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, you and We agree that:

1. In underwriting your application We may conduct a telephone or personal interview to determine your health status as of the Application Date. We will not disapprove your application based on any change in your health status that occurs after the Application Date.
2. If We approve your application, We will provide insurance under the policy for which application was made, and the Policy will be Effective as of the Application Date.
3. If We disapprove your application, We will provide temporary insurance for loss which begins between the Application Date and the date your application is disapproved. Your application shall be deemed disapproved if We do not approve it within 120 days of the Application Date. The temporary insurance will provide the same benefits and be subject to the same provisions, conditions, limitations and exclusions as found in the policy for which application is being made; except that it will only pay benefits for expenses that are incurred within 180 days following the Application Date. In no event will the total of the benefits payable by Us under the temporary insurance exceed the lesser of: (a) $10,000; and (b) the actual expenses incurred.

No applicant, agent, producer or representative has any power or authority to change any of the provisions of this Agreement.

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N. PRIVACY NOTICE

Although your application is our initial source of information, we also collect information pertaining to your health history through copies of your medical records and may conduct telephone or in-person interviews.

Information regarding your insurability will be treated as confidential. Genworth Life Insurance Company, its affiliates or its reinsurer(s) may collect information from the Medical Information Bureau, a non-profit organization of life insurance companies, which provides an information exchange for its members. If you apply for coverage or file a claim with another Bureau member company, the Bureau, upon request, will supply the company with information in its file. At your request, the Bureau will arrange disclosure to you of the information in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of the information, you may seek a correction in accordance with the Federal Fair Credit Reporting Act, and by contacting the Bureau at: P.O.Box 105, Essex Station, Boston, MA 02112, 1-866-692-6901.

The Company, its affiliates, or its reinsurer(s) may also release information in its file to other insurance companies to whom you submit a claim, provided you have authorized them to obtain such information. Upon written request, we will provide directly to you with all information in your file with the exception of Medical Information of a sensitive nature. Medical Information of a sensitive nature will be provided to you through a physician of your choice. Should you wish to request correction, amendment or deletion of any information in our file, which you believe is inaccurate, please contact us and we will advise you of the necessary procedures.

For more information about any of the above, please write to:
Genworth Life Insurance Company
Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501

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Genworth Life Insurance Company

Administrative Office: 3100 Albert Lankford Dr.
Lynchburg, Virginia 24501-4948
Phone 1-800-456-7766

LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE - POLICY FORM 7044NE

Complete and Retain for Your Records

CAUTION. The issuance of this long term care insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application will be attached to Your issued Policy. If Your answers are incorrect or untrue, the company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the company at this address: 3100 Albert Lankford Drive, Lynchburg, Virginia 24501-4948.

NOTICE TO BUYER. The Policy may not cover all costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

1. POLICY DESIGNATION. This is an individual Policy of insurance.

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual or group Policy contains governing contractual provisions. This means that the Policy or group Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.

3. FEDERAL TAX CONSEQUENCES. This Policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE**.** This means You have the right, subject to the terms of the Policy, to continue this Policy by paying Your premiums on time until the Lifetime Maximum is exhausted. Genworth Life Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

WAIVER OF PREMIUM: The Policy includes a Waiver of Premium Benefit that applies while continuing benefits are payable under: (a) the Nursing Home Benefit; (b) the Assisted Care Facility Benefit; (c) the Home Care Benefit after a qualifying period has been satisfied; or (d) the Home Care Benefit under a Plan of Care from a Privileged Care Coordinator.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. Premiums can be changed based on premium class; but only if they are changed for all similar policies issued in Your state on the same Policy form. You cannot be singled out for an increase based on a change in Your age or health. We will notify You at least 45 days before the Policy Anniversary Date on which any such change would take effect.

You will be given the right to reduce coverage or convert to a limited paid-up benefit in the event of substantial cumulative premium increases.

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

Unconditional 30 Day Free Look: You have 30 days to return the policy to the company if You are not satisfied with it for any reason. All premiums paid will be returned within 30 days after return of the Policy or denial of the application.

Unearned Premium Refunds: The Policy provides for the refund of unearned premium in the event it terminates due to: death; or surrender or cancellation of the Policy.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither Genworth Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

8. LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, curing, treating, mitigating, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as a Nursing Home, in the community or in the Home.

This Policy provides coverage in the form of reimbursement for covered long term care expenses. It is subject to Policy limitations, elimination periods, and other requirements.

9. BENEFITS PROVIDED BY THIS POLICY.

Shared Coverage Provisions: The following apply when a couple are insured under the same Policy:

- Separate and equal coverage: The Elimination Period and all other maximums and limits for each Benefit will apply separately to each Insured.
- Sharing the Lifetime Maximum**:** The Lifetime Maximum will be shared and will be exhausted by the combined benefit payments made on behalf of both Insureds.
- Dual Waiver of Premium: The Waiver of Premium Benefit will apply to all premiums, not just the premium attributed to the Insured who is receiving benefits.

There is a Limited Conversion Option available if Your relationship terminates due to divorce or final separation and Shared Coverage is no longer desired.

COVERAGE SELECTION

Shared Coverage ☐ Yes ☐ No

For Shared Coverage the same choices must be made by both Applicants

Applicant(s)	_____	_____
Monthly Maximum	$ _____	$ _____
Benefit Multiplier	_____	_____
Lifetime Maximum	_____	_____
	With Shared Benefits there is One Limit for both	
Elimination Period	_____ Days	_____ Days
	(Applies only to the Nursing Home and Assisted Care Facility Benefits)	
Benefit Increases	☐ 5% Full Compound ☐ 5% Equal ☐ None	☐ 5% Full Compound ☐ 5% Equal ☐ None
Nonforfeiture Benefit	☐ Yes ☐ No	☐ Yes ☐ No
Restoration of Benefits	☐ Yes ☐ No	☐ Yes ☐ No
Enhanced Survivorship	☐ Yes ☐ No	☐ Yes ☐ No

BENEFIT ELIGIBILITY: For You to be eligible for the Benefits provided by this Policy We must have both:

- A Current Eligibility Certification; and
- On-going proof which demonstrates that the Covered Care You receive is needed due to Your continually being a Chronically Ill Individual.

The proof can be based on information from care providers, personal physicians and other Licensed Health Care Practitioners.

An *"Activity of Daily Living"* is one of the following: bathing (washing oneself); dressing (putting on and taking off clothes and assistive devices); eating (taking nourishment); continence (control of bowel and bladder functions); toileting (including performing associated personal hygiene tasks); and transferring (moving in and out of a bed, chair or wheelchair).

A *"Chronically Ill Individual"* is a person who has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- Requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

A *"Current Eligibility Certification"* is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that You meet the above requirements for being a Chronically Ill Individual.

"Substantial Assistance" is either:

- *"Hands-on Assistance,"* which is the physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living; or
- *"Standby Assistance,"* which is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to Yourself while You are performing the Activity of Daily Living.

"Severe Cognitive Impairment" is a loss or deterioration in intellectual capacity that:

- Is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- Is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: (a) short-term or long-term memory; (b) orientation as to people, places, or time; (c) deductive or abstract reasoning; or (d) judgment as it relates to safety awareness.

"Substantial Supervision" is continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired person from threats to his or her health or safety (such as may result from wandering).

A *"Plan of Care"* is a written, individualized plan for care and support services for You that:

- Has been developed as a result of an assessment and incorporates any information provided by Your personal physician; and
- Has been prescribed by a Licensed Health Care Practitioner; and
- Fairly, accurately and appropriately addresses Your long term care and support service needs; and
- Specifies: (1) the type, frequency and duration of all services required to meet those needs; (2) the providers appropriate to furnish those services; and (3) an estimate of the appropriate cost of such services.

CONDITIONS: Benefits will be paid only as reimbursement for expenses incurred for care and services that:

- Are Qualified Long Term Care Services; and
- Are consistent with, and received pursuant to, Your Plan of Care as prescribed by a Licensed Health Care Practitioner; and
- Meet the requirements for payment in accordance with the Benefits, services, and all other provisions of this Policy; and
- Are received while Your insurance under this Policy is in force. An expense, fee or charge is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

Benefit payments cease when the Lifetime Maximum is exhausted and are subject to: the Elimination Period requirements; and all other limits determined from the specific Benefits and other provisions of this Policy.

"Covered Care" is only those Qualified Long Term Care Services for which this Policy pays benefits or would pay benefits in the absence of an Elimination Period.

The "*Elimination Period*" is the number of days that You must receive Covered Care before benefits are payable under: the Nursing Home Benefit; the Assisted Care Facility Benefit and the International Care Benefit. It can be satisfied by days for

which payment would otherwise be made under those Benefits. It can also be satisfied by days for which You receive payment under the Home Care Benefit in accordance with a Plan of Care developed by a Privileged Care Coordinator. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for this Policy.

A "*Licensed Health Care Practitioner*" is any of the following who is not a family member: a physician, as defined in section 1861(r)(1) of the Social Security Act; a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

The "*Lifetime Maximum*" is the maximum amount of benefits the Policy will pay. This amount will increase over time in accordance with any Benefit Increases that apply. The Lifetime Maximum is exhausted only when the total of all benefits paid equals the applicable Lifetime Maximum including any Benefit Increases.

The "*Monthly Maximum*" is the combined total amount We will pay for all expenses which are incurred in a calendar month and are covered by: the Nursing Home Benefit; the Assisted Care Facility Benefit; the Home Care Benefit; and the International Coverage Benefit. This amount will increase over time in accordance with any Benefit Increases that apply.

A "*Nurse*" is a licensed Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN).

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which: are required by a Chronically Ill Individual; and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. "Maintenance or Personal Care Services" as used in this definition means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the person is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

PRIVILEGED CARE COORDINATION SERVICES: *This is an option You may choose to use when You become a Chronically Ill Individual.* These services are intended to help identify care needs and community resources available to deliver care. We will pay for the services described below when a Privileged Care Coordinator provides them to You while Your insurance is in force under this Policy. These payments will be at Our expense; and will NOT count against any payment maximum.

When You use these services, the Privileged Care Coordinator will:

- Meet with You in Your Home to obtain a full understanding of Your unique situation and condition. Based on that information the Privileged Care Coordinator will develop and prescribe a Plan of Care appropriate for Your needs. This may include care in Your Home and in the community.
- Provide the initial and subsequent Current Eligibility Certifications.
- Suggest a variety of formal and informal care and support service providers. This may include negotiating service and care provider rates for You; and identifying other financial resources available to meet the needs specified in Your Plan of Care.
- Help in completion of claims forms required to get payment under this Policy.
- Assist with implementing the Plan of Care by scheduling and coordinating the care and support service providers chosen by You.
- Monitor the care and support services being received. This will include periodic re-assessments to determine revisions to Your Plan of Care warranted by changing needs.

A *"Privileged Care Coordinator"* is a Licensed Health Care Practitioner provided by Us at no cost to You. He or she will assist You in identifying Your long term care needs and matching those needs with available care and service providers and resources. The Privileged Care Coordinator will be a professional whose duties are to: gather objective information specific to Your circumstances; use the information gathered to help develop Your Plan of Care; and identify qualified providers that can deliver the needed care and services.

Privileged Care Coordinators are familiar with the care and service providers available in Your area. Those providers vary greatly from skilled professionals to lay caregivers, based on the degree and type of assistance needed. Privileged Care Coordinators will help identify qualified caregivers that are acceptable to You and Your family. In all cases, You are responsible for choosing the actual care and service providers to be used. If for any reason You are not satisfied with a Privileged Care Coordinator or care or service provider, You can request that an alternative be identified.

Additional Feature: When Home Care is provided in accordance with a Plan of Care developed by a Privileged Care Coordinator:

- We will count days for which Home Care Benefits are paid toward satisfying the Elimination Period; and
- The Waiver of Premium Benefit applies.

Payment for these Privileged Care Coordination Services is not subject to, and cannot be used to satisfy, the Elimination Period.

HOME CARE BENEFIT: We will pay for expenses You incur for care and support services defined below that, other than Hospice Care, are received while You are living at Home and are provided by someone who normally does not reside in Your Home.

- ***Nurse and Therapist Services***: These are health care services provided in Your Home by a Nurse, or a licensed physical, occupational, respiratory or speech therapist.
- ***Services from Other Care Providers***: These are Home Health Aide and Personal Care Attendant Services, Homemaker Services, and Chore Services (as defined below) that:
  - A person provides in Your Home because they are necessary to enable You to continue to stay independent and safe at Home; and

- Are necessary because You alone are not able to perform them due to Your being a Chronically Ill Individual; and
- Are consistent with the needs addressed in Your Plan of Care.

Providers of these services do not need to be affiliated with a home health care agency.

- ***Home Health Aide and Personal Care Attendant Services:*** This is assistance with: simple health care tasks; personal hygiene; managing medications; and help in performing Activities of Daily Living.
- ***Homemaker Services:*** This is assistance with one or more of the following tasks: meal planning and preparation; doing laundry; and light house cleaning (such as: vacuuming, dry mopping, dishwashing, cleaning the kitchen or bath, and changing soiled bedding).
- ***Chore Services:*** This is assistance with the following light work activities: minor household repairs related to Your safety at Home (such as to handrails and safety rails, stairs, or floors); taking out the garbage; and simple cleaning tasks to remove unsafe debris or dirt in the Home. Chore Services do not include any type of: residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; vehicle or equipment maintenance; or similar tasks.

- ***Community Care:*** This is Adult Day Care and Hospice Care as defined below.
  - ***Adult Day Care:*** This is a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.
  - ***Hospice Care:*** This consists of services (not including prescription drugs) that are designed to provide palliative care to You or to alleviate Your physical, emotional and spiritual discomforts because You are experiencing the last phases of life due to a terminal disease (diagnosed with 6 months or less to live). Hospice Care can be provided in Your Home, or in a separate facility that is licensed or certified to provide Hospice Care by the State in which it is located.

Payment of this Benefit is subject to: the Monthly Maximum; and the Lifetime Maximum. No payment will be made under this Benefit for any period for which You are receiving Nursing Home Benefits, Assisted Care Facility Benefits, or Bed Reservation Benefits. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period; except that days of Covered Care under this Benefit can be used to satisfy the Elimination Period when the care is received in accordance with a Plan of Care developed by a Privileged Care Coordinator.

RESPITE CARE BENEFIT: When You receive Respite Care We will pay benefits under the Nursing Home Benefit, the Assisted Care Facility Benefit and the Home Care Benefit, without requiring You to satisfy the Elimination Period. Respite Care can be received in Your Home, or during a temporary stay in a Nursing Home or Assisted Care Facility.

"Respite Care" is short-term care that is provided to You in order to relieve the person who normally provides You with informal (unpaid) care in Your Home. The Respite Care must be stated in, and furnished in accordance with, Your Plan of Care.

Payment of this Benefit is subject to the Lifetime Maximum; and not more than the Monthly Maximum will be paid for all such expenses that are incurred during a Policy Year. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

CAREGIVER TRAINING BENEFIT: We will pay for expenses You incur for training an informal (unpaid) caregiver to care for You in Your Home. All the following conditions apply to this Benefit:

- We will not pay to train someone who will be paid to care for You.
- The training can be received while You are confined in a hospital, Nursing Home, or Assisted Care Facility only if it is reasonably expected that the training will make it possible for You to go Home where You can be cared for by the person receiving the training.

Payment of this Benefit is subject to: a lifetime maximum equal to 20% of the Monthly Maximum; and the Lifetime Maximum of the Policy. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

EQUIPMENT BENEFIT: We will pay for expenses, including installation fees, labor and related costs, You incur for the purchase or rental of Supportive Equipment if:

- The equipment is intended to assist You in living at Home by relieving Your need for direct physical assistance; and
- Your Plan of Care states that it is expected that the equipment will enable You to remain at Home for at least 90 days after the date of purchase or first rental.

"Supportive Equipment" is items such as the following:

- Pumps and other devices for intravenous injection;
- Ramps to permit movement from one level of a residence to another;
- Grab bars to assist in toileting, bathing or showering; and
- Stair lifts for going between levels of Your Home.

Supportive Equipment does not include either:

- Equipment that will, other than incidentally, increase the value of the residence in which it is installed; or
- Artificial limbs, teeth, medical supplies, or equipment placed in Your body, temporarily or permanently.

Payment of this Benefit is subject to: a lifetime maximum equal to 2 times the Monthly Maximum; and the Lifetime Maximum of the Policy. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

NURSING HOME BENEFIT: We will pay for expenses You incur for care and support services (including room and board, but not prescription drugs) provided by a Nursing Home while You are confined there as a resident inpatient. This includes

expenses for: private duty nursing care provided by a Nurse who is not employed by the facility; and all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Home. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that facility.

A *"Nursing Home"* is a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse; the facility must employ at least one full-time Nurse; and a Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Home only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Home does NOT include any of the following: (a) a hospital or clinic; (b) a sub-acute care or rehabilitation hospital or unit; (c) a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; (d) an Assisted Care Facility; (e) Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or (f) a substantially similar adult residence establishment or environment.

Payment of this Benefit is subject to: the Monthly Maximum; the Lifetime Maximum; and the Elimination Period.

ASSISTED CARE FACILITY BENEFIT: We will pay for expenses You incur for care and support services (including room and board, but not prescription drugs) provided by an Assisted Care Facility while You are confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

An *"Assisted Care Facility"* is a facility, not excluded below, that satisfies the Conditions below and is engaged primarily in providing continual (24 hours-a-day, every day) assistance and supervision to at least 10 resident inpatients due to their inability to perform Activities of Daily Living or Severe Cognitive Impairment.

Conditions: To satisfy this definition, such facility (e.g., assisted care, assisted living, or Alzheimer's dementia care facility) must at all times:

- Provide such care and services under a license, certificate, or substantially similar permit and oversight from the federal government or the State in which it is located;

OR

- Provide such care and services in accordance with all applicable laws; and continuously meet all of the following requirements:
  - It maintains records for all care and services provided to each resident inpatient;
  - It has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment;
  - It has an awake employee who is aware of the whereabouts of the resident inpatients;
  - It provides, at a minimum, assistance with Bathing and Dressing;
  - It provides 3 meals a day and accommodates special dietary needs;
  - It has formal arrangements with a duly licensed physician or Nurse to furnish medical care and services in case of an emergency; and
  - It has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Care Facility is NOT any of the following: (a) a hospital or clinic; (b) a Nursing Home; (c) a sub-acute care or rehabilitation hospital or unit; (d) a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; (e) Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or (f) a substantially similar adult residence establishment or environment.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Care Facility only if it is engaged primarily in providing care that satisfies the above definition.

Payment of this Benefit is subject to: the Monthly Maximum; the Lifetime Maximum; and the Elimination Period.

BED RESERVATION BENEFIT: We will continue to pay benefits, or give Elimination Period credit, under the Nursing Home Benefit and the Assisted Care Facility Benefit while You:

- Are temporarily absent during a stay in a Nursing Home or Assisted Care Facility; and
- Are charged to reserve Your accommodations in that facility.

The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay, or spending holidays or other time with Your family.

This Benefit is subject to the Lifetime Maximum; and will be payable for no more than 60 days per Policy Year.

ALTERNATIVE CARE BENEFIT: *(For expenses not otherwise covered. Prior approval by Us is required.)* We will pay for expenses You incur for care, treatment, services, supplies or other items not specifically covered by another Benefit of this Policy when all of the following conditions are met:

- They are clearly specified in Your Plan of Care.

- You, Your personal physician and We mutually agree that they are cost-effective alternatives to Benefits specifically available under this Policy.
- They are for qualified long term care services as defined in Section 7702B(c) of the Internal Revenue Code.
- They are incurred while such mutual agreement is in effect.
- They are incurred while Your insurance is in force under this Policy.

Agreement to use these alternatives will not waive any of the rights You or We have under this Policy. The agreement may be discontinued at any time without affecting Your right to the Benefits otherwise available under this Policy.

Examples include, but are not limited to:
- In-Home safety devices.
- Community-based services that provide meals in the Home for disabled individuals (such as Meals on Wheels).
- Equipment in Your Home that is not covered under the Equipment Benefit.
- Rental or lease of emergency medical response devices.
- Other services designed to help You remain at Home.

The agreement will state how payment is affected by the Elimination Period. It will also state any time and payment maximums. Payment of this Benefit is also subject to: the Lifetime Maximum; and all other provisions and conditions of this Policy.

WAIVER OF PREMIUM BENEFIT: We will waive the premium payments for each coverage month that begins during a period for which benefits are paid or payable under:
- The Nursing Home Benefit or the Assisted Care Facility Benefit (after satisfying the Elimination Period); or
- The Home Care Benefit in accordance with a Plan of Care developed by a Privileged Care Coordinator (for which no Elimination Period is required); or
- The Home Care Benefit after satisfying a qualifying period which is equal to the number of days in the Elimination Period. In determining when the qualifying period has been satisfied we will count:
  - Days used to satisfy the Elimination Period that occur while You are confined in a Nursing Home or Assisted Care Facility; and
  - Days for which the Home Care Benefit is paid.

This waiver applies to the entire premium for this Policy and all attachments.

This Benefit stops when You cease to receive Covered Care during any period for which benefits are paid under the Nursing Home Benefit, the Assisted Care Facility Benefit, or the Home Care Benefit. When this Benefit stops, We will give credit for any premium paid for periods during which the waiver applied, against future premiums when due. You will be required: to pay the remaining premiums due in accordance with this Policy's previous premium payment mode; and to continue to make future premium payments as they become due.

SURVIVORSHIP BENEFIT: If a couple have been insured under this Policy, or separate policies issued by Us, for at least 10 years when one of them dies, no further premium payments will be required for this Policy if:
- The survivor is insured under this Policy; and
- Both persons continuously had long term care insurance coverage in force with Us, other than under a Nonforfeiture Benefit, on the date of the deceased person's death and for at least the prior 10 year period; and
- Both persons were a couple with coverage that included a similar Survivorship Benefit for the entire period of concurrent coverage; and
- No long term care benefits were paid or payable by Us for either person for the first 10 years of such concurrent Survivorship Benefit coverage; and
- We receive due written proof of such death.

This waiver applies to the premium for this Policy and all attached riders in force on the date of such death.

INTERNATIONAL COVERAGE BENEFIT: We will pay for expenses You incur while confined as a resident inpatient in an Out-of-Country Nursing Home (as defined in the Policy). At Your own expense You must provide Us with satisfactory proof that You meet the Policy's Benefit Eligibility and other proof of loss requirements of the Policy and this Benefit. This Benefit will not qualify for waiver of premium; and is in lieu of all other Benefits and reimbursements otherwise provided by the policy for expenses incurred during the same period.

Payment of this Benefit is subject to: the Lifetime Maximum; the Elimination Period; a calendar month maximum equal to 75% of the Monthly Maximum; and a lifetime maximum payment period of no more than 48 months. Payments for periods of less than a full month will be pro-rated based on a 30-day month and the number of days for which payment is being made.

CONTINGENT NONFORFEITURE BENEFIT: If the Nonforfeiture Benefit does not apply, You will be given the right to reduce coverage or convert to a limited paid-up benefit only in the event of substantial cumulative premium increases. The amount of the reduced coverage available is the same as described above for the Optional Nonforfeiture Benefits.

OPTIONAL NONFORFEITURE BENEFIT: *This is an optional Benefit for which an additional premium is charged.* It provides continued coverage in the event the Policy terminates (lapses) due to a default in the payment of any premium after it has been in force for at least 3 years. If the lapse occurs while this Benefit is in force, the Policy will be continued (without further premium payments) with a reduced Lifetime Maximum. The amount of the continued reduced coverage will be the greater of: the maximum benefit amount applicable, at the time of lapse, under the Nursing Home Benefit for one month (30 days); or the total of all premiums actually paid and attributed to You for Your insurance under the Policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

OPTIONAL RESTORATION OF BENEFITS RIDER: *This is an optional rider for which an additional premium is charged.* It will restore the Policy's Lifetime Maximum to the amount that would have applied if no benefits had been paid under the Policy. Except as limited below, this applies whenever a period of 180 consecutive days elapses during which no Insured required, or received, either:

- Substantial Assistance from another individual in performing at least two (2) Activities of Daily Living due to a loss of functional capacity; or
- Substantial Supervision due to Severe Cognitive Impairment.

This restoration will not apply when the Policy is in force under a Nonforfeiture Benefit. In addition, if the Policy originally covered 2 people who were both Insureds under the Policy on the date of death of one Insured, the restoration will operate to restore only that portion of the Lifetime Maximum that was actually used by the surviving Insured and was not previously restored.

OPTIONAL ENHANCED SURVIVORSHIP BENEFIT RIDER: *This is an optional rider for which an additional premium is charged.* It provides that, if a couple have been insured under this Policy, or separate policies issued by Us, for at least 7 years when one of them dies, no further premium payments will be required for this Policy if:

- The survivor is insured under this Policy; and
- Both persons continuously had long term care insurance coverage in force with Us, other than under a Nonforfeiture Benefit, on the date of the deceased person's death and for at least the prior 7 year period; and
- Both persons were a couple with coverage that included a similar Enhanced Survivorship Benefit for the entire period of concurrent coverage; and
- We receive due written proof of such death.

This waiver applies to the premium for this Policy and all attached riders in force on the date of such death. It is in lieu of any Survivorship Benefit under the Policy.

10. LIMITATIONS AND EXCLUSIONS.

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: A Nursing Home, Assisted Care Facility, or Out-of-Country Nursing Home is not covered unless it meets the applicable definition for such a facility. Your "Home" is Your primary place of residence in an area used principally for independent residential living. This could be a house, condominium, apartment, unit in a congregate care community, or similar residential environment. Your Home does not include a hospital, Nursing Home, or Assisted Care Facility.

Non-eligible Levels of Care: Coverage is not based on the specific level of care; but is for care furnished, for a specific covered reason, by or through the covered facilities and providers. Care from family members is not covered.

Exclusions/Exceptions and Limitations: No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- Provided by a Family Member, unless:
  - The Family Member is a regular employee of the organization that is providing the services; and
  - Such organization receives payment for the services; and
  - The Family Member receives no compensation other than the normal compensation for employees in her or his job category.
- For which no charge is normally made in the absence of insurance.
- Provided outside of the United States of America, its territories and possessions; except as described in the International Coverage Benefit.
- Provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to You or Your estate.
- Resulting, directly or indirectly, from:
  - War or act of war, whether declared or not.
  - Attempted suicide or an intentionally self-inflicted injury.
  - Your alcoholism or addiction to drugs or narcotics; but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

Note: We will pay benefits for mental illness and Alzheimer's disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care under this Policy.

Non-Duplication: Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid). However, this Non-Duplication provision will not disqualify an expense for Covered Care from being used to satisfy the Elimination Period.

Other Coverage with Us: We may reduce benefits payable under this Policy for Covered Care if We also pay benefits for that Covered Care under any other policy issued by Us. This applies to policies providing long term care insurance (including policies providing nursing home and/or home care coverage) whether payable on an expense reimbursement, indemnity or any other basis. Benefits will be reduced under this Policy only when payment would result in Our paying, under this and all other such policies, more than the expense You actually incur for an item of Covered Care. Any such reduction will be limited to the amount payment under this Policy causes the total amount of benefits under this and all other such policies to be more than 100% of the expense You actually incurred for that Covered Care.

Any policy without a similar Other Coverage With Us provision will pay first without any reduction in its benefits.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the cost of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. You may choose from two options at

the time of application that will increase Your benefits. They will be available to pay for expenses incurred on or after the date of the increases and while this Policy is in force. These increases are not reduced by benefit payments. Benefit Increases cease when the Policy terminates.

5% Equal Increases means that on each Policy Anniversary Date Your Monthly Maximum and Lifetime Maximum will each increase by 5% of their original respective amounts applicable on the Policy Effective Date.

5% Full Compound Increases means that on each Policy Anniversary Date Your Monthly Maximum and Lifetime Maximum will each increase by 5% of the prior years respective Monthly Maximum and Lifetime Maximum amounts.

If You do not purchase a Benefit Increases option, You will need to provide satisfactory evidence of insurability to later increase coverage. If You elect a Benefit Increase, premiums will be higher; but they will not increase due to a change in age or the automatic benefit increases.

At the end of this outline is a graphic comparison of the benefit levels of policies that increase benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

12. ALZHEIMER'S DISEASE AND OTHER BRAIN DISORDERS. Once insurance goes into force, coverage is provided if You are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses and meet the Benefit Eligibility requirements.

13. PREMIUM. The following shows the annual premium for: the base Policy and any chosen benefit options; Your premium payment mode; and the corresponding modal premium.

Applicant(s)	_____	_____
Annual Premium		
Basic Policy with any Benefit Increases	$ _____	$ _____
Optional Riders		
Nonforfeiture	$ _____	$ _____
Restoration of Benefits Rider	$ _____	$ _____
Enhanced Survivorship	$ _____	$ _____
Subtotal Before Discounts	**$** _____	**$** _____
Anticipated Discounts	$ _____	$ _____
Total Annual Payment Mode Premium	**$** _____	**$** _____
Mode Factor x____(Factor from table below)		
Modal Premium	**$** _____	**$** _____
(Annual Payment Mode Premium x Factor)		
Annual Total of Modal Premiums	$ _____	$ _____
(Modal Premium times 1, 2, 4 or 12)		

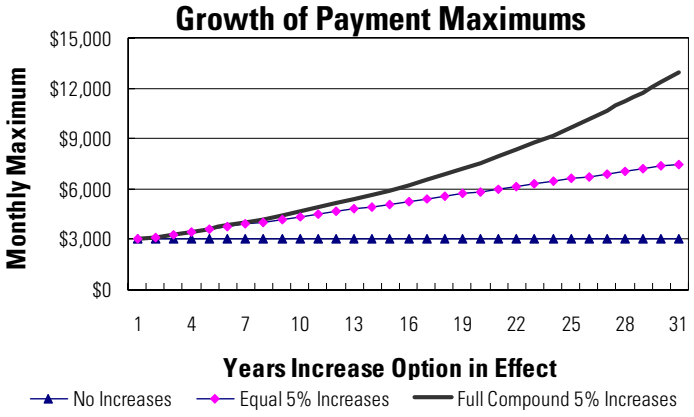
Premium Payment Mode (Factor)
☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26)
☐ Monthly (.09) - requires Electronic Funds Transfer

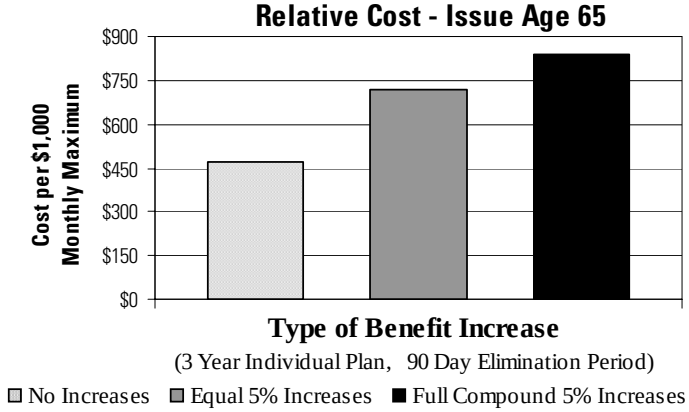
How Long Premium Will Be Payable
☐ Lifetime ☐ 10 Years
☐ Until the Policy Anniversary coinciding with or next following the date You reach 65 years of age.

14. ADDITIONAL FEATURES. Applications are subject to medical underwriting; and are approved only if we are provided evidence of insurability which is satisfactory and acceptable to the company. Insurance is not available to those who are 85 years of age or older when applying.

Continuation for Lapse Due to Alzheimer's Disease and Other Forms of Cognitive or Functional Impairment: We will provide a retroactive continuation of coverage if the Policy terminates due to nonpayment of premiums (lapse) and within 7 months after termination we are given proof that You met the Benefit Eligibility requirements. We must receive proof of Your impairment or incapacity and all past due premiums within that 7 month period. Any benefits for which You qualified during the continuation period will be paid to the same extent they would have been paid if the Policy and its riders had remained in force from the date of termination.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY OR CERTIFICATE.





Genworth Life Insurance Company

Administrative Office: 3100 Albert Lankford Drive
Lynchburg, Virginia 24501
Phone 1-800-456-7766

LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE - POLICY FORM 7042NE

Complete and Retain for Your Records

CAUTION. The issuance of this long term care insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application will be attached to Your issued Policy. If Your answers are incorrect or untrue, the company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the company at this address: 3100 Albert Lankford Drive, Lynchburg, Virginia 24501.

NOTICE TO BUYER. The Policy may not cover all costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

1. POLICY DESIGNATION. This is an individual Policy of insurance.

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual or group Policy contains governing contractual provisions. This means that the Policy or group Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.

3. FEDERAL TAX CONSEQUENCES. This Policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE**.** This means You have the right, subject to the terms of the Policy, to continue this Policy by paying Your premiums on time until the Lifetime Maximum is exhausted. Genworth Life Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

WAIVER OF PREMIUM: The Policy includes a Waiver of Premium Benefit that applies after the Elimination Period has been satisfied and while continuing benefits are payable under: (a) the Nursing Home Benefit; (b) the Assisted Care Facility Benefit; or (c) the Home Care Benefit.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. Premiums can be changed based on premium class; but only if they are changed for all similar policies issued in Your state on the same Policy form. You cannot be singled out for an increase based on a change in Your age or health. We will notify You at least 45 days before the Policy Anniversary Date on which any such change would take effect.

You will be given the right to reduce coverage or convert to a limited paid-up benefit in the event of substantial cumulative premium increases.

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

Unconditional 30 Day Free Look: You have 30 days to return the policy to the company if You are not satisfied with it for any reason. All premiums paid will be returned within 30 days after return of the Policy or denial of the application.

Unearned Premium Refunds: The Policy provides for the refund of unearned premium in the event it terminates due to: death; or surrender or cancellation of the Policy.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither Genworth Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

8. LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, curing, treating, mitigating, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as a Nursing Home, in the community or in the Home.

This Policy provides coverage in the form of reimbursement for covered long term care expenses. It is subject to Policy limitations, elimination periods, and other requirements.

9. BENEFITS PROVIDED BY THIS POLICY.

Shared Coverage Provisions: The following apply when a couple are insured under the same Policy:

- Separate and equal coverage: The Elimination Period and all other maximums and limits for each Benefit will apply separately to each Insured.
- Sharing the Lifetime Maximum**:** The Lifetime Maximum will be shared and will be exhausted by the combined benefit payments made on behalf of both Insureds.
- Dual Waiver of Premium: The Waiver of Premium Benefit will apply to all premiums, not just the premium attributed to the Insured who is receiving benefits.

There is a Limited Conversion Option available if Your relationship terminates due to divorce or final separation and Shared Coverage is no longer desired.

COVERAGE SELECTION

Shared Coverage ☐ Yes ☐ No

For Shared Coverage the same choices must be made by both Applicants

Applicant(s)	_____	_____
Daily Maximum	$ _____	$ _____
Benefit Multiplier	_____	_____
Lifetime Maximum	_____	_____
	With Shared Benefits there is One Limit for both	
Home Care Maximum Expressed as % of the Daily Maximum	☐ 100% ☐ 50%	☐ 100% ☐ 50%
Elimination Period	_____ Days	_____ Days
Benefit Increases	☐ 5% Compound ☐ 5% Equal ☐ None	☐ 5% Compound ☐ 5% Equal ☐ None
Nonforfeiture Benefit	☐ Yes ☐ No	☐ Yes ☐ No
Restoration of Benefits	☐ Yes ☐ No	☐ Yes ☐ No
Survivorship	☐ Yes ☐ No	☐ Yes ☐ No
Enhanced Survivorship	☐ Yes ☐ No	☐ Yes ☐ No
Monthly Benefits	☐ Yes ☐ No	☐ Yes ☐ No
Waiver of Home Care Elimination Period	☐ Yes ☐ No	☐ Yes ☐ No

BENEFIT ELIGIBILITY: For You to be eligible for the Benefits provided by this Policy We must have both:

- A Current Eligibility Certification; and
- On-going proof which demonstrates that the Covered Care You receive is needed due to Your continually being a Chronically Ill Individual.

The proof can be based on information from care providers, personal physicians and other Licensed Health Care Practitioners.

An *"Activity of Daily Living"* is one of the following: bathing (washing oneself); dressing (putting on and taking off clothes and assistive devices); eating (taking nourishment); continence (control of bowel and bladder functions); toileting (including performing associated personal hygiene tasks); and transferring (moving in and out of a bed, chair or wheelchair).

A *"Chronically Ill Individual"* is a person who has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- Requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

A *"Current Eligibility Certification"* is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that You meet the above requirements for being a Chronically Ill Individual.

"Substantial Assistance" is either:

- *"Hands-on Assistance,"* which is the physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living; or
- *"Standby Assistance,"* which is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to Yourself while You are performing the Activity of Daily Living.

"Severe Cognitive Impairment" is a loss or deterioration in intellectual capacity that:

- Is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- Is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: (a) short-term or long-term memory; (b) orientation as to people, places, or time; (c) deductive or abstract reasoning; or (d) judgment as it relates to safety awareness.

"Substantial Supervision" is continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired person from threats to his or her health or safety (such as may result from wandering).

A *"Plan of Care"* is a written, individualized plan for care and support services for You that:

- Has been developed as a result of an assessment and incorporates any information provided by Your personal physician; and
- Has been prescribed by a Licensed Health Care Practitioner; and
- Fairly, accurately and appropriately addresses Your long term care and support service needs; and
- Specifies: (1) the type, frequency and duration of all services required to meet those needs; (2) the providers appropriate to furnish those services; and (3) an estimate of the appropriate cost of such services.

CONDITIONS: Benefits will be paid only as reimbursement for expenses incurred for care and services that:

- Are Qualified Long Term Care Services; and
- Are consistent with, and received pursuant to, Your Plan of Care as prescribed by a Licensed Health Care Practitioner; and
- Meet the requirements for payment in accordance with the Benefits, services, and all other provisions of this Policy; and
- Are received while Your insurance under this Policy is in force. An expense, fee or charge is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

Benefit payments cease when the Lifetime Maximum is exhausted and are subject to: the Elimination Period requirements; and all other limits determined from the specific Benefits and other provisions of this Policy.

"Covered Care" is only those Qualified Long Term Care Services for which this Policy pays benefits or would pay benefits in the absence of an Elimination Period.

The "*Daily Maximum*" is the combined total amount We will pay for all expenses which are incurred on a calendar day and are covered by: the Nursing Home Benefit; and the Assisted Care Facility Benefit. It is also used to determine limits for other Benefits. This amount will increase over time in accordance with any Benefit Increases that apply.

The "*Elimination Period*" is the number of days that You must receive Covered Care before benefits are payable under: the Nursing Home Benefit; the Assisted Care Facility Benefit, and the Home Care Benefit. It can be satisfied by days for which payment would otherwise be made under those Benefits. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for this Policy.

A "*Licensed Health Care Practitioner*" is any of the following who is not a family member: a physician, as defined in section 1861(r)(1) of the Social Security Act; a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

The "*Lifetime Maximum*" is the maximum amount of benefits the Policy will pay. Except when Compound Increases apply, the Lifetime Maximum is exhausted when the total of all benefits paid equals the applicable Lifetime Maximum including any Benefit Increases. When Compound Increases apply, the Lifetime Maximum available reduces as benefits are paid; increases when a Benefit Increase applies; and is exhausted when there is no remaining amount available.

A "*Nurse*" is a licensed Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN).

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which: are required by a Chronically Ill Individual; and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. "Maintenance or Personal Care Services" as used in this definition means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the person is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

PRIVILEGED CARE COORDINATION SERVICES: *This is an option You may choose to use when You become a Chronically Ill Individual.* These services are intended to help identify care needs and community resources available to deliver care. We will pay for the services described below when a Privileged Care Coordinator provides them to You while Your insurance is in force under this Policy. These payments will be at Our expense; and will NOT count against any payment maximum.

When You use these services, the Privileged Care Coordinator will:

- Meet with You in Your Home to obtain a full understanding of Your unique situation and condition. Based on that information the Privileged Care Coordinator will develop and prescribe a Plan of Care appropriate for Your needs. This may include care in Your Home and in the community.
- Provide the initial and subsequent Current Eligibility Certifications.
- Suggest a variety of formal and informal care and support service providers. This may include negotiating service and care provider rates for You; and identifying other financial resources available to meet the needs specified in Your Plan of Care.
- Help in completion of claims forms required to get payment under this Policy.
- Assist with implementing the Plan of Care by scheduling and coordinating the care and support service providers chosen by You.
- Monitor the care and support services being received. This will include periodic re-assessments to determine revisions to Your Plan of Care warranted by changing needs.

A *"Privileged Care Coordinator"* is a Licensed Health Care Practitioner provided by Us at no cost to You. He or she will assist You in identifying Your long term care needs and matching those needs with available care and service providers and resources. The Privileged Care Coordinator will be a professional whose duties are to: gather objective information specific to Your circumstances; use the information gathered to help develop Your Plan of Care; and identify qualified providers that can deliver the needed care and services.

Privileged Care Coordinators are familiar with the care and service providers available in Your area. Those providers vary greatly from skilled professionals to lay caregivers, based on the degree and type of assistance needed. Privileged Care Coordinators will help identify qualified caregivers that are acceptable to You and Your family. In all cases, You are responsible for choosing the actual care and service providers to be used. If for any reason You are not satisfied with a Privileged Care Coordinator or care or service provider, You can request that an alternative be identified.

Payment for these Privileged Care Coordination Services is not subject to, and cannot be used to satisfy, the Elimination Period.

HOME CARE BENEFIT: We will pay for expenses You incur for care and support services defined below that, other than Hospice Care, are received while You are living at Home and are provided by someone who normally does not reside in Your Home.

- ***Nurse and Therapist Services***: These are health care services provided in Your Home by a Nurse, or a licensed physical, occupational, respiratory or speech therapist.
- ***Services from Other Care Providers***: These are Home Health Aide and Personal Care Attendant Services, Homemaker Services, and Chore Services (as defined below) that:

- A person provides in Your Home because they are necessary to enable You to continue to stay independent and safe at Home; and
- Are necessary because You alone are not able to perform them due to Your being a Chronically Ill Individual; and
- Are consistent with the needs addressed in Your Plan of Care.

Providers of these services do not need to be affiliated with a home health care agency.

- ***Home Health Aide and Personal Care Attendant Services:*** This is assistance with: simple health care tasks; personal hygiene; managing medications; and help in performing Activities of Daily Living.
- ***Homemaker Services:*** This is assistance with one or more of the following tasks: meal planning and preparation; doing laundry; and light house cleaning (such as: vacuuming, dry mopping, dishwashing, cleaning the kitchen or bath, and changing soiled bedding).
- ***Chore Services:*** This is assistance with the following light work activities: minor household repairs related to Your safety at Home (such as to handrails and safety rails, stairs, or floors); taking out the garbage; and simple cleaning tasks to remove unsafe debris or dirt in the Home. Chore Services do not include any type of: residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; vehicle or equipment maintenance; or similar tasks.

- ***Community Care:*** This is Adult Day Care and Hospice Care as defined below.
  - ***Adult Day Care:*** This is a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.
  - ***Hospice Care:*** This consists of services (not including prescription drugs) that are designed to provide palliative care to You or to alleviate Your physical, emotional and spiritual discomforts because You are experiencing the last phases of life due to a terminal disease (diagnosed with 6 months or less to live). Hospice Care can be provided in Your Home, or in a separate facility that is licensed or certified to provide Hospice Care by the State in which it is located.

Payment of this Benefit is subject to: the Lifetime Maximum; the Elimination Period; and a calendar day maximum equal to Your Home Care Daily Maximum. No payment will be made under this Benefit for any period for which You are receiving Nursing Home Benefits, Assisted Care Facility Benefits, or Bed Reservation Benefits.

RESPITE CARE BENEFIT: When You receive Respite Care We will pay benefits under the Nursing Home Benefit, the Assisted Care Facility Benefit and the Home Care Benefit, without requiring You to satisfy the Elimination Period. Respite Care can be received in Your Home, or during a temporary stay in a Nursing Home or Assisted Care Facility.

"Respite Care" is short-term care that is provided to You in order to relieve the person who normally provides You with informal (unpaid) care in Your Home. The Respite Care must be stated in, and furnished in accordance with, Your Plan of Care.

Payment of this Benefit is subject to the Lifetime Maximum; and this Benefit will be payable for no more than 21 days per Policy Year. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

CAREGIVER TRAINING BENEFIT: We will pay for expenses You incur for training an informal (unpaid) caregiver to care for You in Your Home. All the following conditions apply to this Benefit:

- We will not pay to train someone who will be paid to care for You.
- The training can be received while You are confined in a hospital, Nursing Home or Assisted Care Facility only if it is reasonably expected that the training will make it possible for You to go Home where You can be cared for by the person receiving the training.

Payment of this Benefit is subject to: a lifetime maximum equal to 5 times the Daily Maximum; and the Lifetime Maximum of the Policy. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

EQUIPMENT BENEFIT: We will pay for expenses, including installation fees, labor and related costs, You incur for the purchase or rental of Supportive Equipment if:

- The equipment is intended to assist You in living at Home by relieving Your need for direct physical assistance; and
- Your Plan of Care states that it is expected that the equipment will enable You to remain at Home for at least 90 days after the date of purchase or first rental.

"Supportive Equipment" is items such as the following:

- Pumps and other devices for intravenous injection;
- Ramps to permit movement from one level of a residence to another;
- Grab bars to assist in toileting, bathing or showering; and
- Stair lifts for going between levels of Your Home.

Supportive Equipment does not include either:

- Equipment that will, other than incidentally, increase the value of the residence in which it is installed; or
- Artificial limbs, teeth, medical supplies, or equipment placed in Your body, temporarily or permanently.

Payment of this Benefit is subject to: a lifetime maximum equal to 50 times the Daily Maximum; and the Lifetime Maximum of the Policy. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

NURSING HOME BENEFIT: We will pay for expenses You incur for care and support services (including room and board, but not prescription drugs) provided by a Nursing Home while You are confined there as a resident inpatient. This includes expenses for:

private duty nursing care provided by a Nurse who is not employed by the facility; and all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Home. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that facility.

A *"Nursing Home"* is a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse; the facility must employ at least one full-time Nurse; and a Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Home only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Home does NOT include any of the following:

- A hospital or clinic.
- A sub-acute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- An Assisted Care Facility.
- Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- A substantially similar adult residence establishment or environment.

Payment of this Benefit is subject to: the Daily Maximum; the Lifetime Maximum; and the Elimination Period.

ASSISTED CARE FACILITY BENEFIT: We will pay for expenses You incur for care and support services (including room and board, but not prescription drugs) provided by an Assisted Care Facility while You are confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

An *"Assisted Care Facility"* is a facility, not excluded below, that satisfies the Conditions below and is engaged primarily in providing continual (24 hours-a-day, every day) assistance and supervision to at least 10 resident inpatients due to their inability to perform Activities of Daily Living or Severe Cognitive Impairment.

Conditions: To satisfy this definition, such facility (e.g., assisted care, assisted living, or Alzheimer's dementia care facility) must at all times:

- Provide such care and services under a license, certificate, or substantially similar permit and oversight from the federal government or the State in which it is located;

OR

- Provide such care and services in accordance with all applicable laws; and continuously meet all of the following requirements:
  - It maintains records for all care and services provided to each resident inpatient;
  - It has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment;
  - It has an awake employee who is aware of the whereabouts of the resident inpatients;
  - It provides, at a minimum, assistance with Bathing and Dressing;
  - It provides 3 meals a day and accommodates special dietary needs;
  - It has formal arrangements with a duly licensed physician or Nurse to furnish medical care and services in case of an emergency; and
  - It has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Care Facility is NOT any of the following: (a) a hospital or clinic; (b) a Nursing Home; (c) a sub-acute care or rehabilitation hospital or unit; (d) a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; (e) Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or (f) a substantially similar adult residence establishment or environment.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Care Facility only if it is engaged primarily in providing care that satisfies the above definition.

Payment of this Benefit is subject to: the Daily Maximum; the Lifetime Maximum; and the Elimination Period.

BED RESERVATION BENEFIT: We will continue to pay benefits, or give Elimination Period credit, under the Nursing Home Benefit and the Assisted Care Facility Benefit while You:

- Are temporarily absent during a stay in a Nursing Home or Assisted Care Facility; and
- Are charged to reserve Your accommodations in that facility.

The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay, or spending holidays or other time with Your family.

This Benefit is subject to the Lifetime Maximum; and will be payable for no more than 30 days per Policy Year.

ALTERNATIVE CARE BENEFIT: *(For expenses not otherwise covered. Prior approval by Us is required.)* We will pay for expenses You incur for care, treatment, services, supplies or other items not specifically covered by another Benefit of this Policy when all of the following conditions are met:

- They are clearly specified in Your Plan of Care.
- You, Your personal physician and We mutually agree that they are cost-effective alternatives to Benefits specifically available under this Policy.
- They are for qualified long term care services as defined in Section 7702B(c) of the Internal Revenue Code.
- They are incurred while such mutual agreement is in effect.
- They are incurred while Your insurance is in force under this Policy.

Agreement to use these alternatives will not waive any of the rights You or We have under this Policy. The agreement may be discontinued at any time without affecting Your right to the Benefits otherwise available under this Policy.

Examples include, but are not limited to:
- In-Home safety devices.
- Community-based services that provide meals in the Home for disabled individuals (such as Meals on Wheels).
- Equipment in Your Home that is not covered under the Equipment Benefit.
- Rental or lease of emergency medical response devices.
- Other services designed to help You remain at Home.

The agreement will state how payment is affected by the Elimination Period. It will also state any time and payment maximums. Payment of this Benefit is also subject to: the Lifetime Maximum; and all other provisions and conditions of this Policy.

WAIVER OF PREMIUM BENEFIT: We will waive the premium payments for each coverage month that begins after You have satisfied the Elimination Period and during a period for which benefits are paid or payable under: (a) the Nursing Home Benefit; or (b) the Assisted Care Facility Benefit; or (c) the Home Care Benefit. This waiver applies to the entire premium for this Policy and all attachments.

This Benefit stops when You cease to receive Covered Care during any period for which benefits are paid under the Nursing Home Benefit, the Assisted Care Facility Benefit, or the Home Care Benefit. When this Benefit stops, We will give credit for any premium paid for periods during which the waiver applied, against future premiums when due. You will be required: to pay the remaining premiums due in accordance with this Policy's previous premium payment mode; and to continue to make future premium payments as they become due.

CONTINGENT NONFORFEITURE BENEFIT: If the Nonforfeiture Benefit does not apply, You will be given the right to reduce coverage or convert to a limited paid-up benefit only in the event of substantial cumulative premium increases. The amount of the reduced coverage available is the same as described above for the Optional Nonforfeiture Benefits.

OPTIONAL NONFORFEITURE BENEFIT: *This is an optional Benefit for which an additional premium is charged.* It provides continued coverage in the event the Policy terminates (lapses) due to a default in the payment of any premium after it has been in force for at least 3 years. If the lapse occurs while this Benefit is in force, the Policy will be continued (without further premium payments) with a reduced Lifetime Maximum. The amount of the continued reduced coverage will be the greater of: the maximum benefit amount applicable, at the time of lapse, under the Nursing Home Benefit for one month (30 days); or the total of all premiums actually paid and attributed to You for Your insurance under the Policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

OPTIONAL RESTORATION OF BENEFITS RIDER: *This is an optional rider for which an additional premium is charged.* It will restore the Policy's Lifetime Maximum to the amount that would have applied if no benefits had been paid under the Policy. Except as limited below, this applies whenever a period of 180 consecutive days elapses during which no Insured required, or received, either:
- Substantial Assistance from another individual in performing at least two (2) Activities of Daily Living due to a loss of functional capacity; or
- Substantial Supervision due to Severe Cognitive Impairment.

This restoration will not apply when the Policy is in force under a Nonforfeiture Benefit. In addition, if the Policy originally covered 2 people who were both Insureds under the Policy on the date of death of one Insured, the restoration will operate to restore only that portion of the Lifetime Maximum that was actually used by the surviving Insured and was not previously restored.

OPTIONAL SURVIVORSHIP BENEFIT: *This is an optional rider for which an additional premium is charged.* If a couple have been insured under this Policy, or separate policies issued by Us, for at least 10 years when one of them dies, no further premium payments will be required for this Policy if:
- The survivor is insured under this Policy; and
- Both persons continuously had long term care insurance coverage in force with Us, other than under a Nonforfeiture Benefit, on the date of the deceased person's death and for at least the prior 10 year period; and
- Both persons were a couple with coverage that included a similar Survivorship Benefit for the entire period of concurrent coverage; and
- No long term care benefits were paid or payable by Us for either person for the first 10 years of such concurrent Survivorship Benefit coverage; and
- We receive due written proof of such death.

This waiver applies to the premium for this Policy and all attached riders in force on the date of such death.

OPTIONAL ENHANCED SURVIVORSHIP BENEFIT RIDER: *This is an optional rider for which an additional premium is charged.* It provides that, if a couple have been insured under this Policy, or separate policies issued by Us, for at least 7 years when one of them dies, no further premium payments will be required for this Policy if:
- The survivor is insured under this Policy; and
- Both persons continuously had long term care insurance coverage in force with Us, other than under a Nonforfeiture Benefit, on the date of the deceased person's death and for at least the prior 7 year period; and

- Both persons were a couple with coverage that included a similar Enhanced Survivorship Benefit for the entire period of concurrent coverage; and
- We receive due written proof of such death.

This waiver applies to the premium for this Policy and all attached riders in force on the date of such death.

OPTIONAL MONTHLY BENEFITS RIDER: *This is an optional rider for which an additional premium is charged. It is available only if Your Home Care Maximum is 100% of the Daily Maximum.* It provides that while this Rider is in force we will pay up to 30 times the Daily Maximum for all expenses that are incurred during a calendar month and are covered under: the Nursing Home Benefit, the Assisted Care Facility Benefit; the Bed Reservation Benefit; and the Home Care Benefit.

OPTIONAL WAIVER OF HOME CARE ELIMINATION PERIOD RIDER: *This is an optional rider for which an additional premium is charged.* This Rider waives the Elimination Period for the Home Care Benefit. It also provides that, when a Plan of Care from a Privileged Care Coordinator is used: (1) Home Care Benefit days will count toward satisfying the Elimination Period; and (2) the Waiver of Premium Benefit will apply without requiring an Elimination Period.

10. LIMITATIONS AND EXCLUSIONS.

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: A Nursing Home or Assisted Care Facility is not covered unless it meets the applicable definition for such a facility. Your "Home" is Your primary place of residence in an area used principally for independent residential living. This could be a house, condominium, apartment, unit in a congregate care community, or similar residential environment. Your Home does not include a hospital, Nursing Home, or Assisted Care Facility.

Non-eligible Levels of Care: Coverage is not based on the specific level of care; but is for care furnished, for a specific covered reason, by or through the covered facilities and providers. Care from family members is not covered.

Exclusions/Exceptions and Limitations: No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- Provided by a Family Member, unless: (1) the Family Member is a regular employee of the organization that is providing the services; and (2) such organization receives payment for the services; and (3) the Family Member receives no compensation other than the normal compensation for employees in her or his job category.
- For which no charge is normally made in the absence of insurance.
- Provided outside of the United States of America, its territories and possessions.
- Provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to You or Your estate.
- Resulting, directly or indirectly, from:
  - War or act of war, whether declared or not.
  - Attempted suicide or an intentionally self-inflicted injury.
  - Your alcoholism or addiction to drugs or narcotics; but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

Note: We will pay benefits for mental illness and Alzheimer's disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care under this Policy.

Non-Duplication: Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid). However, this Non-Duplication provision will not disqualify an expense for Covered Care from being used to satisfy the Elimination Period.

Other Coverage with Us: We may reduce benefits payable under this Policy for Covered Care if We also pay benefits for that Covered Care under any other policy issued by Us. This applies to policies providing long term care insurance (including policies providing nursing home and/or home care coverage) whether payable on an expense reimbursement, indemnity or any other basis.

Benefits will be reduced under this Policy only when payment would result in Our paying, under this and all other such policies, more than the expense You actually incur for an item of Covered Care. Any such reduction will be limited to the amount payment under this Policy causes the total amount of benefits under this and all other such policies to be more than 100% of the expense You actually incurred for that Covered Care.

Any policy without a similar Other Coverage With Us provision will pay first without any reduction in its benefits.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the cost of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. You may choose from two options at the time of application that will increase Your benefits. They will be available to pay for expenses incurred on or after the date of the increases and while this Policy is in force. Benefit Increases cease when the Policy terminates.

5% Equal Increases means that on each Policy Anniversary Date Your Daily Maximum and Lifetime Maximum will each increase by 5% of their original respective amounts applicable on the Policy Effective Date.

5% Compound Increases means that on each Policy Anniversary Date Your Daily Maximum and the remaining Lifetime Maximum will each increase by 5% of the respective Daily Maximum and remaining Lifetime Maximum amounts applicable on that Policy Anniversary Date.

If You do not purchase a Benefit Increases option, You will need to provide satisfactory evidence of insurability to later increase coverage. If You elect Benefit Increases, premiums will be higher; but they will not increase due to a change in age or the automatic benefit increases. At the end of this outline is a graphic comparison of the benefit levels of policies that increase benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

12. ALZHEIMER'S DISEASE AND OTHER BRAIN DISORDERS. Once insurance goes into force, coverage is provided if You are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses and meet the Benefit Eligibility requirements.

13. PREMIUM. The following shows the annual premium for: the base Policy and any chosen benefit options; Your premium payment mode; and the corresponding modal premium.

Applicant(s)	_____	_____
Annual Premium		
Basic Policy with any Benefit Increases	$ _____	$ _____
Optional Riders		
Nonforfeiture	$ _____	$ _____
Restoration of Benefits	$ _____	$ _____
Survivorship	$ _____	$ _____
Enhanced Survivorship	$ _____	$ _____
Monthly Benefits	$ _____	$ _____
Waiver of Home Care Elimination Period	$ _____	$ _____
Subtotal Before Discounts	**$** _____	**$** _____
Anticipated Discounts	$ _____	$ _____
Total Annual Payment Mode Premium	**$** _____	**$** _____
	Mode Factor x____(Factor from table below)	
Modal Premium	**$** _____	**$** _____
	(Annual Payment Mode Premium x Factor)	
Annual Total of Modal Premiums	$ _____	$ _____
	(Modal Premium times 1, 2, 4 or 12)	

Premium Payment Mode (Factor)

☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26)
☐ Monthly (.09) - requires Electronic Funds Transfer

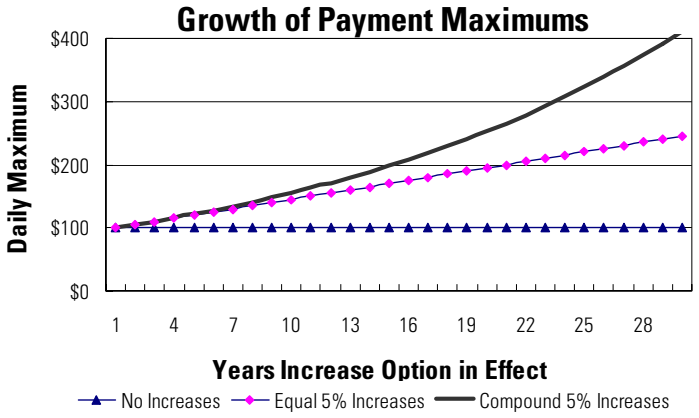
How Long Premium Will Be Payable

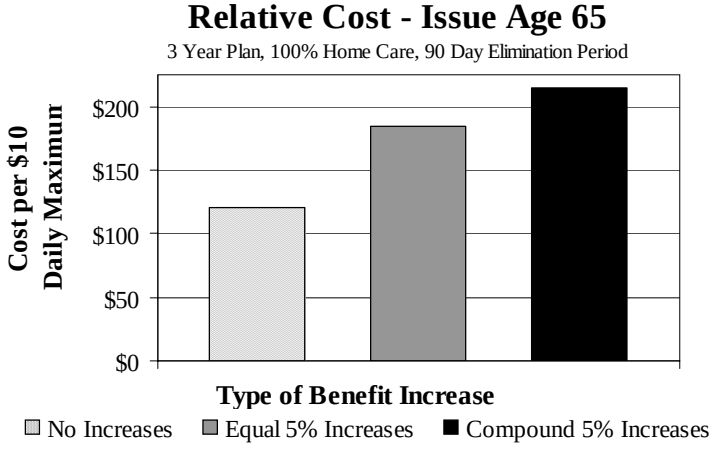
☐ Lifetime ☐ 10 Years
☐ Until the Policy Anniversary coinciding with or next following the date You reach 65 years of age.

14. ADDITIONAL FEATURES. Applications are subject to medical underwriting; and are approved only if We are provided evidence of insurability which is satisfactory and acceptable to the company. Insurance is not available to those who are 85 years of age or older when applying.

Continuation for Lapse Due to Alzheimer's Disease and Other Forms of Cognitive or Functional Impairment: We will provide a retroactive continuation of coverage if the Policy terminates due to nonpayment of premiums (lapse) and within 7 months after termination we are given proof that You met the Benefit Eligibility requirements. We must receive proof of Your impairment or incapacity and all past due premiums within that 7 month period. Any benefits for which You qualified during the continuation period will be paid to the same extent they would have been paid if the Policy and its riders had remained in force from the date of termination.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY OR CERTIFICATE.





Genworth Life Insurance Company
6620 West Broad Street - Building 4
Richmond, VA 23230

ACKNOWLEDGMENT OF RELEASE OF CERTAIN HEALTH RELATED INFORMATION

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

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

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

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

Representative Name	Phone Number
Address of Representative	

In addition, I understand that:

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

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

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

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

[1]Products underwritten by Genworth Life Insurance Company

Genworth[SM]
Financial

LONG TERM CARE INSURANCE SUITABILITY STATEMENT

MAKE SURE LONG TERM CARE INSURANCE IS RIGHT FOR YOU

Underwritten by Genworth Life Insurance Company

82174M 01/01/06

Things You Should Know Before You Buy Long Term Care Insurance

– APPLICANT COPY –

Long Term Care Insurance
A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.

The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare
Medicare does **not** pay for most long term care.

Medicaid
Medicaid will generally pay for long term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services. When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide
Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long Term Care Insurance." Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling
Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

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Additional Information to Help You with the Long Term Care Insurance Personal Worksheet

As part of your application for long term care insurance, your state long term care insurance regulations require that we ask you to provide us with documentation that would demonstrate the purchase of this insurance is appropriate in relation to your financial resources.

The inclusion of your financial information in this form, **the Long Term Care Insurance Personal Worksheet**, is voluntary. Your decision to provide or not provide the income and asset information will not affect your right as an individual to choose to purchase any form of insurance.

Completion of **the Long Term Care Insurance Personal Worksheet** will help you determine whether the purchase of this insurance will affect your standard of living. Again, the final choice to purchase or not remains with you. **Please be assured that all of your answers will be held in strictest confidence.**

As your long term care insurance provider, we have established some reasonable guidelines to help you in your considerations. If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care. While the purchase of long term care insurance can help you maintain your independence, help preserve your assets, and give you more freedom of choice as to nursing home or other care providers, we would advise against purchasing any policy that would create a financial hardship for you. The purchase of long term care insurance should be viewed as a commitment that may extend over many years. Your ability to pay the initial premium and renewal premiums must be taken into account in your decision to buy.

Your long term care insurance representative is well qualified to discuss **the Long Term Care Insurance Personal Worksheet** with you as well as appropriateness of your planned purchase. Thank you very much for considering us as your long term care insurance provider.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

– COMPANY COPY –

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

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

SECTION A

Premium Information

Policy Form #: ☐ **7042** or state equivalent ☐ **7044** or state equivalent

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

$ _____ annually $ _____ semi-annually
$ _____ quarterly $ _____ monthly

The Company's Right to Increase Premiums

The company has a right to increase premiums in the future.

Rate Increase History

The company has sold long term care insurance since 1974, and has sold this policy since 2003. The company has not raised its rates for this policy, and has never increased premiums for any prior policies providing essentially the same coverage.

Questions Related to Your Income

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?
☐ Yes ☐ No

How will you pay for each year's premium
☐ From my Income ☐ From my Savings\Investments ☐ My Family will Pay ☐ Other (friends, entities, etc.)

SECTION B

What is your annual income (include all sources such as interest on investments, etc.)?
Check One: ☐ Under $10,000 ☐ $10,000-$20,000 ☐ $20,000-$50,000 ☐ Over $50,000

How do you expect your income to change in the next 10 years? (check one)
Check One: ☐ No change ☐ Increase ☐ Decrease
If you will be paying with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets worth (your savings & investments) ? (check one)
Check One: ☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
Check One: ☐ Stay about the same ☐ Increase ☐ Decrease
If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Please Note:
If your assets are under $30,000 but over $20,000, this coverage may still be suitable if your income is over $10,000.
The purchase of this policy may not be suitable for you if:
(1) your annual income is less than $10,000 or (2) the value of all your savings and investments is under $20,000.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET *(continued)*

– COMPANY COPY –

Disclosure Statement

Check one

☐ The answers to the preceding questions accurately describe my financial situation.

-or-

☐ I choose not to complete this information (in section B on the prior page), and I have signed the Verification of Financial Non-Disclosure below.

NOTE: Section A on the prior page must be completed even if you do not disclose your financial information.

X _____ _____ _____
Applicant A **Signature** **Printed Name** **Date**

X _____ _____ _____
Applicant B **Signature** **Printed Name** **Date**

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

X _____ _____
Agent's Signature **Date**

_____
Agent's Printed Name

Complete this section ONLY if your agent has advised you that this policy may not be suitable for you.

My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

X _____ _____ X _____ _____
Applicant A **Signature** **Date** **Applicant** B **Signature** **Date**

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

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Verification of Financial Non-Disclosure

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

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

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

X _____ _____ _____
Applicant A **Signature** **Printed Name** **Date**

X _____ _____ _____
Applicant B **Signature** **Printed Name** **Date**

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

HEALTH INFORMATION AUTHORIZATION

Genworth Life Insurance Company

Administrative Office:
3100 Albert Lankford Dr., Lynchburg, VA 24501-4948
Herein called the Company

This is a HIPAA Compliant Authorization

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

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

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company; its insurance support organizations (such as EMSI); its affiliates and reinsurers. A copy of my application may also be attached to any policy of a co-applicant who is issued coverage as a result of the same application.

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

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; and determine premium amounts.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to Genworth Life Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Signature of Applicant **A**	Date Signed	Signature of Applicant **B**	Date Signed
Printed Name of Applicant **A**		Printed Name of Applicant **B**	
Address of Applicant **A**		Address of Applicant **B**	

Company Copy

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(Return signed copy with the application.)

Other Important Information

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, 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, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

HEALTH INFORMATION AUTHORIZATION

Genworth Life Insurance Company

Administrative Office:
3100 Albert Lankford Dr., Lynchburg, VA 24501-4948
Herein called the Company

This is a HIPAA Compliant Authorization

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

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

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company; its insurance support organizations (such as EMSI); its affiliates and reinsurers. A copy of my application may also be attached to any policy of a co-applicant who is issued coverage as a result of the same application.

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

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; and determine premium amounts.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to Genworth Life Insruance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Signature of Applicant **A**	Date Signed	Signature of Applicant **B**	Date Signed
Printed Name of Applicant **A**		Printed Name of Applicant **B**	
Address of Applicant **A**		Address of Applicant **B**	

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Applicant Copy

Other Important Information

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, 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, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.