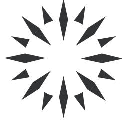

Genworth[SM]
Financial

# LONG TERM CARE INSURANCE FORMS BOOK

**California** Underwritten by Genworth Life Insurance Company

**List of Contents:**

- HIPAA Form
- Acknowledgement of Release
- Suitability Form
- Rate Disclosure
- Electronic Fund Transfer Form
- Special (Couples) Benefits Form
- Replacement Notice
- Kaiser Authorization

38778CA 06/01/10

Genworth Life Insurance Company
Long Term Care Insurance Division
Administrative Office:
3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

**This is a HIPAA Compliant Authorization**

# HEALTH INFORMATION AUTHORIZATION

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

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

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

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

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

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

| Signature of Applicant A | Date Signed |
|---|---|
| Printed Name of Applicant A | |
| Address of Applicant A | |
| Signature of Applicant B | Date Signed |
| Printed Name of Applicant B | |
| Address of Applicant B | |

**COMPANY COPY** (Return signed copy with the application.)

62397 03/21/07

## Other Important Information

**Producer Compensation:** When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Genworth Life Insurance Company
Long Term Care Insurance Division
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3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

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

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

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

| Signature of Applicant A | Date Signed |
|---|---|
| Printed Name of Applicant A | |
| Address of Applicant A | |
| Signature of Applicant B | Date Signed |
| Printed Name of Applicant B | |
| Address of Applicant B | |

**APPLICANT COPY**

62397 03/21/07

## Other Important Information

**Producer Compensation:** When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

# ACKNOWLEDGMENT OF RELEASE OF CERTAIN HEALTH RELATED INFORMATION

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

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

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

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

| Representative Name | Phone Number |
|---|---|
| Address of Representative | |

In addition, I understand that:

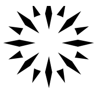
- At any time prior to the disclosure of my health or medical records to my Representative, I may send a written notice to the Company, at the address shown below, requesting that the Company not disclose my health or medical records to my Representative.

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

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

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

[1]Products underwritten by Genworth Life Insurance Company



Genworth® Financial

Genworth Life Insurance Company
Long Term Care Insurance Division

**Applicant Copy**

# SUITABILITY STATEMENT

## THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG TERM CARE INSURANCE

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

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

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

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

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

Many people become eligible for Medi-Cal after they have used up their own financial resources by paying for long term care services.

When Medi-Cal pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

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

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

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

## ADDITIONAL INFORMATION TO HELP YOU WITH THE LONG TERM CARE INSURANCE PERSONAL WORKSHEET

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

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

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

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

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

Long Term Care Insurance is underwritten by Genworth Life Insurance Company.

# LONG TERM CARE INSURANCE PERSONAL WORKSHEET

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

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

## SECTION A

**Premium Information**

**Policy Form #:** ○ **7035AX Rev 2009** ○ **7037C Rev 2009**

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

$ annually $ semi-annually $ quarterly $ monthly

**Type of Policy** Guaranteed renewable.

**The Company's Right to Increase Premiums** The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

**Rate Increase History** The company has sold long-term care insurance since 1974 and has sold this policy since 2009. The company has not raised its rates on this policy form in this or any other state, but in the past 10 years it has raised or requested to raise its rates on similar policy forms that are no longer available for sale. *Following is a summary of the rate increases:*

| Policy Form Series | States | Years Available For sale | Year of Increase/ Percentage of Increase |
|---|---|---|---|
| 50023 | CA, ID, ME, MI, OR, RI, VT& WI | 1991-1998 | 2007-2008: 9% |
| 50024D-7030AP | IN | 1998-2001 | 11% |
| 7000 | All states except, MA & MN | 1994-1998 | 2007-2009: 10%-12%* |
| 7020 | All states except, CA, GA & MA | 1996-1999 | 2007-2009: 10%-12%* |
| 7021 | All states except, AK, CA, KS, MA, ME, MN & RI | 1996-1998 | 2007-2009: 9%-11%* |
| 7030 | All states | 1997-2003 | 2007-2009: 10%-11%* |
| 7031 | All states except, AK, CT, GA, MA, MD, MN & PA | 1998-2003 | 2007-2009: 10%-11%* |
| 7032 | All states except, AK, GA, KS, MA, MI, OR, RI & VT | 1997-2003 | 2007-2009: 10%-11%* |
| 7033 | CT | 1998-2002 | 2008: 11% |
| 7034 &7034A | CA | 1998-2001 | 2008: 11% |

* Percentage may vary by state

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

**Questions Related to Your Income**

**How will you pay each year's premium?** ○ From my Income ○ From my Savings/Investments ○ My Family will Pay ○ Other (friends, entities, etc.)

**Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?**
○ Yes ○ No — *If you have not considered this possibility, please do not proceed with the application until doing so.*

## SECTION B

**What is your annual income?** (check one)

○ Under $10,000 ○ $10,000-$20,000 ○ $20,000-$50,000 ○ Over $50,000

**How do you expect your income to change in the next 10 years?** (check one) ○ No change ○ Increase ○ Decrease

*If you will be paying with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

**Will you buy inflation protection?** (check one) ○ Yes ○ No

**If not, how will you pay for the difference between future costs and your daily benefit amount?**

○ From my Income ○ From my Savings/Investments ○ My Family will Pay ○ Other (friends, entities, etc.)

*The national average annual cost of care in 2008 was $76,460 ($209 per day), but this figure varies across the country. In ten years the national average annual cost would be about $124,545, if costs increase 5% annually.*

**What Elimination Period are you considering?** *Number of days*

**Approximate cost for that period of care:** $ *$209 (national average) X Elimination Period*

**How are you planning to pay for your care during the Elimination Period?** (check one)

○ From my Income ○ From my Savings/Investments ○ My Family will Pay ○ Other (friends, entities, etc.)

**Questions Related to Your Savings and Investments**

**Not counting your home, about how much are all of your assets (your savings and investments) worth?** (check one)

○ Under $20,000 ○ $20,000-$30,000 ○ $30,000-$50,000 ○ Over $50,000

**How do you expect your assets to change over the next ten years?** (check one)

○ Stay about the same ○ Increase ○ Decrease

*If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.*

# LONG TERM CARE INSURANCE PERSONAL WORKSHEET *continued*

## DISCLOSURE STATEMENT

**Check one:**
- ○ The answers to the preceding questions accurately describe my financial situation.
- ○ I choose not to complete this information (in section B on the prior page), and I have signed the Verification of Financial Non-Disclosure below.

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

**Check the box to acknowledge you have read the following statement and sign below.**

○ (this box must be checked) I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures.
**I understand that the rates for this policy may increase in the future.**

| Applicant A Signature<br>X | Printed Name | Date *mm/dd/yyyy* |
|---|---|---|
| Applicant B Signature<br>X | Printed Name | Date *mm/dd/yyyy* |

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

| Agent's Signature<br>X | Agent's Printed Name | Date *mm/dd/yyyy* |
|---|---|---|

***Complete this section ONLY if your agent has advised you that this policy may not be suitable for you.***
My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

| Applicant A Signature<br>X | Date *mm/dd/yyyy* | Applicant B Signature<br>X | Date *mm/dd/yyyy* |
|---|---|---|---|

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



## VERIFICATION OF FINANCIAL NON-DISCLOSURE

Please check below and return this form with your signed Personal Worksheet.
- ○ Yes, I wish to purchase this coverage. I still choose not to complete the financial information required in the **Long Term Care Insurance Personal Worksheet**. Please resume your review of my application.
- ○ No, I have decided not to buy a policy at this time.

| Applicant A Signature<br>X | Printed Name | Date *mm/dd/yyyy* |
|---|---|---|
| Applicant B Signature<br>X | Printed Name | Date *mm/dd/yyyy* |

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

**Complete and submit this form with the application to:**
**Genworth Life Insurance Company**
**Long Term Care Insurance Division**
**3100 Albert Lankford Drive**
**Lynchburg, Virginia 24501-4948**

# LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

1. The **annual premium rate** that is applicable to you and that will be in effect until a request is made and approved for an increase is $ ______________.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective on the next policy anniversary date.

4. **Potential Rate Revisions:** *This policy is Guaranteed Renewable.* This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   *If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:*
   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

**I have read the above information concerning "Potential Rate Increases."**

| Applicant A's Signature | Date |
|---|---|
| Applicant B's Signature | Date |

*** CONTINGENT NONFORFEITURE**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:
- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose the Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

**Example:**
- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

*(over)*

**Retain a copy for your records and return a signed copy with your application.**

## CONTINGENT NONFORFEITURE

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture

*(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)*

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

# LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

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   *If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:*
   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

**I have read the above information concerning "Potential Rate Increases."**

| Applicant A's Signature | Date |
|---|---|
| Applicant B's Signature | Date |

*** CONTINGENT NONFORFEITURE**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:
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- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

*(over)*

**Retain a copy for your records and return a signed copy with your application.**

## CONTINGENT NONFORFEITURE

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture

*(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)*

| Issue Age | Percent Increase Over Initial Premium |
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| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

Genworth Life Insurance Company
Long Term Care Insurance Division
3100 Albert Lankford Drive, Lynchburg, VA 24501-4948
800 456.7766

**Please print using black ink.**

# ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

**Use this form to authorize use of electronic fund transfers (EFT) for either:**
**1. All Initial Premium modes as long as this form is submitted with the application.**
**2. Monthly renewal premium payments.**

**Instructions:**
- **Monthly Payment Mode:** Initial & Renewal – Complete section A, B & C. For Renewal Only – complete sections A & C.
- **All other Payment Modes for initial only:** Complete sections A, B & C. Future premiums will be billed directly.
- Attach a copy of a Voided Check from your checking account.
- For Shared and Two Individual Policies, please provide signatures for both applicants.
- Complete and sign page 2 and provide to customer.

**SECTION A**

**Print Name of Proposed Insured(s) below**

| Applicant A | Applicant B |
|---|---|
| | |

**SECTION B (Initial Premium Only)**

**Initial Premium Amount (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required. Only one month is allowed in California and for New Hampshire applicants over 65.)**

Applicant A
$

Applicant B (to be used for 2 Individual policies only; do not enter an amount for Shared Plans.)
$

**TOTAL (The Total amount below is the amount we will deduct for the initial premium)**
$

**SECTION C (Please complete the below required fields)**

| Account Holder's Name | Street Address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

Name of Financial Institution

| ABA/Routing/Transit Number *9 digits* | Bank Account Number *12 digits* |
|---|---|
| *Bank Account Holder(s) Signature *(If other than Applicant.)* | Date *mm/dd/yyyy* |
| *Applicant A Signature | Date *mm/dd/yyyy* |
| *Applicant B Signature | Date *mm/dd/yyyy* |

***By signing above, I am agreeing to the terms and conditions listed on page two (2) of this form**

| Print Name of Agent | Agent Signature |
|---|---|
| | |

Office Use Only
A R

# ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

## CUSTOMER COPY

### TERMS & CONDITIONS

I authorize Genworth Life Insurance Company (Company) to collect the Initial Premium and renewal for monthly mode, stated in this form from the Bank Account described in this form. I understand and agree that this Authorization is subject to the following conditions:

- This Authorization form must be completed in its entirety in order to be valid.
- Signing this Authorization does not mean that coverage is effective; coverage is effective only as stated in the application.
- Payment by EFT does not alter any contract issued by the Company.
- Any refund for coverage not taken or declinations will be made directly via check, not as a credit to the Bank Account. Otherwise, refunds will be applied in accordance with applicable laws.
- If the EFT charge request is not honored, no further attempt to use the EFT to collect premium will be made and Conditional Insurance Agreement (CIA) will not apply. A bill will be issued for the required premium. See CIA box of this form for additional information regarding CIA.
- Your Bank Account will be charged for the Initial Premium promptly after receiving authorization.
- Any refund of the premium will NOT include reimbursements for interest, fees or other obligations that the Financial Institution company may impose.
- If the appropriate premium split between applicants is not indicated, the Company will determine the split in the manner most appropriate. Please note that it may affect conditional insurance coverage.
- For questions regarding your EFT payment, please contact us at 800 309.0047.

### CONDITIONAL INSURANCE AGREEMENT

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

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

1. The EFT authorization is approved for at least the full three (3) months of premium (one month in CA and for NH applicants over 65) set forth in the application for insurance; and
2. Applicant(s) did not request in writing, an Effective Date that is later than the Application Date; and
3. Applicant(s) accurately answered NO to all parts of the Insurability Profile in the application; and
4. The answers in the application accurately indicate that:
   A. Within the past 5 years applicant(s) HAVE NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Epilepsy, Convulsions, Seizures, Fainting Spells, Blackouts, Mental Illness, or Paralysis; or been medically advised to have surgery that has not been performed; or received home health care; used an adult day care facility; been confined to a nursing home, assisted care facility, or other long term care facility.
   B. For CA residents ONLY. The answers in the application accurately indicate that:
      - Within the past 5 years applicant(s) 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, Blackouts, Mental Illness, or Paralysis.
      - Within the past 3 years applicant(s) 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 be confined to a nursing home, assisted care facility, or other long term care facility.
5. NO material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, the applicant(s) and the Company agree that:

1. In underwriting the application Company may conduct a telephone or personal interview to determine your health status as of the Application Date. The Company will not disapprove your application based on any change in the applicant(s) health status that occurs after the Application Date.
2. If Company approves the application, Company will provide insurance under the policy for which application was made, and the Policy will be Effective as of the Application Date.

**Paragraph three (3) of the following Agreement does not apply in the following states: CT, MD and TX.**

3. If Company disapproves the application, Company will provide temporary insurance for loss which begins between the Application Date and the date the application was disapproved. The application shall be deemed disapproved if Company does not approve the application within 120 days of the Application Date. The temporary insurance will provide the same benefits and be subject to the same provision, 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 Company under the temporary insurance exceed the lesser of: (a) $10,000; and (b) the actual expenses incurred.

**Initial Premium Amount (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required. Only one month is allowed in California and for New Hampshire applicants over 65.)**

Applicant A

$

Applicant B (to be used for 2 Individual policies only; do not enter an amount for Shared Plans.)

$

| Signature of Agent | Date Signed *mm/dd/yyyy* |
|---|---|

Print Agent's Business Address

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

**Complete and submit this form with the application to:**
**Genworth Life Insurance Company Long Term Care Insurance Division, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948**

# REQUIREMENTS TO ACCESS COUPLES BENEFITS

California

**Married couples are eligible to receive a couples discount on our Individual plans. If you are not married but meet the criteria below, you may be eligible to receive a couples discount on an Individual plan.**

**Criteria to Access Couples Benefits: Two people who**

- are registered by the Secretary of State as Domestic Partners in California, **or**
- are named in a legal union other than marriage validly formed in another jurisdiction, that is substantially equivalent to a domestic partnership in California regardless of whether it bears the name domestic partnership

**or, all of the following:**

- are and have been living together for the past three consecutive years in a committed relationship as partners or family members, sharing basic living expenses, and
- are not married to each other, or to anyone else; and
- if related, must belong to the same generation of the same family, (e.g., brothers, sisters, cousins)

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

| Applicant's Signature | Printed Name of Applicant | Date *mm/dd/yyyy* |
|---|---|---|
| X | | |
| Applicant's Signature | Printed Name of Applicant | Date *mm/dd/yyyy* |
| X | | |
| Agent's Signature | Printed Name of Agent | Date *mm/dd/yyyy* |
| X | | |

**This form MUST be submitted with the application(s) for couples discount eligibility consideration.**

**– APPLICANT COPY –**
*Keep this copy for your records.*

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

# NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with long term care insurance coverage issued by Genworth Life Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.

(1) Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas similar claims might have been payable under your present coverage.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Applicant **A**
X ____________________
The above "Notice to Applicant" was delivered to me on: Date / /

Signature of Applicant **B**
X ____________________
The above "Notice to Applicant" was delivered to me on: Date / /

**COMPARISON TO YOUR PRESENT COVERAGE**: I have reviewed your current long term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

____ Additional or different benefits (please specify) ____________________

____ No change in benefits, but lower premium.

____ Fewer benefits and lower premium.

____ Other (please specify) ____________________

Signature of Applicant **A**
X ____________________
Date / /

Signature of Applicant **B**
X ____________________
Date / /

Signature of Insurance Producer, Agent, Broker, or other Representative Agent
X ____________________

Type Name and Address of Insurance Producer, or other Representative of Agent or Broker.

**– APPLICANT COPY –**
*Keep this copy for your records.*

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

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

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Signature of Applicant **A**
X ______________________
The above "Notice to Applicant" was delivered to me on: Date / /

Signature of Applicant **B**
X ______________________
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____ Additional or different benefits (please specify) ______________________
____ No change in benefits, but lower premium.
____ Fewer benefits and lower premium.
____ Other (please specify) ______________________

Signature of Applicant **A**
X ______________________
Date / /

Signature of Applicant **B**
X ______________________
Date / /

Signature of Insurance Producer, Agent, Broker, or other Representative Agent
X ______________________

Type Name and Address of Insurance Producer, or other Representative of Agent or Broker.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

# AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

**I hereby authorize:**

Name of Disclosing Party

Address

City State ZIP

**to disclose to:**

Name of Recipient

Address

City State ZIP

**records and information pertaining to:**

Name of Member/Patient (List Other Names Used)

Medical Record Number

Date of Birth

Address

Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here ______________ (Date).

**REVOCATION:** This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

**REDISCLOSURE:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**SPECIFY RECORDS:** Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL INFORMATION** __________ (Initial)
- ☐ **PSYCHIATRIC INFORMATION** Signature ______ Date ______
- ☐ **DRUG/ALCOHOL INFORMATION** Signature ______ Date ______
- ☐ **RESULTS OF AN HIV TEST** Signature ______ Date ______
- ☐ **GENETIC RECORDS** Signature ______ Date ______
- ☐ **OTHER HEALTH INFORMATION** __________ (Initial) (specify below)

Specify the records to be disclosed: ______________________________

The recipient may use the health information authorized on this form for the following purposes:

______________________________

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date ______ Signature ______ If Signed by Other than Member/Patient, Indicate Relationship ______

KAISER PERMANENTE®

Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

# AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

**I hereby authorize:**

Name of Disclosing Party ______

Address ______

City ______ State ______ ZIP ______

**to disclose to:**

Name of Recipient ______

Address ______

City ______ State ______ ZIP ______

**records and information pertaining to:**

Name of Member/Patient (List Other Names Used) ______ Medical Record Number ______ Date of Birth ______

Address ______ Telephone Number ______

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______

A copy of this authorization is as valid as the original.
Member/Patient has a right to a copy of this authorization.

Date ______ Signature ______ If Signed by Other than Member/Patient, Indicate Relationship ______

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

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