Genworth®
Financial

APPLICATION & OUTLINE OF COVERAGE

LONG TERM CARE INSURANCE

Underwritten by
Genworth Life Insurance Company

An Approved Participant In

CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

37122CAP 06/01/10

California Partnership

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

What Happens When Long-Term Care Costs Rise?

A Comparison of Costs and Benefit Amounts

Protecting your benefits against inflation is one of the most important features you can have in a long-term care policy. You may hesitate to purchase inflation protection since it adds significantly to a policy's cost. Yet without it, years from now you may find yourself needing long-term care, and owning a policy the benefits of which have not kept pace with the increasing cost of services.

2010

All policies approved by the California Partnership for Long-Term Care have a built-in inflation protection benefit.

Experts estimate the cost of long-term care will continue to increase by at least 5% annually. **Chart 1** below compares the anticipated cost for nursing home care over the next twenty years against a long-term care policy that does not include an inflation protection feature which increases the value of the benefits as time goes by.[1]

If a 55 year old purchases a policy in the year 2010 that provides $230 worth of daily benefits, the policy's benefits will cover a full days worth of care in a nursing home at the time of purchase.[2] As shown in **Chart 1**, care that costs $230 per day in the year 2010 is likely to cost $671 per day in twenty years. Without inflation protection, the $230 per day policy purchased today will still only pay $230 when the policyholder reaches age 75. That benefit amount will cover just over a third of the projected cost of care. The $441 difference between the value of the policy and the projected cost of care would have to be paid by the policyholder.

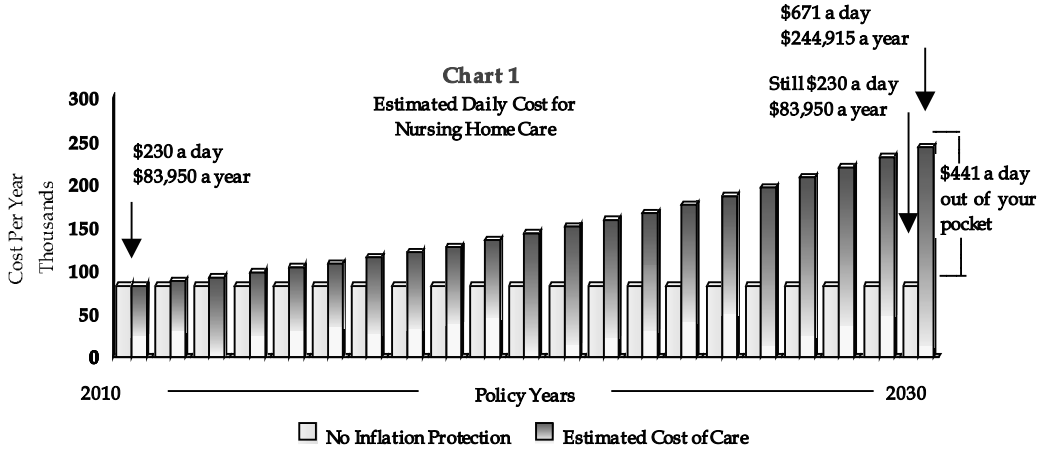
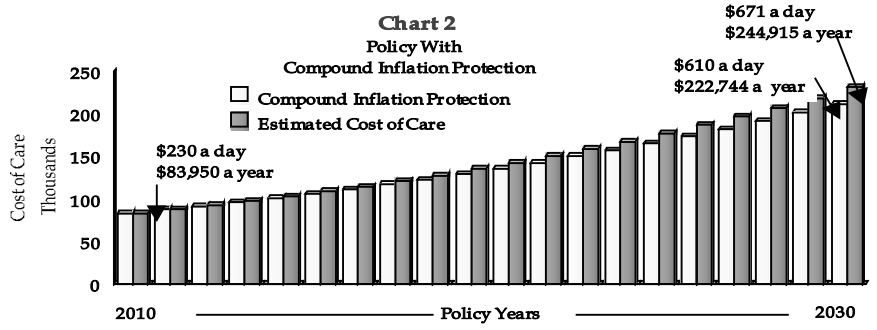


Chart 1
Estimated Daily Cost for Nursing Home Care

[NOTE: In 2010, the cost of care for one year is $83,950]

Chart 2 compares the anticipated increase in the cost for one day of nursing home care over the next twenty years with a long-term care policy that has a 5% compounded annual inflation protection benefit. The benefits of a policy that pays $230 in the year 2010 will grow by 5% each year. In twenty years, the policy will provide $610 in daily benefits. The actual cost for the care may be more or less than this projection, but **Chart 2** shows that a policy with inflation protection does much better at keeping up with the expected cost of care.

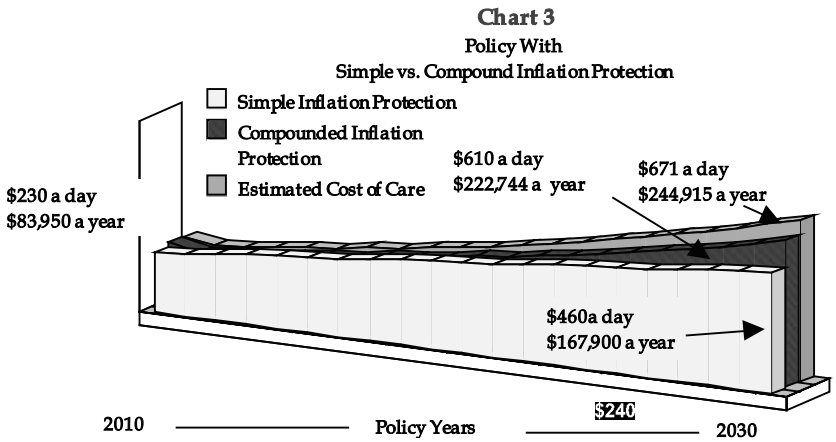


[NOTE: In 2010, the cost of care for one year is $83,950]

There are two types of inflation protection, Simple or Compounded:

Compounded increases: The policy daily benefits will grow by 5% compounded each year as described above. For example, an initial daily benefit of $230 will be worth $610 twenty years later. **Simple increases:** The policy daily benefits will grow by a fixed dollar amount each year. The amount of increase is equal to 5% of the policy's original daily benefit amount. For example, an initial benefit of $230 per day will be worth $460 twenty years later.

Chart 3 below compares how well these two types of inflation protection keep up with the expected future increases in the cost of one day and one year of nursing home care.



[NOTE: In 2010, the cost of care for one day is $230]

You should know that, if you are younger than 70 years of age, you automatically have 5% yearly compounded inflation protection.

If you are 70 years or older, you have a choice between the two types of inflation protection.

[1] No one can precisely predict future increases in the cost of care. This graph is based on an expected 5.5% annual increase in nursing home private pay rates.

[2] This estimate of the cost for one day of nursing home care is based on the California statewide average daily nursing home rate. Actual rates vary in different regions of the state.

CALIFORNIA
APPLICATION INSTRUCTIONS

Step 1 – Ensure basic underwriting eligibility.
Check applicant height and weight to see if they meet the Basic Eligibility Requirements in the table provided in the right hand column.

Step 2 – Complete the *entire* application to avoid returned applications and processing delays. Do NOT use correction fluid. Cross out and initial changes.

CONDITIONAL INSURANCE AGREEMENT

An initial premium (one month; 9% of the annual premium) must be submitted with the application in order to be eligible for the Conditional Insurance Agreement. If eligible, coverage begins on the date the application is signed, unless a later effective date is requested on the coverage selection page. For EFT payments, use the EFT authorization form.

DISCOUNTS

Couples Discounts will be provided to applicants in one of two situations: 1) when both submit valid applications, together or within 12 months of each other, correctly answering NO to questions 1 through 5; or 2) when one submits a valid application correctly answering NO to questions 1 through 5 and his or her partner is covered under a long term care insurance policy issued by Genworth Life Insurance Company. Preferred Health Discounts are given to applicants who accurately answer NO to all parts of questions 1 through 10. See the chart below for the discount amount(s) based on discount combinations.

	POLICY TYPE	COUPLES DISCOUNT	PREFERRED HEALTH DISCOUNT APPLICANT		TOTAL DISCOUNT APPLICANT	
			1	2	1	2
1 Applicant with Preferred Health	Individual	n/a	20%	–	20%	–
2 Applicants Both Issued/Both Preferred	Individual	40%	10%	10%	50%	50%
2 Applicants Both Issued/One Preferred	Individual	40%	10%	–	50%	40%
2 Applicants One Issued/With Preferred	Individual	25%	10%	–	35%	–
2 Applicants One Issued/No Preferred	Individual	25%	–	–	25%	–

COUPLES

In addition to married couples, applicants who are not married but meet certain criteria may be eligible to apply for or to receive a Couples Discount. Please refer to the "Requirements to Access Special (Couples) Benefits" form for an explanation of the state criteria and instructions on how to access these couples' benefits.

BASIC ELIGIBILITY REQUIREMENTS

If over or under limits below, do not take the application. For diabetic or osteoporosis height/weight tables, please see the underwriting guide.

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
5′ 3″	96	203	214
5′ 4″	99	210	221
5′ 5″	102	216	228
5′ 6″	106	223	235

HEIGHT	WEIGHT		
	MIN.	MAX. *Female*	MAX. *Male*
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
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

PHONE AND IN-PERSON HEALTH INTERVIEW REQUESTS

When needed, phone and in-person health interviews will be ordered by the Home Office.

Please provide applicants with the Guide and Checklist For Your Long Term Care Insurance Application (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 30 minutes. The Phone Cognitive Interview is a cognitive screen given over the phone which takes 15 to 20 minutes.

SUBMIT TO HOME OFFICE CHECKLIST

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

- ◯ Application *(fully completed using blue or black ink. Must be received at Genworth Home Office within 30 days of the date the application was signed by the client)*
- ◯ Outline of Coverage *(leave applicant(s) the Outline of Coverage)*
- ◯ EFT Authorization *(if paying by this method)*
- ◯ Health Information Authorization
- ◯ Replacement Notice *(when required)*
- ◯ Suitability form
- ◯ Potential Rate Increase Disclosure Notice
- ◯ State specific forms *(when required)*
- ◯ Requirements to Access Special (Couples) Benefits form *(when required)*

Please complete the above forms, provide agent and client signatures, date all forms, and mail (with any collected premium payment made payable to):

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

MINIMUM UNDERWRITING REQUIREMENTS Pre Qualification 800 354-6892

		Doctor Visit in Last 2 Years				No Doctor Visit in 2 Years			
	Age	18-54	55-64	65-71	72-79	18-54	55-64	65-71	72-79
Preferred Health	Phone Cognitive Interview			x					
	Medical Records Request			x	x				
	In Person Health Interview				x			x	x
	Phone Health Interview	x*	x			x*	x		
	Prescription Drug Report	x**				x**			
Standard Health	Phone Cognitive Interview			x					
	Medical Records Request	x	x	x	x				
	In Person Health Interview				x	x	x	x	x

*Only If Unlimited Benefit Multiplier Requested **For All Other Benefit Multipliers Requested

COVERAGE SELECTION — INDIVIDUAL BENEFIT

APPLICANT A	APPLICANT B
Print Name **Age**	**Print Name** **Age**
BASIC BENEFIT SELECTIONS	
Daily Maximum $_____	**Daily Maximum** $_____
Benefit Multiplier ○ Unlimited ○ 2190 ○ 1460 ○ 1095 ○ 730 ○ 365	**Benefit Multiplier** ○ Unlimited ○ 2190 ○ 1460 ○ 1095 ○ 730 ○ 365
Elimination Period ○ 30 days ○ 90 days* **Not available with 365 Benefit Multiplier*	**Elimination Period** ○ 30 days ○ 90 days* **Not available with 365 Benefit Multiplier*
Inflation Protection ○ 5% Compound - Mandatory unless 5% Equal applies. ○ 5% Equal - Must be age 70 or older and signed below. I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of a policy with and without inflation protection. Specifically, I have reviewed plans with 5% annual compound inflation protection and 5% equal inflation protection. I reject compound inflation protection and select equal inflation protection.	**Inflation Protection** ○ 5% Compound - Mandatory unless 5% Equal applies. ○ 5% Equal - Must be age 70 or older and signed below. I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of a policy with and without inflation protection. Specifically, I have reviewed plans with 5% annual compound inflation protection and 5% equal inflation protection. I reject compound inflation protection and select equal inflation protection.
Signature of Applicant A (Only when 5% Equal chosen) X_____	**Signature of Applicant B** (Only when 5% Equal chosen) X_____
OPTIONS/RIDERS	
Home Care Benefits ○ 100% ○ 50%	**Home Care Benefits** ○ 100% ○ 50%
High Limit Residential Care ○ Yes ○ No	**High Limit Residential Care** ○ Yes ○ No
This option increases the amount payable under the Residential Care Facility Benefit from 70% to 100% of the Daily Maximum.	
Nonforfeiture Benefit ○ Yes ○ No	**Nonforfeiture Benefit** ○ Yes ○ No
REDUCED COVERAGE OPTIONS	
Survivorship Benefit Coverage will include Survivorship benefit unless rejected at right: ○ Survivorship benefit rejected	
Revised Elimination Period - If selected, the Elimination Period will also apply to Home and Community Based Care Benefits. If not selected, the elimination period will not apply to Home and Community Based Care. ○ Yes	**Revised Elimination Period** - If selected, the Elimination Period will also apply to Home and Community Based Care Benefits. If not selected, the elimination period will not apply to Home and Community Based Care. ○ Yes
DISCOUNTS	
Eligible for Preferred Health Discount ○ Yes† ○ No	**Eligible for Preferred Health Discount** ○ Yes† ○ No
†Must accurately answer No to all parts of questions 1-10. 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 Name _____	
Second Applicant Social Security Number _____	*Second Applicant Existing Policy Number* _____
PREMIUM INFORMATION	
Modal Premium $_____	**Modal Premium** $_____
Premium Payments ○ Standard ○ 10-Pay ○ Pay-to-65△ *△Only available for ages 55 and younger.*	**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.*	**Premium Payment Mode** ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) *‡Automatic draft of checking account required. Must complete EFT form.*
Replacement Is this to replace an existing policy with us? ○ Yes ○ No	**Replacement** Is this to replace an existing policy with us? ○ Yes ○ No

Request for an Effective Date later than the Date of Application: I hereby request that, if my application is approved, no insurance will take effect until the date set by the Company following its approval of my application. I understand that the Company's underwriting decision will consider any changes in my health status that take place after the Date of Application and that the Initial Premium will be applied as of the Effective Date set by the Company.

Signature of Applicant **A** _____	Signature of Applicant **B** _____
MultiLife/List Bill Number **List Bill:** ○ Yes ○ No	**MultiLife/List Bill Number** **List Bill:** ○ Yes ○ No

Agent Name	**Agent Producer Code**	**State in which application is signed**

For Internal Use Cell Code 49231

INDIVIDUAL BENEFIT

Use this page only if you need more room to provide information requested in the Medical Profile.

ADDITIONAL NOTES

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

Signature of Applicant A _____ Signature of Applicant B _____

Date: _____ Date: _____

DETAILS for YES answers. | Provide name of medications and name, address and phone # of prescribing physician.

Details for Applicant A Ques.#		**Details for Applicant B** Ques.#	

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

Genworth Life Insurance Company

Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501

An Approved Participant In
CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

Comprehensive Policy Application

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits.

**** Print Clearly – Use Black Ink***

Ⓐ APPLICANT A INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss
☐ Ms. ☐ Other Title: _____
☐ Married ☐ Single ☐ Widowed

Name _____
(as it should appear on your policy)

Social Security No. ___-___-____

Birthdate ___/___/___ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ ☐a.m. ☐p.m.

Street Address _____
(No P.O. Box please)

City _____ State _____ Zip _____

APPLICANT B INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss
☐ Ms. ☐ Other Title: _____
☐ Married ☐ Single ☐ Widowed

Name _____
(as it should appear on your policy)

Social Security No. ___-___-____

Birthdate ___/___/___ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ ☐a.m. ☐p.m.

The benefits payable by this policy qualify for Medi-Cal Asset Protection under the California Partnership for Long Term Care. Eligibility for Medi-Cal is not automatic. If and when you need Medi-Cal, you must apply and meet the asset standards in effect at that time. Upon becoming a Medi-Cal beneficiary, you will be eligible for all medically necessary benefits Medi-Cal provides at that time, but you may need to apply a portion of your income toward the cost of your care. Medi-Cal services may be different than the services received under the private insurance.

Ⓑ INSURABILITY PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	1. Are you covered by Medi-Cal (not Medicare)?	☐	☐
☐	☐	2. Do you use a Walker or Wheelchair; 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; Walking?	☐	☐
☐	☐	3. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following? If YES place an "X" next to those that apply to the particular applicant.	☐	☐
☐	☐	Acquired Immune Deficiency Syndrome (AIDS)	☐	☐
☐	☐	AIDS Related Complex (ARC)	☐	☐
☐	☐	ALS (Lou Gehrig's Disease)	☐	☐
☐	☐	Alzheimer's Disease	☐	☐
☐	☐	Congestive Heart Failure (CHF) combined with Heart Attack or Angina	☐	☐
☐	☐	Congestive Heart Failure (CHF) combined with Emphysema/ (COPD)	☐	☐
☐	☐	Congestive Heart Failure (CHF) combined with Angioplasty or Heart Surgery	☐	☐
☐	☐	Congestive Heart Failure (CHF) combined with Asthma or Chronic Bronchitis	☐	☐
☐	☐	Congestive Heart Failure (CHF) combined with Diabetes	☐	☐
☐	☐	Congestive Heart Failure (CHF) combined with Tuberculosis (TB)	☐	☐
☐	☐	Cirrhosis of the Liver	☐	☐
☐	☐	Dementia	☐	☐
☐	☐	Diabetes under treatment with Insulin	☐	☐
☐	☐	Emphysema/COPD combined with current smoking	☐	☐
☐	☐	Emphysema/COPD combined with Congestive Heart Failure (CHF)	☐	☐
☐	☐	Emphysema/COPD combined with Asthma	☐	☐
☐	☐	Emphysema/COPD combined with Chronic Bronchitis	☐	☐
☐	☐	Frequent or persistent Forgetfulness	☐	☐
☐	☐	Memory Loss	☐	☐
☐	☐	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 combined with Diabetes or Heart Surgery	☐	☐
☐	☐	TIA two or more times	☐	☐
☐	☐	4. A. In the past 6 months have you had: Open Heart Surgery?	☐	☐
☐	☐	B. In the past 6 months have you had: Back or Spine Surgery?	☐	☐
☐	☐	5. In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes?	☐	☐

Do NOT complete the application for any applicant answering "YES" to any part of questions 1 through 5.

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, place an "X" next to those that apply and explain under **DETAILS**.

Applicant A	Applicant B		Applicant A	Applicant B		Applicant A	Applicant B		Applicant A	Applicant B	
☐	☐	Alcoholism	☐	☐	Convulsions	☐	☐	Injury due to Falls or Imbalance	☐	☐	Skin Ulcers
☐	☐	Amputation	☐	☐	Depression	☐	☐	Joint Replacement Surgery	☐	☐	Spine Condition
☐	☐	Angina	☐	☐	Diabetes not treated with Insulin	☐	☐	Leukemia	☐	☐	Tremor
☐	☐	Angioplasty	☐	☐	Disabling Back Condition	☐	☐	Lymphoma	☐	☐	Tuberculosis (TB)
☐	☐	Asthma	☐	☐	Drug Addiction	☐	☐	Mental Illness	☐	☐	Other Conditions causing Crippling
☐	☐	Atrial Fibrillation	☐	☐	Emphysema/COPD	☐	☐	Osteoporosis	☐	☐	Other Conditions causing Limited Motion
☐	☐	Blacking Out	☐	☐	Epilepsy	☐	☐	Paralysis	☐	☐	Other Conditions requiring Adaptive Devices
☐	☐	Brain Disorder	☐	☐	Fainting Spells	☐	☐	Rheumatoid Arthritis			
☐	☐	Cancer (excluding basal cell of skin)	☐	☐	Heart Attack	☐	☐	Seizures			
☐	☐	Chronic Bronchitis	☐	☐	Heart Surgery	☐	☐	Shortness of Breath			
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Hodgkin's Disease						

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	7. Have you smoked or used other tobacco products within the past 3 years?	☐	☐
☐	☐	8. A. Do you use a quad cane, hospital bed, or other physical assistance device?	☐	☐
☐	☐	B. Do you need assistance with managing medications?	☐	☐
☐	☐	C. Do you need assistance with shopping?	☐	☐
☐	☐	D. Do you need assistance with using transportation?	☐	☐
☐	☐	E. Do you need assistance with housekeeping/cooking?	☐	☐
		If YES, explain under **DETAILS.**		
		9. In the past 3 years have you:		
☐	☐	A. Received home care?	☐	☐
☐	☐	B. Used an adult day care facility?	☐	☐
☐	☐	C. Been confined to or advised to enter a nursing home, assisted care facility, or other long term care facility?	☐	☐
		If YES, explain under **DETAILS**.		
☐	☐	10. In the past 3 years have you taken any **prescription** medications for High Blood Pressure and/or Osteoarthritis?	☐	☐
		If YES, explain under **DETAILS**.		
☐	☐	11. Are you currently taking *any* prescription medications? List each medication ***and why it is needed*** under **DETAILS**.	☐	☐
		12. In the past 3 years have you:		
☐	☐	A. Been medically advised to have surgery which has not been performed? If YES, explain under **DETAILS**.	☐	☐
☐	☐	B. Been medically advised to enter or been confined to a hospital or other health care facility? If YES, explain under **DETAILS**.	☐	☐
☐	☐	C. Consulted with or been treated by a licensed health care practitioner (including osteopaths, chiropractors, physical therapists, and medical doctors, but excluding eye doctors, podiatrists, and dentists) *other than* your primary care doctor for any reason not previously stated? If YES, explain under **DETAILS**.	☐	☐
☐	☐	13. Have 2 or more years passed since your last office visit, treatment, or examination by ***any*** doctor?	☐	☐

DETAILS for YES answers. Provide name of medications and name, address and phone # of prescribing physician.

Details for Applicant A

Ques.# _____

Details for Applicant B

Ques.# _____

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

14. Who is the primary care doctor with most of your medical records?

Applicant A	**Applicant B**
Doctor's Name	Doctor's Name
Address	Address
City, State, Zip	City, State, Zip
( ) Phone No.	( ) Phone No.

D PERSONAL PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	15A. Do you work 20 or more hours a week outside your home? If YES, list occupation. ..... Applicant **A**: _____ Applicant **B**: _____	☐	☐
☐	☐	B. Do you perform volunteer work? If YES, list type of work and if full-time or part-time. ..... Applicant **A**: _____ ☐full ☐part Applicant **B**: _____ ☐full ☐part	☐	☐
☐	☐	C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? If YES, please describe. ..... Applicant **A**: _____ Applicant **B**: _____	☐	☐
☐	☐	16. Do you drive an automobile? If YES, provide approximate annual mileage: ..... Applicant **A**: _____ Applicant **B**: _____	☐	☐
☐	☐	17. Are you receiving disability income, workers compensation or any state or Social Security Disability Benefits? ..... If YES, explain type and cause: Applicant **A**: _____ Applicant **B**: _____	☐	☐
☐	☐	18. Do you live in some form of a residential retirement community? If YES, list the specific services that you receive (e.g., housekeeping, laundry, meals): Applicant **A**: _____ Applicant **B**: _____	☐	☐

E OTHER COVERAGE AND REPLACEMENT

☐	☐	19A. Do you have any accident and sickness or long term care insurance policy or certificate (including health care service contract, health maintenance organization contract, or life insurance based long term care coverage) in force or applied for? ..... If YES, give 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 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 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**: _____ Applicant **B**: _____	☐	☐
☐	☐	D. Did you have another long term care application denied during the last 12 months? If YES, with which company? ..... Applicant **A**: _____ Applicant **B**: _____	☐	☐
☐	☐	20. Do you intend to replace ***any*** of your long term care, medical, or health insurance coverage with this policy? ..... If YES, name insurer being replaced: Applicant A: _____ Annual Premium:$ _____ Applicant B _____ Annual Premium:$ _____ **Agent**: If YES, be sure to fill out the Replacement Notice. Leave one copy with applicant; send one copy with application.	☐	☐

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

(F) AUTHORIZATIONS

PROTECTION AGAINST UNINTENTIONAL LAPSE: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. ***Check only one box. If selecting this option, we recommend designating someone other than a spouse or agent.***

Applicant **A**	Applicant **B**
☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:	☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:
☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title:	☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title:
Full Name_____ Relationship_____	Full Name_____ Relationship_____
Home Address_____	Home Address_____
City, State, Zip_____ Phone:( )	City, State, Zip_____ Phone:( )
☐ I elect NOT to designate any person to receive such notice.	☐ I elect NOT to designate any person to receive such notice.

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.

AUTHORIZATION: I authorize Genworth Life Insurance Company, its insurance support organizations (such as PMSI), 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 a photocopy 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 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.

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 a part of the policy for which I am applying; and (3) no insurance will take effect under the policy for which I am applying: (a) until this application is approved by the Company; (b) unless the first premium is paid; (c) prior to the effective date which is established by the Company; and (d) if an answer given to any question on this application changes materially after the date this application is signed but prior to the date this application is approved by the Company.

CAUTION: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.

X_____ _____ **X**_____ _____
Signature of Applicant **A** Date Signed Signature of Applicant **B** Date Signed

X_____
Signature of Licensed and Appointed Agent

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long term care insurance policy to the State of California for the purpose of documenting my Medi-Cal asset disregard under the Medi-Cal program, evaluating the California Partnership for Long Term Care, and meeting Department of Health Services or Department of Insurance audit or quality control requirements. As part of the evaluation of the California Partnership for Long Term Care, the State is trying to determine how well this program is reaching people with varying amounts of income and assets. You will therefore be asked to fill out a brief survey, prepared by the State, and indicate what range your income and assets fall into. I understand that the information contained in these records will be used for no purpose other than stated above, and will be kept strictly confidential by the State of California.

X_____ _____ **X**_____ _____
Signature of Applicant **A** Date Signed Signature of Applicant **B** Date Signed

NOTICE TO APPLICANT REGARDING MEDI-CAL ELIGIBILITY

I understand that eligibility for Medi-Cal is not automatic; an application is necessary. Once my long term care insurance begins paying benefits, the insurer will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any other asset exemptions available to a Californian applying for Medi-Cal. I understand that should I want to apply for Medi-Cal it is my responsibility to complete the application process. I further understand that before receiving Medi-Cal I will first have to use any additional assets I have not protected. If I become a Medi-Cal beneficiary, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medi-Cal services at that time may not be the same services I was receiving under my private long term care insurance. I understand that the Medi-Cal program does not include a residential care facility benefit. Medi-Cal will not pay for any continuing care I may require in a residential care facility if I exhaust the total benefits of my private long-term care insurance while residing in a residential care facility.

X_____ _____ **X**_____ _____
Signature of Applicant **A** Date Signed Signature of Applicant **B** Date Signed

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

CHECKLIST: (Check the appropriate boxes below for items received at the time of application.)

- ☐ The Privacy Notice which I have read.
- ☐ Before You Buy a complete description of the California Partnership For Long-Term Care as prepared by the Department of Health Services, including an explanation of how Medi-Cal Asset Protection is achieved.
- ☐ Taking Care of Tomorrow - A Consumer's Guide to Long Term Care prepared by the California Department of Aging.
- ☐ The notice entitled "Things You Should Know Before You Buy Long Term Care Insurance".
- ☐ A Long Term Care Insurance Personal Worksheet for completion and to return to the insurer.
- ☐ Information on the State of California Health Insurance Counseling and Advocacy Program (HICAP) and the name, address and telep hone number of the local HICAP Program and the statewide HICAP number, 1-800-434-0222.
- ☐ The Outline of Coverage which includes graphic comparisons showing the projected increase in the cost of nursing facility care over a twenty (20) year period between a policy or certificate that does not increase benefits and: (1) a policy or certificate that increases benefits, but not premiums over the policy or certificate period; and (2) a policy or certificate that increases premiums and benefits over the policy or certificate period.
- ☐ A copy of What Happens When Long-Term Care Costs Rise?
- ☐ I read and signed the Consent and Authorization to Release Information and the Notice to Applicant Regarding Medi-Cal Eligibility.
- ☐ A Shopper's Guide to Long Term Care Insurance.
- ☐ A copy of the Notice to Applicant Regarding Replacement of Accident and Sickness or Long Term Care Insurance if Question 20 i ndicates that this is a replacement.

X _____ _____
Signature of Applicant **A** Date Signed

X _____ _____
Signature of Applicant **B** Date Signed

Agent Certification: I delivered the documents checked above to the applicant(s):

X _____
Signature of Licensed and Appointed Agent

G 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**: _____		

AGENT INFORMATION

Name of Licensed and Appointed Agent (Please print)

Street Address

Social Security No. or Tax ID of Licensed and Appointed Agent

City, State, Zip

X _____ ( ) ( )

Signature of Licensed and Appointed Agent — Phone No. — Fax No.

Email Address of Licensed and Appointed Agent

H PREMIUM RECEIPT AND CONDITIONAL INSURANCE AGREEMENT

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

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.

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

Print Name of **Applicant A** Application Date	Print Name of **Applicant B** Application Date
Initial Premium (Minimum 1 month premium) $_____	Initial Premium (Minimum 1 month premium) $_____
Printed Name of Agent	Agent's Business Address & Phone Number (please print)
Signature of Agent Date Signed **X**	

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:
   A. Within the past 5 years you HAD NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Convulsions, Seizures, Fainting Spells, Black Outs, Mental Illness, or Paralysis.
   B. Within the past 3 years you HAD NOT: been medically advised to have surgery that has not been performed; or received home health care; or been medically advised to enter or been confined to a nursing facility, residential care facility, or any other 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.

61232E **No applicant, agent, producer or representative has any power or authority to change any of the provisions of this Agreement.**

I 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.

61221

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 your written request, we will provide you with information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. 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 Drive
Lynchburg, Virginia 24501

Genworth Life Insurance Company

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

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

COMPREHENSIVE LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE

For Policy Form 7037C Rev 2009

Complete and Retain for Your Records

Applicant: _____

Date of Application: _____

The benefits payable by this policy qualify for Medi-Cal Asset Protection under the California Partnership for Long Term Care.

Eligibility for Medi-Cal is not automatic. If and when you need Medi-Cal, you must apply and meet the asset standards in effect at that time. Upon becoming a Medi-Cal beneficiary, you will be eligible for all medically necessary benefits Medi-Cal provides at that time, but you may need to apply a portion of your income toward the cost of your care. Medi-Cal services may be different than the services r eceived under the private insurance.

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits.

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.

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 misstated 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.

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

If you are not satisfied with the policy, you have 30 days to return it to the company. All premiums paid will be returned within 30 days after return of the policy or denial of the application. The policy contains a provision for the return of unearned premium in the event of termination due to death. It also provides for return of unearned premium upon surrender or cancellation of the policy.

4. 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.

5. 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, 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 reimburses you for covered long term care expenses incurred by you. It is subject to limitations, elimination periods, coinsurance and other requirements.

6. BENEFITS PROVIDED BY THIS POLICY

<table>
<tr><th colspan="4">COVERAGE SELECTION</th></tr>
<tr><td colspan="2">Daily Payment Maximum
$ _____
Home Care
☐ 100% ☐ 50%</td><td>Benefit Multiplier
☐ Unlimited
☐ 2190 ☐ 1460
☐ 1095 ☐ 730
☐ 365</td><td>Lifetime Payment Maximum
The Daily Payment Maximum times the Benefit Multiplier</td></tr>
<tr><td>Inflation Protection
Compound 5% (default)
☐ Equal 5% chosen (must be age 70 or older)</td><td>Elimination Period
☐ 30 Days
☐ 90 Days</td><td>Nonforfeiture Benefit
☐ Yes
☐ No</td><td>High Limit Residential Care Benefit
☐Yes ☐No</td></tr>
<tr><td colspan="4">Reduced Coverage Options
☐ None ☐ Rider Deleting Survivorship Benefit
☐ Revised Elimination Period Rider</td></tr>
</table>

BENEFIT ELIGIBILITY: For you to be eligible for Benefits provided by the policy we must receive ongoing proof that your receipt of the covered care is due to your being qualified for Benefits, as described below.

How to Qualify for Benefits: We will pay for the Qualified Long Term Care Services covered by this policy if:

- You are a Chronically Ill Individual; and
- The Qualified Long Term Care Services are prescribed for you in a written Plan of Care.

You will be considered a "Chronically Ill Individual" when one of the following criteria is met:

- You are unable to perform, without Standby Assistance or Hands-on Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity and this loss of functional capacity is expected to last at least 90 days; or
- You have a Severe Cognitive Impairment requiring Substantial Supervision to protect you from threats to health and safety.

The certification that you are a Chronically Ill Individual must be made by a Licensed Health Care Practitioner, independent of us, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid by this policy must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner.

All services covered by this policy are Qualified Long Term Care Services.

Definitions: The following definitions will help explain how you qualify for benefits under the policy:

An "Activity of Daily Living" is one of the following: Bathing; Dressing; Eating; Continence; Toileting; and Transferring.

"Standby Assistance" means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living (such as being ready to catch you if you fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from your throat if you choke while eating).

"Hands-on Assistance" means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

"Severe Cognitive Impairment" means a loss or deterioration in intellectual capacity that: (a) is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) is measured by clinical evidence and standardized tests prescribed by or approved by the California Partnership for Long Term Care.

"Substantial Supervision" means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a person who has Severe Cognitive Impairment from threats to his or her health or safety (as may result from wandering).

A "Licensed Health Care Practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. The Licensed Health Care Practitioner must be employed by a Provider Agency or be a Qualified Official Designee of a Care Management Provider Agency.

A "Plan of Care" is a written individualized plan of services prescribed by a Licensed Health Care Practitioner which specifies the type, frequency and providers of all Formal and Informal Long Term Care Services required for the individual, and the cost, if any, of any Formal Long Term Care Services prescribed. Changes in the Plan of Care must be documented to show that such alterations are required by changes in the client's medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Care Services which are needed to assist you with the disabling conditions that cause you to be a Chronically Ill Individual. "Maintenance or Personal Care Services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a Chronically Ill Individual, including the protection from threats to health and safety due to Severe Cognitive Impairment.

CONDITIONS: Benefit payments are subject to: the Elimination Period requirements; the applicable Daily, Monthly, and Lifetime Payment Maximums; and all other provisions of the policy. Benefits will be paid only for expenses you incur for Qualified Long Term Care Services that are covered by this policy, and are received pursuant to your Plan of Care and while your insurance is in force.

Once you have met the Chronically Ill Individual criteria and expect to incur expenses covered by the policy, a Plan of Care will be prepared. The Plan of Care will be developed as a result of a face-to-face assessment, by a Licensed Health Care Practitioner who is either employed by or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care. The Plan of Care will be updated periodically, as appropriate based on your condition, or upon our request. In no event will we require updating more frequently than once in any 60 day period. We must be sent a copy of your Plan of Care immediately upon its completion and updating, or as soon thereafter as is reasonably possible.

Note: Your personal physician will not be able to develop the Plan of Care for this policy unless he or she is either employed by or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care.

A "Privileged Care Coordinator" means a person who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

A "Care Management Provider Agency" means an agency or other entity that provides Care Coordination and meets the standards established for participation in the California Partnership for Long Term Care.

A "Qualified Official Designee of a Care Management Provider Agency" is an individual who meets the Privileged Care Coordinator qualifications and is designated by the Care Management Provider Agency to certify that you are a Chronically Ill Individual and/or to perform Care Management.

Your Right to Request Payment for Care Not Otherwise Covered by the Policy: The policy provides the Benefits described below. When you meet the Benefit Eligibility provisions and Conditions, you may request payment for care or services not otherwise covered by this policy. We may, at our sole discretion, determine that providing benefits for those expenses is appropriate and payable under this policy. Payment of such benefits will count against the Lifetime Payment Maximum; and when benefits are provided for care in a facility, they will be subject to the policy's Elimination Period requirements.

Examples under which we may provide benefits include, but are not limited to the following: in-home safety devices; home delivered meals; stays in other types of facilities; and additional equipment benefits.

Remember: Any payment made under these circumstances must be included in your Plan of Care and be as agreed to by us.

CARE COORDINATION BENEFIT

Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Care Coordination services furnished by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care. Expenses paid under this Benefit will NOT count against the policy's Lifetime Payment Maximum. The Care Management Provider Agency cannot stand to benefit financially if you receive benefits under the policy for recommended care, other than the Care Coordination.

"Care Coordination" includes, but is not limited to the following:

1. The performance of a comprehensive individualized face-to-face assessment conducted in the client's place of residence;
2. The development of a Plan of Care. The Plan of Care will be a written plan of services which specifies the type, frequency and providers of all Formal and Informal Long Term Care Services required by the individual; and the cost, if any, of any Formal Long Term Care Services prescribed;
3. Providing the initial and ongoing Current Eligibility Certifications.
4. The performance of a comprehensive, individualized reassessment at least every six months;

5. When desired by the individual and determined necessary by the Care Management Provider Agency, coordination of appropriate service and ongoing monitoring of the delivery of such services. It may include negotiating service and care provider rates for the client;
6. Help with completion of claims forms required to obtain payment under the policy; and
7. The development of a discharge plan when the Care Management Provider Agency's services, or the policy's benefits, are about to be terminated if further care is needed. If you are immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan.

Care Coordination takes an all-inclusive look at a person's total needs and resources, and links the person to a full range of appropriate services using all available funding sources.

Payments Do Not Count Against the Lifetime Payment Maximum: Expenses paid under this Benefit will not count against the Lifetime Payment Maximum of this policy.

No Daily Payment Maximum or Elimination Period: The Daily Payment Maximum does not apply to payments made under this Benefit. Expenses covered by this Benefit are not subject to, and may not be used to satisfy, any Elimination Period.

An *Eligible Provider* of Care Coordination is a Privileged Care Coordinator who is either employed by or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care.

A "Privileged Care Coordinator" is a Licensed Health Care Practitioner who, either alone, or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

Privileged Care Coordinators are familiar with the care and service providers available in the 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 the client and his or her family. In all cases, the client is responsible for choosing the actual care and service providers to be used. If for any reason the client is not satisfied with a care or service provider, he or she may request that the Privileged Care Coordinator identify other providers from which to choose.

HOME AND COMMUNITY-BASED CARE BENEFIT

Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for care and support services you receive in accordance with a Plan of Care prepared by a Privileged Care Coordinator employed by, or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care:

- Home Health Care Services provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist or audiologist.
- Adult Day Health/Social Care.
- Hospice Services;
- Personal Care; and
- Homemaker Services.

No payment will be made under this Benefit for expenses incurred while you are confined in a Nursing Facility, or on a day for which payment is made under either the Respite Care Benefit or while you are in a Residential Care Facility in which event, the Residential Care Facility Benefit provides coverage which includes, but is not limited to, the same services covered by this Benefit.

Payment for the above expenses is subject to the Home and Community-Based Care Monthly Payment Maximum; and counts against the Lifetime Payment Maximum.

The "Home and Community-Based Care Monthly Payment Maximum" is the greatest amount we will pay for all expenses covered by this Benefit that are incurred during a Coverage Month. It is equal to:

- 31 times the applicable Daily Payment Maximum if you have the 100% Home Care option; and
- 15 times the applicable Daily Payment Maximum if you have the 50% Home Care option.

Elimination Period/Considerations: If you have chosen the Revised Elimination Period Rider, payment of this Benefit is subject to the Elimination Period.

Otherwise, payment under this Benefit is not subject to the Elimination Period requirement. In addition, each day you incur expenses for care and support services that are covered by this Benefit will count toward satisfying your Elimination Period for other benefits that are subject to an Elimination Period.

Eligible Care and Services Defined

"Adult Day Health/Social Care" means a structured, comprehensive program which provides a variety of community-based services including health, social, and related supportive services in a protective setting on a less than 24-hour basis. These community-based services are designed to meet the needs of functionally impaired adults through an individualized service plan, and include the following:

- personal care and supervision as needed;
- the provision of meals, as long as the meals do not meet a full daily nutritional regimen;
- transportation to and from the service site; and
- social, health and recreational activities.

Eligible Providers of Adult Day Health/Social Care in California include:

- Adult Day Care Facilities, and Adult Social Day Care Facilities, which are licensed by the Department of Social Services;
- Adult Day Health Care Facilities licensed by the Department of Health Services; and
- Alzheimer Day Care Resource Centers administered by the Department of Health Services.

"Home Health Care Services" means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Eligible Providers: Home Health Care Services may be provided by personnel from home health care agencies, or directly by individuals who are licensed or certified to provide those services if no home health care agency exists in the area.

"Homemaker Services" means assistance with activities necessary to or consistent with your ability to remain in your residence, that is provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner.

Eligible Providers: Homemakers Services may be provided by a nurses aide, a home health aide, or a person who is qualified by training and/or experience to provide care in accordance with the Plan of Care.

"Hospice Services" are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an individual who is

experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a Plan of Care developed by a physician or a multidisciplinary team under medical direction.

Eligible Providers of Hospice Services are individuals furnished by a hospice organization or hospital, or other skilled or unskilled persons hired within the community.

"Personal Care Services" includes: ambulation assistance; bathing and grooming; dressing; bowel, bladder and menstrual care; repositioning, transfer skin care, and range of motion exercises; feeding and hydration assistance; assistance with self-administration of medications; and assistance with instrumental activities of daily living.

Eligible Providers of Personal Care Services may be nurse aides, home health aides, or persons qualified by training and/or experience to provide care in accordance with the Plan of Care. It is not required that the provision of Personal Care Services be at a level of certification or licensure greater than that required by the eligible services, or that those services be provided by Medicare-certified agencies or providers.

CAREGIVER TRAINING BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for training an informal (unpaid) caregiver to care for you in your home. All of the following conditions apply to the payment of this Benefit.

- The person receiving the training can be a relative or someone else chosen by you; but in no event will we pay for training provided to someone who will be paid to care for you.
- The training cannot be received while you are confined in a hospital, Nursing Facility or Residential Care Facility, unless 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.

Eligible Providers of caregiver training include, but are not limited to state licensed home health care agencies as well as licensed or certified professionals such as nurses and therapists.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Caregiver Training Benefit is an amount equal to five (5) times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily Payment Maximum; but does count against the Lifetime Payment Maximum.

RESPITE CARE BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Respite Care.

"Respite Care" means the supervision and care of a Chronically Ill Individual in the home or out of the home while the family or other individuals who normally provide care take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving.

We will not limit or exclude benefits by requiring that the provision of Respite Care be at a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers. Providers for which no license or certification is required must be qualified by training and/or experience to provide that service.

Eligible Providers of Respite Care include, but are not limited to: a Nursing Facility, a Residential Care Facility, community-based programs such as an Adult Day Health/Social Care provider, persons employed by a home health agency, and a person who is qualified by training and/or experience to provide the care.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitation on Benefit Payments: This Benefit will be paid for no more than 21 days of Respite Care during any one calendar year. Benefit payments are subject to the Daily Payment Maximum; and count against the Lifetime Payment Maximum.

SUPPORTIVE EQUIPMENT BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for the purchase or rental of Supportive Equipment when all of the following conditions are satisfied.

- The equipment must be intended to assist you in living at home or in any other residential housing (which does not include a hospital, a Nursing Facility or a Residential Care Facility) by relieving your need for direct physical assistance.
- If the equipment is being purchased, rather than rented, it must be reasonably expected (as stated in your Plan of Care) that the equipment will enable you to remain at home or in other residential housing (which does not include a hospital, Nursing Facility, or Residential Care Facility) for at least 90 days after the date of purchase.
- The equipment must be specified in, and consistent with, your Plan of Care.

"Supportive Equipment" means items, such as the following, which meet the above conditions: ramps to permit movement from one level of the residence to another; grab bars and toilet modifications to assist in toileting; more extensive bathroom modifications to assist in bathing or showering; mechanical lifts; and other mechanical aids. It 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.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Supportive Equipment Benefit is an amount equal to 50 times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily or Monthly Payment Maximum; but does count against the Lifetime Payment Maximum.

RESIDENTIAL CARE FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Residential Care you receive in a Residential Care Facility. The maximum amount we will pay for all such expenses incurred on any one day will be 70% of the Daily Payment Maximum (100% of the Daily Payment Maximum if you have the High Limit Residential Care Benefit Rider). Benefit payments count against the Lifetime Payment Maximum.

Eligible Providers of this care include, but are not restricted to, the facility in which you reside as well as those persons and other entities which provide Qualified Long Term Care Services to you while you are in the facility. This includes facilities and services provided by the Residential Care Facility, care and services covered under other benefits of the policy, and any other care and services that are needed to assist you with the disabling conditions that caused you to be a Chronically Ill Individual.

A "Residential Care Facility" means a facility licensed as a "residential care facility" or a "residential care facility for the elderly" as defined in the California Health and Safety Code.

Outside California a Residential Care Facility is a facility which meets the applicable licensing standards, if any, and is engaged primarily in providing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impaired cognitive ability. It must also:

- Provide such care and services on a twenty-four hour a day basis;
- Have a trained and ready-to-respond employee on duty in the facility at all times to provide such care and services;
- Provide 3 meals a day and accommodate special dietary needs;
- Have agreements to ensure that residents receive the medical care services of a physician or Nurse in case of an emergency; and
- Have the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

It should be noted that this definition would generally NOT be met by: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; a Nursing Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

NURSING FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay, for each day you are confined as a resident inpatient in a Nursing Facility, the lesser of: the Daily Payment Maximum; or the expenses you incur for care and support services (including room and board and ancillary supplies and services) provided by the Nursing Facility. This includes expenses you incur for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that Nursing Facility. Benefit payments count against the Lifetime Payment Maximum.

A "Nursing Facility" is an institution which is licensed by the appropriate licensing agency to engage primarily in providing nursing care to inpatients and meets all of the following criteria:

- It provides twenty-four hour a day nursing services under policies and procedures developed with the advice of, and periodically reviewed and executed by, a professional group of at least one duly licensed physician and one Nurse.
- It has a duly licensed physician available to furnish medical care in case of emergency.
- It has at least one Nurse who is employed there full time.
- It has a Nurse on duty or on call at all times.
- It maintains clinical records for all patients.
- It has appropriate methods and procedures for handling and administering drugs and biologicals.

A Nursing Facility is NOT: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; a Residential Care Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

BED RESERVATION BENEFIT: We will continue to pay benefits, or give Elimination Period credit, under the Nursing Facility and the Residential Care Facility Benefits for each day you:

- are temporarily absent during a stay in a Nursing Facility or Residential Care Facility; and
- are charged to reserve your accommodations in that facility.

We will do this for a total of not more than the first 50 days (continuous or not) of such absence during a Policy Year. Benefit payments are subject to the Daily Payment Maximum; and they count against the Lifetime Payment Maximum.

SURVIVORSHIP BENEFIT *(This Benefit applies unless you have chosen the Rider Deleting Survivorship Benefit):*
When your spouse dies after this policy has been in force for at least ten years, no further premium payments will be required for this policy if:

- Both you and such spouse continuously had long term care insurance coverage in force with us, other than under a Nonforfeiture Benefit, on the date of death of the spouse and for at least the prior ten year period; and
- Such spouse's coverage included a similar Survivorship Benefit; and
- No long term care benefits were paid or payable by us for you or such spouse during the first ten years of such concurrent coverage.

OPTIONAL NONFORFEITURE BENEFIT: This is an optional Benefit for which an additional premium is charged. It provides continued coverage in the event your 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 Payment Maximum. The amount of the continued reduced coverage will be the greater of: 90 times your Daily Payment Maximum; or the total of all premiums paid for the policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

GENERAL DEFINITIONS: The following definitions apply:
The "Daily Payment Maximum" is the greatest amount we will pay for all expenses you incur on any one day that are covered by the Nursing Facility Benefit. As described in the Benefit Provisions, this maximum also applies to the Respite Care Benefit and is used to determine maximum amounts applicable to some other Benefits. Based on the Benefit Increases provision that applies, this amount will increase over time.

The "Elimination Period" is the total number of days that covered, Formal Long Term Care Services (services for which the provider is paid) must be received after you are determined to be a Chronically Ill Individual and before the benefits covered by the policy are payable. The number of days may be accumulated within any time period after you are determined to be a Chronically Ill Individual before filing a claim. Days used to satisfy the Elimination Period do not need to be consecutive. The Elimination Period need only be met once during your lifetime. Any day when covered services are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period.

Home and Community-Based Care is subject to the Elimination Period only if you have chosen the Revised Elimination Period Rider.

Respite Care, Care Coordination, Caregiver Training, and Supportive Equipment are not subject to the Elimination Period; and days for which you receive Home and Community-Based Care Benefits will count toward satisfying your Elimination Period.

The "Lifetime Payment Maximum" is the combined total amount we will pay as Benefits under the policy. This amount is determined by multiplying the Daily Payment Maximum by the applicable Benefit Multiplier. When Benefit Increases apply, this amount increases over time. The Lifetime Payment Maximum may be used interchangeably for any services covered by the policy.

"Medi-Cal Asset Protection" is the right extended to you by California law when you use the benefits of this policy. This right allows you to protect one dollar of your assets for every dollar this policy pays out in benefits, in the event you later apply for Medi-Cal benefits or other qualifying State long-term care benefits. The amount of this asset protection at any time is equal to the sum of all benefit payments made for your care by this policy. Should you later apply for Medi-Cal benefits or other qualified long term care benefits, you will not be required to expend your protected assets prior to becoming eligible for these public benefits. Your protected assets will also be exempt from any claim the State of California may have against your estate to recover the cost of State-paid long term care or medical services provided to you.

"Medi-Cal Property Exemption" is the total equity value of real and personal property not otherwise exempt under Medi-Cal regulations equal to the sum of qualifying insurance benefit payments made on your behalf.

A "Nurse" is someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN); and is operating within the scope of that license.

7. LIMITATIONS AND EXCLUSIONS

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: If an institution has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a covered facility only if it meets the criteria in the definition of such a facility; is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and is engaged principally in providing not only room and board, but also care and services which meet all of those criteria.

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: Benefits are not payable for care, stays, or other items:

- Provided by a family member;
- When no charge is normally made in the absence of insurance;
- Provided outside of the U.S.A. or its territories or possessions;
- Provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to you or your estate;
- Resulting from war or act of war;
- Resulting from an attempted suicide or an intentionally self-inflicted injury; or
- For alcoholism and drug addiction; unless it has occurred as a result of the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

Note: Mental illness and Alzheimer's disease are covered, subject to the same exclusions, limitations and provisions applicable to other conditions.

Non-Duplication: Benefits will be paid only for expenses incurred for Qualified Long Term Care Services covered by this policy that are in excess of the amount paid or payable under any Other Plan. The term "Other Plan" means:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- any other national, state or other governmental health care plan or law (except Medicaid/Medi-Cal); and
- any insurance policy (including other long term care insurance policies or certificates), subscriber contract, group coverage through HMOs and other prepayment, group practice or individual practice plans.

If you have any Other Plan under which you are entitled to benefits for expenses for covered confinement or services, benefits will be paid under this policy:

- only after benefits for like expenses are paid under those Other Plans (including amounts that would be reimbursable under Medicare but for the application of a deductible or coinsurance amount); and
- only to the extent that the Benefits under this policy, together with the amount of benefits paid under those Other Plans (including amounts that would be reimbursable under Medicare but for the application of a deductible or coinsurance amount), do not exceed the actual expenses incurred for the confinement or services received.

We will count, for the purposes of satisfying the Elimination Period, days on which you incur expenses that would otherwise qualify for payment under the Nursing Facility Benefit or the Residential Care Facility Benefit but are excluded from coverage solely because benefits are paid or payable under Medicare or any other national, state or other governmental health care plans or law.

Actions in the Event of a Public Funded National or State Plan: If a non-Medicaid/Medi-Cal national or state long term care program created through public funding substantially duplicates benefits provided by this policy, we will implement one of the following actions based on mutual agreement between us and the California Department of Insurance.

- We will reduce your future premium payments; or
- We will increase future benefits.

The amount of premium reductions and future benefit increases to be made by us will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and our claims experience. Our premium reduction and benefit increase plans will first be filed with and approved by the California Department of Insurance.
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. 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. The California Partnership for Long Term Care requires your policy to include 5% Compound Increases unless you are at least 70 years of age and apply for 5% Equal Increases. Equal Increases means the daily, monthly and lifetime limits will increase by 5% of their original amounts; and Compound Increases means the daily, monthly and lifetime limits will increase by 5% of the most recent amounts.

Increases will occur on each anniversary of the policy's effective date. Increased amounts will apply to each day benefits are payable on or after the date of the increase. Your premiums will not increase due to a change in age or the automatic benefit increases. On the following page is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

9. 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 as long as you pay your premiums on time. 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.

The policy includes a Waiver of Premium for premiums that become due: while continuing benefits are payable under the Residential Care Facility, Nursing Facility or Bed Reservation Benefits; and when continued Home and Community-Based Care Benefits are payable.

When the waiver stops, we will give credit for any premium paid for periods during which the waiver applied against future premiums then due. You will then be required to pay the pro rata premium needed to return the policy to its previous premium payment mode. Premiums can be changed, but only if they are changed for all California Partnership policies.

10. ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES

Once insurance goes into force, coverage is provided if you are clinically diagnosed as having Alzheimer's disease, organic disorders, or related degenerative and dementing illnesses and meet the Benefit Eligibility requirements.

11. PREMIUM

The table below shows the annual premium for the policy and any options you have chosen. It also shows your premium payment mode and the corresponding modal premium. An additional premium credit applies when this policy replaces a prior policy that has been in force with us for at least 1 year.

Eligible for Preferred Discount ☐Yes ☐No **Eligible for Spousal Discount** ☐Yes ☐No	Basic Policy (including Reduced Premium Riders): $
	Nonforfeiture Benefit: $
Premium Payment Mode (Adjustment Factor) ☐ **Annual** (1.0) ☐ **Semi-Annual** (.51) ☐ **Quarterly** (.26) ☐ **Monthly** (.09) - requires Electronic Funds Transfer	High Limit Residential Care: $ Total of Above: $ Total Discount: $ **Total Annual Premium:** $ **Modal Premium:** $ (Annual x mode factor)

12. ADDITIONAL FEATURES

Applications are subject to medical underwriting; and are approved only if you provide evidence of your insurability which is satisfactory and acceptable to the company. Insurance is not available if you are 85 years of age or older when you apply.

Continuation for Lapse Due to Alzheimer's Disease, Organic Disorders 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 meet the Benefit Eligibility requirements for any other reason. 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.

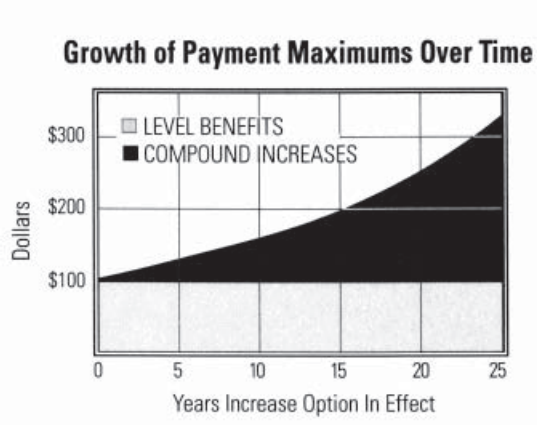
13. INFORMATION AND COUNSELING

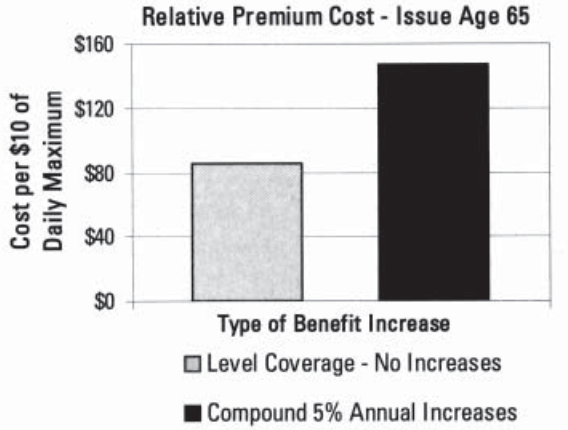
The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.

Local HICAP Office:_____
Agency Name

_____
Agency Address

_____
Agency Phone Number





Genworth Life Insurance Company
Home Office: Richmond, Virginia
Administrative Office Address: 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948
Phone: 1 800 456.7766

Complete and retain for your records.

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE ADDENDUM

Policy form series 7037C Rev 2009

The following optional Riders are available to modify coverage and reduce Policy premiums.

I RIDER DELETING THE SURVIVORSHIP BENEFIT

This Rider deletes the Survivorship Benefit from the Policy.

When this Rider applies, premiums are reduced by $ _____.

II REVISED ELIMINATION PERIOD RIDER

This Rider adds the Home and Community-Based Care Benefit to the Benefits to which the Elimination Period applies. It makes the following changes to the coverage described in the Outline:

1. The Elimination Period definition is changed to read:

   The "Elimination Period" is the total number of days that covered, Formal Long Term Care Services must be received after you are determined to be a Chronically Ill Individual and before the benefits covered by the Policy are payable. The number of days may be accumulated within any time period after you are determined to be a Chronically Ill Individual before filing a claim. Days used to satisfy the Elimination Period do not need to be consecutive. The Elimination Period need only be met once during your lifetime. Any day when covered services are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period.

   Respite Care, Care Coordination, Caregiver Training, and Supportive Equipment are not subject to the Elimination Period.

2. The Home and Community-Based Care Benefit is changed by substituting the following for the provision entitled "No Elimination Period/Credit Toward Your Elimination Period".

   Elimination Period Applicable to this Home and Community-Based Care Benefit: No payment will be made under this Benefit for expenses incurred prior to the date the Elimination Period has been satisfied.

   When this Rider applies, premiums are reduced by $ _____.

When selecting the Revised Elimination Period Rider, I considered the financial implications of having to pay added out-of-pocket expenses for home and community-based care during the Elimination Period.

Applicant Name _____

Selected Rider(s)

- ◯ Rider Deleting the Survivorship Benefit
- ◯ Revised Elimination Period Rider
- ◯ Neither Riders selected

Including any credit for the Riders chosen, Your Total Annual Premium will be: $_____

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

Genworth Life Insurance Company

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

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

COMPREHENSIVE LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE

For Policy Form 7037C Rev 2009

Complete and Retain for Your Records

Applicant: _____

Date of Application: _____

The benefits payable by this policy qualify for Medi-Cal Asset Protection under the California Partnership for Long Term Care.

Eligibility for Medi-Cal is not automatic. If and when you need Medi-Cal, you must apply and meet the asset standards in effect at that time. Upon becoming a Medi-Cal beneficiary, you will be eligible for all medically necessary benefits Medi-Cal provides at that time, but you may need to apply a portion of your income toward the cost of your care. Medi-Cal services may be different than the services r eceived under the private insurance.

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits.

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.

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 misstated 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.

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

If you are not satisfied with the policy, you have 30 days to return it to the company. All premiums paid will be returned within 30 days after return of the policy or denial of the application. The policy contains a provision for the return of unearned premium in the event of termination due to death. It also provides for return of unearned premium upon surrender or cancellation of the policy.

4. 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.

5. 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, 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 reimburses you for covered long term care expenses incurred by you. It is subject to limitations, elimination periods, coinsurance and other requirements.

6. BENEFITS PROVIDED BY THIS POLICY

<table>
<tr><th colspan="4">COVERAGE SELECTION</th></tr>
<tr><td colspan="2">Daily Payment Maximum
$ _____
Home Care
☐ 100% ☐ 50%</td><td>Benefit Multiplier
☐ Unlimited
☐ 2190 ☐ 1460
☐ 1095 ☐ 730
☐ 365</td><td>Lifetime Payment Maximum
The Daily Payment Maximum times the Benefit Multiplier</td></tr>
<tr><td>Inflation Protection
Compound 5% (default)
☐ Equal 5% chosen (must be age 70 or older)</td><td>Elimination Period
☐ 30 Days
☐ 90 Days</td><td>Nonforfeiture Benefit
☐ Yes
☐ No</td><td>High Limit Residential Care Benefit
☐Yes ☐No</td></tr>
<tr><td colspan="4">Reduced Coverage Options
☐ None ☐ Rider Deleting Survivorship Benefit
☐ Revised Elimination Period Rider</td></tr>
</table>

BENEFIT ELIGIBILITY: For you to be eligible for Benefits provided by the policy we must receive ongoing proof that your receipt of the covered care is due to your being qualified for Benefits, as described below.

How to Qualify for Benefits: We will pay for the Qualified Long Term Care Services covered by this policy if:

- You are a Chronically Ill Individual; and
- The Qualified Long Term Care Services are prescribed for you in a written Plan of Care.

You will be considered a "Chronically Ill Individual" when one of the following criteria is met:

- You are unable to perform, without Standby Assistance or Hands-on Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity and this loss of functional capacity is expected to last at least 90 days; or
- You have a Severe Cognitive Impairment requiring Substantial Supervision to protect you from threats to health and safety.

The certification that you are a Chronically Ill Individual must be made by a Licensed Health Care Practitioner, independent of us, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid by this policy must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner.

All services covered by this policy are Qualified Long Term Care Services.

Definitions: The following definitions will help explain how you qualify for benefits under the policy:

An "Activity of Daily Living" is one of the following: Bathing; Dressing; Eating; Continence; Toileting; and Transferring.

"Standby Assistance" means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living (such as being ready to catch you if you fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from your throat if you choke while eating).

"Hands-on Assistance" means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

"Severe Cognitive Impairment" means a loss or deterioration in intellectual capacity that: (a) is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) is measured by clinical evidence and standardized tests prescribed by or approved by the California Partnership for Long Term Care.

"Substantial Supervision" means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a person who has Severe Cognitive Impairment from threats to his or her health or safety (as may result from wandering).

A "Licensed Health Care Practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. The Licensed Health Care Practitioner must be employed by a Provider Agency or be a Qualified Official Designee of a Care Management Provider Agency.

A "Plan of Care" is a written individualized plan of services prescribed by a Licensed Health Care Practitioner which specifies the type, frequency and providers of all Formal and Informal Long Term Care Services required for the individual, and the cost, if any, of any Formal Long Term Care Services prescribed. Changes in the Plan of Care must be documented to show that such alterations are required by changes in the client's medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Care Services which are needed to assist you with the disabling conditions that cause you to be a Chronically Ill Individual. "Maintenance or Personal Care Services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a Chronically Ill Individual, including the protection from threats to health and safety due to Severe Cognitive Impairment.

CONDITIONS: Benefit payments are subject to: the Elimination Period requirements; the applicable Daily, Monthly, and Lifetime Payment Maximums; and all other provisions of the policy. Benefits will be paid only for expenses you incur for Qualified Long Term Care Services that are covered by this policy, and are received pursuant to your Plan of Care and while your insurance is in force.

Once you have met the Chronically Ill Individual criteria and expect to incur expenses covered by the policy, a Plan of Care will be prepared. The Plan of Care will be developed as a result of a face-to-face assessment, by a Licensed Health Care Practitioner who is either employed by or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care. The Plan of Care will be updated periodically, as appropriate based on your condition, or upon our request. In no event will we require updating more frequently than once in any 60 day period. We must be sent a copy of your Plan of Care immediately upon its completion and updating, or as soon thereafter as is reasonably possible.

Note: Your personal physician will not be able to develop the Plan of Care for this policy unless he or she is either employed by or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care.

A "Privileged Care Coordinator" means a person who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

A "Care Management Provider Agency" means an agency or other entity that provides Care Coordination and meets the standards established for participation in the California Partnership for Long Term Care.

A "Qualified Official Designee of a Care Management Provider Agency" is an individual who meets the Privileged Care Coordinator qualifications and is designated by the Care Management Provider Agency to certify that you are a Chronically Ill Individual and/or to perform Care Management.

Your Right to Request Payment for Care Not Otherwise Covered by the Policy: The policy provides the Benefits described below. When you meet the Benefit Eligibility provisions and Conditions, you may request payment for care or services not otherwise covered by this policy. We may, at our sole discretion, determine that providing benefits for those expenses is appropriate and payable under this policy. Payment of such benefits will count against the Lifetime Payment Maximum; and when benefits are provided for care in a facility, they will be subject to the policy's Elimination Period requirements.

Examples under which we may provide benefits include, but are not limited to the following: in-home safety devices; home delivered meals; stays in other types of facilities; and additional equipment benefits.

Remember: Any payment made under these circumstances must be included in your Plan of Care and be as agreed to by us.

CARE COORDINATION BENEFIT

Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Care Coordination services furnished by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care. Expenses paid under this Benefit will NOT count against the policy's Lifetime Payment Maximum. The Care Management Provider Agency cannot stand to benefit financially if you receive benefits under the policy for recommended care, other than the Care Coordination.

"Care Coordination" includes, but is not limited to the following:

1. The performance of a comprehensive individualized face-to-face assessment conducted in the client's place of residence;
2. The development of a Plan of Care. The Plan of Care will be a written plan of services which specifies the type, frequency and providers of all Formal and Informal Long Term Care Services required by the individual; and the cost, if any, of any Formal Long Term Care Services prescribed;
3. Providing the initial and ongoing Current Eligibility Certifications.
4. The performance of a comprehensive, individualized reassessment at least every six months;

5. When desired by the individual and determined necessary by the Care Management Provider Agency, coordination of appropriate service and ongoing monitoring of the delivery of such services. It may include negotiating service and care provider rates for the client;
6. Help with completion of claims forms required to obtain payment under the policy; and
7. The development of a discharge plan when the Care Management Provider Agency's services, or the policy's benefits, are about to be terminated if further care is needed. If you are immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan.

Care Coordination takes an all-inclusive look at a person's total needs and resources, and links the person to a full range of appropriate services using all available funding sources.

Payments Do Not Count Against the Lifetime Payment Maximum: Expenses paid under this Benefit will not count against the Lifetime Payment Maximum of this policy.

No Daily Payment Maximum or Elimination Period: The Daily Payment Maximum does not apply to payments made under this Benefit. Expenses covered by this Benefit are not subject to, and may not be used to satisfy, any Elimination Period.

An *Eligible Provider* of Care Coordination is a Privileged Care Coordinator who is either employed by or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care.

A "Privileged Care Coordinator" is a Licensed Health Care Practitioner who, either alone, or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

Privileged Care Coordinators are familiar with the care and service providers available in the 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 the client and his or her family. In all cases, the client is responsible for choosing the actual care and service providers to be used. If for any reason the client is not satisfied with a care or service provider, he or she may request that the Privileged Care Coordinator identify other providers from which to choose.

HOME AND COMMUNITY-BASED CARE BENEFIT

Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for care and support services you receive in accordance with a Plan of Care prepared by a Privileged Care Coordinator employed by, or is designated by a Care Management Provider Agency that has been selected by us and approved by the California Partnership for Long Term Care:

- Home Health Care Services provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist or audiologist.
- Adult Day Health/Social Care.
- Hospice Services;
- Personal Care; and
- Homemaker Services.

No payment will be made under this Benefit for expenses incurred while you are confined in a Nursing Facility, or on a day for which payment is made under either the Respite Care Benefit or while you are in a Residential Care Facility in which event, the Residential Care Facility Benefit provides coverage which includes, but is not limited to, the same services covered by this Benefit.

Payment for the above expenses is subject to the Home and Community-Based Care Monthly Payment Maximum; and counts against the Lifetime Payment Maximum.

The "Home and Community-Based Care Monthly Payment Maximum" is the greatest amount we will pay for all expenses covered by this Benefit that are incurred during a Coverage Month. It is equal to:

- 31 times the applicable Daily Payment Maximum if you have the 100% Home Care option; and
- 15 times the applicable Daily Payment Maximum if you have the 50% Home Care option.

Elimination Period/Considerations: If you have chosen the Revised Elimination Period Rider, payment of this Benefit is subject to the Elimination Period.

Otherwise, payment under this Benefit is not subject to the Elimination Period requirement. In addition, each day you incur expenses for care and support services that are covered by this Benefit will count toward satisfying your Elimination Period for other benefits that are subject to an Elimination Period.

Eligible Care and Services Defined

"Adult Day Health/Social Care" means a structured, comprehensive program which provides a variety of community-based services including health, social, and related supportive services in a protective setting on a less than 24-hour basis. These community-based services are designed to meet the needs of functionally impaired adults through an individualized service plan, and include the following:

- personal care and supervision as needed;
- the provision of meals, as long as the meals do not meet a full daily nutritional regimen;
- transportation to and from the service site; and
- social, health and recreational activities.

Eligible Providers of Adult Day Health/Social Care in California include:

- Adult Day Care Facilities, and Adult Social Day Care Facilities, which are licensed by the Department of Social Services;
- Adult Day Health Care Facilities licensed by the Department of Health Services; and
- Alzheimer Day Care Resource Centers administered by the Department of Health Services.

"Home Health Care Services" means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Eligible Providers: Home Health Care Services may be provided by personnel from home health care agencies, or directly by individuals who are licensed or certified to provide those services if no home health care agency exists in the area.

"Homemaker Services" means assistance with activities necessary to or consistent with your ability to remain in your residence, that is provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner.

Eligible Providers: Homemakers Services may be provided by a nurses aide, a home health aide, or a person who is qualified by training and/or experience to provide care in accordance with the Plan of Care.

"Hospice Services" are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an individual who is

experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a Plan of Care developed by a physician or a multidisciplinary team under medical direction.

Eligible Providers of Hospice Services are individuals furnished by a hospice organization or hospital, or other skilled or unskilled persons hired within the community.

"Personal Care Services" includes: ambulation assistance; bathing and grooming; dressing; bowel, bladder and menstrual care; repositioning, transfer skin care, and range of motion exercises; feeding and hydration assistance; assistance with self-administration of medications; and assistance with instrumental activities of daily living.

Eligible Providers of Personal Care Services may be nurse aides, home health aides, or persons qualified by training and/or experience to provide care in accordance with the Plan of Care. It is not required that the provision of Personal Care Services be at a level of certification or licensure greater than that required by the eligible services, or that those services be provided by Medicare-certified agencies or providers.

CAREGIVER TRAINING BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for training an informal (unpaid) caregiver to care for you in your home. All of the following conditions apply to the payment of this Benefit.

- The person receiving the training can be a relative or someone else chosen by you; but in no event will we pay for training provided to someone who will be paid to care for you.
- The training cannot be received while you are confined in a hospital, Nursing Facility or Residential Care Facility, unless 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.

Eligible Providers of caregiver training include, but are not limited to state licensed home health care agencies as well as licensed or certified professionals such as nurses and therapists.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Caregiver Training Benefit is an amount equal to five (5) times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily Payment Maximum; but does count against the Lifetime Payment Maximum.

RESPITE CARE BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Respite Care.

"Respite Care" means the supervision and care of a Chronically Ill Individual in the home or out of the home while the family or other individuals who normally provide care take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving.

We will not limit or exclude benefits by requiring that the provision of Respite Care be at a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers. Providers for which no license or certification is required must be qualified by training and/or experience to provide that service.

Eligible Providers of Respite Care include, but are not limited to: a Nursing Facility, a Residential Care Facility, community-based programs such as an Adult Day Health/Social Care provider, persons employed by a home health agency, and a person who is qualified by training and/or experience to provide the care.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitation on Benefit Payments: This Benefit will be paid for no more than 21 days of Respite Care during any one calendar year. Benefit payments are subject to the Daily Payment Maximum; and count against the Lifetime Payment Maximum.

SUPPORTIVE EQUIPMENT BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for the purchase or rental of Supportive Equipment when all of the following conditions are satisfied.

- The equipment must be intended to assist you in living at home or in any other residential housing (which does not include a hospital, a Nursing Facility or a Residential Care Facility) by relieving your need for direct physical assistance.
- If the equipment is being purchased, rather than rented, it must be reasonably expected (as stated in your Plan of Care) that the equipment will enable you to remain at home or in other residential housing (which does not include a hospital, Nursing Facility, or Residential Care Facility) for at least 90 days after the date of purchase.
- The equipment must be specified in, and consistent with, your Plan of Care.

"Supportive Equipment" means items, such as the following, which meet the above conditions: ramps to permit movement from one level of the residence to another; grab bars and toilet modifications to assist in toileting; more extensive bathroom modifications to assist in bathing or showering; mechanical lifts; and other mechanical aids. It 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.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Supportive Equipment Benefit is an amount equal to 50 times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily or Monthly Payment Maximum; but does count against the Lifetime Payment Maximum.

RESIDENTIAL CARE FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Residential Care you receive in a Residential Care Facility. The maximum amount we will pay for all such expenses incurred on any one day will be 70% of the Daily Payment Maximum (100% of the Daily Payment Maximum if you have the High Limit Residential Care Benefit Rider). Benefit payments count against the Lifetime Payment Maximum.

Eligible Providers of this care include, but are not restricted to, the facility in which you reside as well as those persons and other entities which provide Qualified Long Term Care Services to you while you are in the facility. This includes facilities and services provided by the Residential Care Facility, care and services covered under other benefits of the policy, and any other care and services that are needed to assist you with the disabling conditions that caused you to be a Chronically Ill Individual.

A "Residential Care Facility" means a facility licensed as a "residential care facility" or a "residential care facility for the elderly" as defined in the California Health and Safety Code.

Outside California a Residential Care Facility is a facility which meets the applicable licensing standards, if any, and is engaged primarily in providing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impaired cognitive ability. It must also:

- Provide such care and services on a twenty-four hour a day basis;
- Have a trained and ready-to-respond employee on duty in the facility at all times to provide such care and services;
- Provide 3 meals a day and accommodate special dietary needs;
- Have agreements to ensure that residents receive the medical care services of a physician or Nurse in case of an emergency; and
- Have the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

It should be noted that this definition would generally NOT be met by: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; a Nursing Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

NURSING FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay, for each day you are confined as a resident inpatient in a Nursing Facility, the lesser of: the Daily Payment Maximum; or the expenses you incur for care and support services (including room and board and ancillary supplies and services) provided by the Nursing Facility. This includes expenses you incur for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that Nursing Facility. Benefit payments count against the Lifetime Payment Maximum.

A "Nursing Facility" is an institution which is licensed by the appropriate licensing agency to engage primarily in providing nursing care to inpatients and meets all of the following criteria:

- It provides twenty-four hour a day nursing services under policies and procedures developed with the advice of, and periodically reviewed and executed by, a professional group of at least one duly licensed physician and one Nurse.
- It has a duly licensed physician available to furnish medical care in case of emergency.
- It has at least one Nurse who is employed there full time.
- It has a Nurse on duty or on call at all times.
- It maintains clinical records for all patients.
- It has appropriate methods and procedures for handling and administering drugs and biologicals.

A Nursing Facility is NOT: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; a Residential Care Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

BED RESERVATION BENEFIT: We will continue to pay benefits, or give Elimination Period credit, under the Nursing Facility and the Residential Care Facility Benefits for each day you:

- are temporarily absent during a stay in a Nursing Facility or Residential Care Facility; and
- are charged to reserve your accommodations in that facility.

We will do this for a total of not more than the first 50 days (continuous or not) of such absence during a Policy Year. Benefit payments are subject to the Daily Payment Maximum; and they count against the Lifetime Payment Maximum.

SURVIVORSHIP BENEFIT *(This Benefit applies unless you have chosen the Rider Deleting Survivorship Benefit):*
When your spouse dies after this policy has been in force for at least ten years, no further premium payments will be required for this policy if:

- Both you and such spouse continuously had long term care insurance coverage in force with us, other than under a Nonforfeiture Benefit, on the date of death of the spouse and for at least the prior ten year period; and
- Such spouse's coverage included a similar Survivorship Benefit; and
- No long term care benefits were paid or payable by us for you or such spouse during the first ten years of such concurrent coverage.

OPTIONAL NONFORFEITURE BENEFIT: This is an optional Benefit for which an additional premium is charged. It provides continued coverage in the event your 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 Payment Maximum. The amount of the continued reduced coverage will be the greater of: 90 times your Daily Payment Maximum; or the total of all premiums paid for the policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

GENERAL DEFINITIONS: The following definitions apply:
The "Daily Payment Maximum" is the greatest amount we will pay for all expenses you incur on any one day that are covered by the Nursing Facility Benefit. As described in the Benefit Provisions, this maximum also applies to the Respite Care Benefit and is used to determine maximum amounts applicable to some other Benefits. Based on the Benefit Increases provision that applies, this amount will increase over time.

The "Elimination Period" is the total number of days that covered, Formal Long Term Care Services (services for which the provider is paid) must be received after you are determined to be a Chronically Ill Individual and before the benefits covered by the policy are payable. The number of days may be accumulated within any time period after you are determined to be a Chronically Ill Individual before filing a claim. Days used to satisfy the Elimination Period do not need to be consecutive. The Elimination Period need only be met once during your lifetime. Any day when covered services are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period.

Home and Community-Based Care is subject to the Elimination Period only if you have chosen the Revised Elimination Period Rider.

Respite Care, Care Coordination, Caregiver Training, and Supportive Equipment are not subject to the Elimination Period; and days for which you receive Home and Community-Based Care Benefits will count toward satisfying your Elimination Period.

The "Lifetime Payment Maximum" is the combined total amount we will pay as Benefits under the policy. This amount is determined by multiplying the Daily Payment Maximum by the applicable Benefit Multiplier. When Benefit Increases apply, this amount increases over time. The Lifetime Payment Maximum may be used interchangeably for any services covered by the policy.

"Medi-Cal Asset Protection" is the right extended to you by California law when you use the benefits of this policy. This right allows you to protect one dollar of your assets for every dollar this policy pays out in benefits, in the event you later apply for Medi-Cal benefits or other qualifying State long-term care benefits. The amount of this asset protection at any time is equal to the sum of all benefit payments made for your care by this policy. Should you later apply for Medi-Cal benefits or other qualified long term care benefits, you will not be required to expend your protected assets prior to becoming eligible for these public benefits. Your protected assets will also be exempt from any claim the State of California may have against your estate to recover the cost of State-paid long term care or medical services provided to you.

"Medi-Cal Property Exemption" is the total equity value of real and personal property not otherwise exempt under Medi-Cal regulations equal to the sum of qualifying insurance benefit payments made on your behalf.

A "Nurse" is someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN); and is operating within the scope of that license.

7. LIMITATIONS AND EXCLUSIONS

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: If an institution has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a covered facility only if it meets the criteria in the definition of such a facility; is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and is engaged principally in providing not only room and board, but also care and services which meet all of those criteria.

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: Benefits are not payable for care, stays, or other items:

- Provided by a family member;
- When no charge is normally made in the absence of insurance;
- Provided outside of the U.S.A. or its territories or possessions;
- Provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to you or your estate;
- Resulting from war or act of war;
- Resulting from an attempted suicide or an intentionally self-inflicted injury; or
- For alcoholism and drug addiction; unless it has occurred as a result of the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

Note: Mental illness and Alzheimer's disease are covered, subject to the same exclusions, limitations and provisions applicable to other conditions.

Non-Duplication: Benefits will be paid only for expenses incurred for Qualified Long Term Care Services covered by this policy that are in excess of the amount paid or payable under any Other Plan. The term "Other Plan" means:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- any other national, state or other governmental health care plan or law (except Medicaid/Medi-Cal); and
- any insurance policy (including other long term care insurance policies or certificates), subscriber contract, group coverage through HMOs and other prepayment, group practice or individual practice plans.

If you have any Other Plan under which you are entitled to benefits for expenses for covered confinement or services, benefits will be paid under this policy:

- only after benefits for like expenses are paid under those Other Plans (including amounts that would be reimbursable under Medicare but for the application of a deductible or coinsurance amount); and
- only to the extent that the Benefits under this policy, together with the amount of benefits paid under those Other Plans (including amounts that would be reimbursable under Medicare but for the application of a deductible or coinsurance amount), do not exceed the actual expenses incurred for the confinement or services received.

We will count, for the purposes of satisfying the Elimination Period, days on which you incur expenses that would otherwise qualify for payment under the Nursing Facility Benefit or the Residential Care Facility Benefit but are excluded from coverage solely because benefits are paid or payable under Medicare or any other national, state or other governmental health care plans or law.

Actions in the Event of a Public Funded National or State Plan: If a non-Medicaid/Medi-Cal national or state long term care program created through public funding substantially duplicates benefits provided by this policy, we will implement one of the following actions based on mutual agreement between us and the California Department of Insurance.

- We will reduce your future premium payments; or
- We will increase future benefits.

The amount of premium reductions and future benefit increases to be made by us will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and our claims experience. Our premium reduction and benefit increase plans will first be filed with and approved by the California Department of Insurance.
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. 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. The California Partnership for Long Term Care requires your policy to include 5% Compound Increases unless you are at least 70 years of age and apply for 5% Equal Increases. Equal Increases means the daily, monthly and lifetime limits will increase by 5% of their original amounts; and Compound Increases means the daily, monthly and lifetime limits will increase by 5% of the most recent amounts.

Increases will occur on each anniversary of the policy's effective date. Increased amounts will apply to each day benefits are payable on or after the date of the increase. Your premiums will not increase due to a change in age or the automatic benefit increases. On the following page is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

9. 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 as long as you pay your premiums on time. 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.

The policy includes a Waiver of Premium for premiums that become due: while continuing benefits are payable under the Residential Care Facility, Nursing Facility or Bed Reservation Benefits; and when continued Home and Community-Based Care Benefits are payable.

When the waiver stops, we will give credit for any premium paid for periods during which the waiver applied against future premiums then due. You will then be required to pay the pro rata premium needed to return the policy to its previous premium payment mode. Premiums can be changed, but only if they are changed for all California Partnership policies.

10. ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES

Once insurance goes into force, coverage is provided if you are clinically diagnosed as having Alzheimer's disease, organic disorders, or related degenerative and dementing illnesses and meet the Benefit Eligibility requirements.

11. PREMIUM

The table below shows the annual premium for the policy and any options you have chosen. It also shows your premium payment mode and the corresponding modal premium. An additional premium credit applies when this policy replaces a prior policy that has been in force with us for at least 1 year.

Eligible for Preferred Discount ☐Yes ☐No **Eligible for Spousal Discount** ☐Yes ☐No	Basic Policy (including Reduced Premium Riders): $
	Nonforfeiture Benefit: $
Premium Payment Mode (Adjustment Factor) ☐ **Annual** (1.0) ☐ **Semi-Annual** (.51) ☐ **Quarterly** (.26) ☐ **Monthly** (.09) - requires Electronic Funds Transfer	High Limit Residential Care: $ Total of Above: $ Total Discount: $ **Total Annual Premium:** $ **Modal Premium:** $ (Annual x mode factor)

12. ADDITIONAL FEATURES

Applications are subject to medical underwriting; and are approved only if you provide evidence of your insurability which is satisfactory and acceptable to the company. Insurance is not available if you are 85 years of age or older when you apply.

Continuation for Lapse Due to Alzheimer's Disease, Organic Disorders 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 meet the Benefit Eligibility requirements for any other reason. 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.

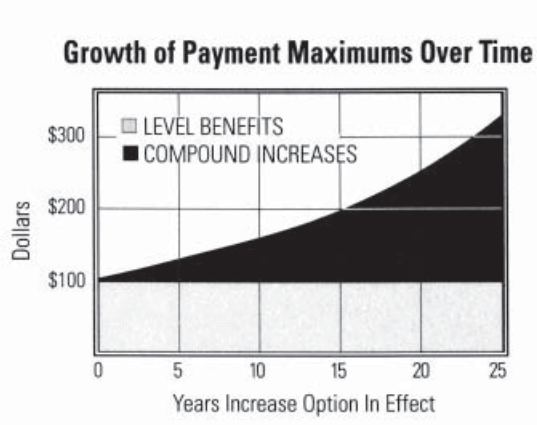
13. INFORMATION AND COUNSELING

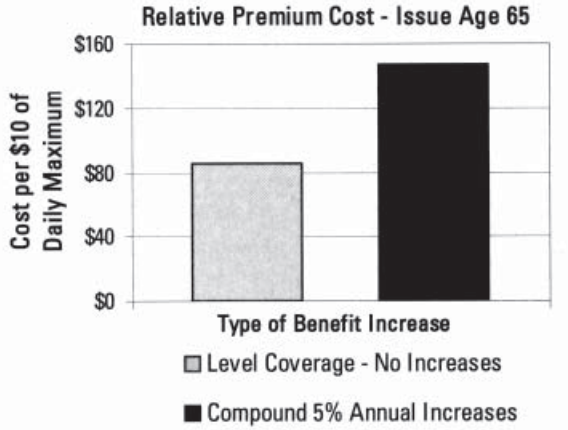
The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.

Local HICAP Office:_____
Agency Name

_____
Agency Address

_____
Agency Phone Number





Genworth Life Insurance Company
Home Office: Richmond, Virginia
Administrative Office Address: 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948
Phone: 1 800 456.7766

Complete and retain for your records.

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE ADDENDUM

Policy form series 7037C Rev 2009

The following optional Riders are available to modify coverage and reduce Policy premiums.

I RIDER DELETING THE SURVIVORSHIP BENEFIT

This Rider deletes the Survivorship Benefit from the Policy.

When this Rider applies, premiums are reduced by $ _____.

II REVISED ELIMINATION PERIOD RIDER

This Rider adds the Home and Community-Based Care Benefit to the Benefits to which the Elimination Period applies. It makes the following changes to the coverage described in the Outline:

1. The Elimination Period definition is changed to read:

   The "Elimination Period" is the total number of days that covered, Formal Long Term Care Services must be received after you are determined to be a Chronically Ill Individual and before the benefits covered by the Policy are payable. The number of days may be accumulated within any time period after you are determined to be a Chronically Ill Individual before filing a claim. Days used to satisfy the Elimination Period do not need to be consecutive. The Elimination Period need only be met once during your lifetime. Any day when covered services are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period.

   Respite Care, Care Coordination, Caregiver Training, and Supportive Equipment are not subject to the Elimination Period.

2. The Home and Community-Based Care Benefit is changed by substituting the following for the provision entitled "No Elimination Period/Credit Toward Your Elimination Period".

   Elimination Period Applicable to this Home and Community-Based Care Benefit: No payment will be made under this Benefit for expenses incurred prior to the date the Elimination Period has been satisfied.

   When this Rider applies, premiums are reduced by $ _____.

When selecting the Revised Elimination Period Rider, I considered the financial implications of having to pay added out-of-pocket expenses for home and community-based care during the Elimination Period.

Applicant Name _____

Selected Rider(s)

- ◯ Rider Deleting the Survivorship Benefit
- ◯ Revised Elimination Period Rider
- ◯ Neither Riders selected

Including any credit for the Riders chosen, Your Total Annual Premium will be: $_____

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

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