Genworth Financial

Genworth Life
Genworth Life of New York
Administrative Office
3100 Albert Lankford Drive
Lynchburg, VA 24501-4948

Long Term Care Insurance Requirements and Underwriting Guidelines–Application Instructions Addendum

from Genworth Life Insurance Company
and in New York Genworth Life Insurance Company of New York†

Effective 08/15/2011

This information updates the Underwriting Requirements if listed on the Application Instructions page.

†Only Genworth Life Insurance Company of New York is admitted in and conducts business in New York.

Ensure basic underwriting eligibility

Check the applicant's height and weight to see if they meet the basic eligibility requirements in the tables provided here. If the applicant falls over or under the limits, do not submit the request for long term care insurance coverage to Genworth.

GENERAL BUILD TABLE (NON DIABETIC)*

HEIGHT	MAXIMUM WEIGHT		MINIMUM WEIGHT (ALL)
	Female	Male	
4'6"	149	157	71
4'7"	155	163	73
4'8"	160	169	76
4'9"	166	175	79
4'10"	172	182	82
4'11"	178	188	84
5'0"	184	194	87
5'1"	190	201	90
5'2"	197	208	93
5'3"	203	214	96
5'4"	210	221	99
5'5"	216	228	102
5'6"	223	235	106
5'7"	230	243	109
5'8"	237	250	112
5'9"	244	257	115
5'10"	251	265	119
5'11"	258	272	122
6'0"	265	280	126
6'1"	273	288	129
6'2"	280	296	133
6'3"	288	304	136
6'4"	296	312	140
6'5"	304	321	144
6'6"	312	329	147

GENERAL BUILD TABLE (DIABETIC)**

HEIGHT	MAXIMUM WEIGHT (ALL)	MINIMUM WEIGHT (ALL)
4'6"	141	71
4'7"	146	73
4'8"	151	76
4'9"	157	79
4'10"	162	82
4'11"	168	84
5'0"	174	87
5'1"	180	90
5'2"	186	93
5'3"	192	96
5'4"	198	99
5'5"	204	102
5'6"	210	106
5'7"	217	109
5'8"	223	112
5'9"	230	115
5'10"	237	119
5'11"	244	122
6'0"	251	126
6'1"	258	129
6'2"	265	133
6'3"	272	136
6'4"	279	140
6'5"	287	144
6'6"	294	147

BUILD TABLE (OSTEOPOROSIS)**

HEIGHT	MINIMUM WEIGHT (ALL)
4'6"	77
4'7"	80
4'8"	82
4'9"	85
4'10"	88
4'11"	92
5'0"	95
5'1"	98
5'2"	101
5'3"	105
5'4"	108
5'5"	111
5'6"	115
5'7"	118
5'8"	122
5'9"	126
5'10"	129
5'11"	133
6'0"	137
6'1"	140
6'2"	144
6'3"	148
6'4"	152
6'5"	156
6'6"	160

* If the applicant is under the minimum weight or over the maximum weight, please do not submit a request.
** Use the diabetic or osteoporosis table if the applicant has been diagnosed with either condition.

Minimum underwriting requirements

Pre-qualification 800 354-6892

		Doctor Visit in Last 2 Years				No Doctor Visit in 2 Years			
	Age	18-59	60-64	65-71	72-79	18-59	60-64	65-71	72-79
Preferred Health	Phone Cognitive Interview			x					
	Medical Records Request	x*	x	x	x				
	In Person Health Interview				x	x	x	x	x
	Prescription Drug Report	x	x				x	x	x
Standard Health	Phone Cognitive Interview			x					
	Medical Records Request	x	x	x	x				
	In Person Health Interview				x	x	x	x	x
	Prescription Drug Report	x	x				x	x	x

x - Indicates required interview/request *Only If Unlimited Benefit Multiplier Requested

Note: Please keep in mind that our underwriters may request additional requirements if they deem necessary.

Prescription drug report

The prescription drug report is used to determine if medical records or interviews are needed to process the application. The report provides information relating to the applicant's prescription drug history.

Phone cognitive and in-person health interview requests

When needed, phone cognitive 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 or #81707NY for NY residents), which explains both interviews. Let applicants know all costs associated with the interviews are paid for by us.

The Phone Cognitive Interview is a cognitive screen given over the phone which takes 15 to 20 minutes. The in-person health interview takes approximately 1 hour.

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 12/31/10

California Partnership

CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

What Happens When Long-Term Care Costs Rise?

A Comparison of Costs and Benefit Amounts

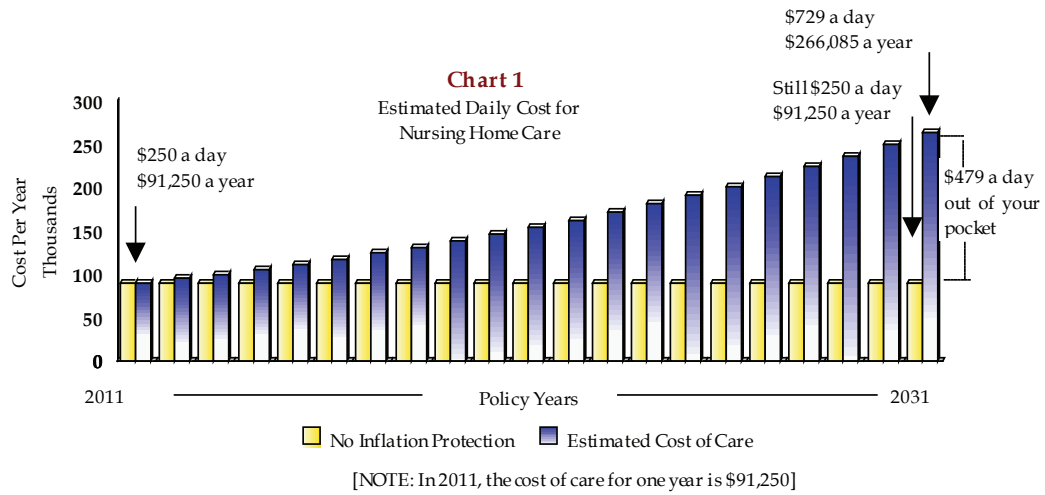
Protecting your benefits against inflation is one of the most important features you can have in a long-term care policy. You may hesitate to purchase inflation protection since it adds significantly to a policy's cost. Yet without it, years from now you may find yourself needing long-term care, and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

2011

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

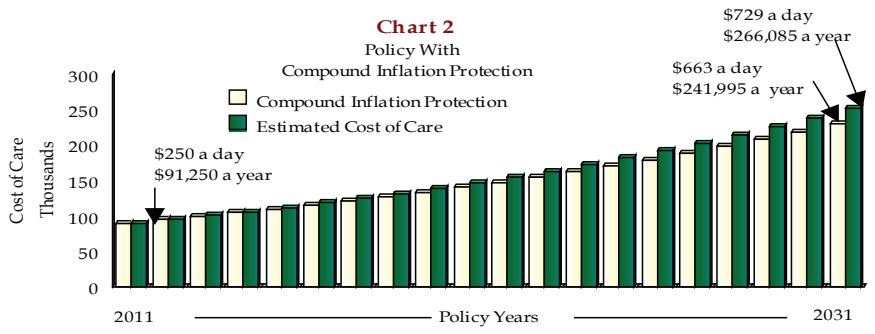
Experts estimate the cost of long-term care will continue to increase by at least 5% annually. **Chart 1** below compares the anticipated cost for nursing home care over the next twenty years against a long-term care policy that does not include an inflation protection feature which increases the value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

If a 55 year old purchases a policy in the year 2011 that provides $250 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 $250 per day in the year 2011 is likely to cost $729 per day in twenty years. Without inflation protection, the $250 per day policy purchased today will still only pay $250 when the policyholder reaches age 75. That benefit amount will cover just over a third of the projected cost of care. The $479 difference between the value of the policy and the projected cost of care would have to be paid by the policyholder.



[NOTE: In 2011, the cost of care for one year is $91,250]

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 $250 in the year 2011 will grow by 5% each year. In twenty years, the policy will provide $663 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.

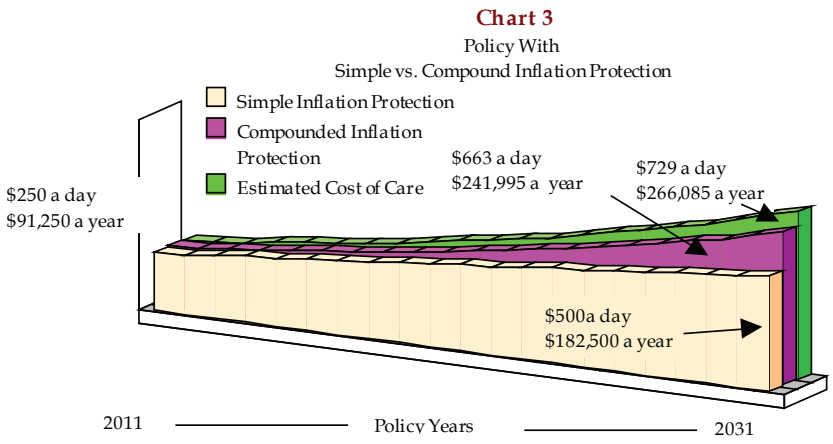


[NOTE: In 2011, the cost of care for one year is $91,250]

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 $250 will be worth $663 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 $250 per day will be worth $500 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 2011, the cost of care for one day is $250]

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-65Δ *ΔOnly available for ages 55 and younger.*	**Premium Payments** ○ Standard ○ 10-Pay ○ Pay-to-65Δ *ΔOnly 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

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

⓫ 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.

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.

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

City _____ State _____ Zip _____

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.	☐	☐
☐	☐	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?	☐	☐

Applicant A	Applicant B		Applicant A	Applicant B		Applicant A	Applicant B	
☐	☐	Acquired Immune Deficiency Syndrome (AIDS)	☐	☐	Congestive Heart Failure (CHF) combined with Tuberculosis (TB)	☐	☐	Memory Loss
☐	☐	AIDS Related Complex (ARC)	☐	☐	Cirrhosis of the Liver	☐	☐	Metastatic Cancer (spread from original site/location)
☐	☐	ALS (Lou Gehrig's Disease)	☐	☐	Dementia	☐	☐	Multiple Sclerosis (MS)
☐	☐	Alzheimer's Disease	☐	☐	Diabetes under treatment with Insulin	☐	☐	Muscular Dystrophy
☐	☐	Congestive Heart Failure (CHF) combined with Heart Attack or Angina	☐	☐	Emphysema/COPD combined with current smoking	☐	☐	Organic Brain Syndrome
☐	☐	Congestive Heart Failure (CHF) combined with Emphysema/ (COPD)	☐	☐	Emphysema/COPD combined with Congestive Heart Failure (CHF)	☐	☐	Parkinson's Disease
☐	☐	Congestive Heart Failure (CHF) combined with Angioplasty or Heart Surgery	☐	☐	Emphysema/COPD combined with Asthma	☐	☐	Senility
☐	☐	Congestive Heart Failure (CHF) combined with Asthma or Chronic Bronchitis	☐	☐	Emphysema/COPD combined with Chronic Bronchitis	☐	☐	Stroke
☐	☐	Congestive Heart Failure (CHF) combined with Diabetes	☐	☐	Frequent or persistent Forgetfulness	☐	☐	Transient Ischemic Attack (TIA) within the past 5 years
						☐	☐	TIA combined with Diabetes or Heart Surgery
						☐	☐	TIA two or more times

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	Applicant A NO		Applicant B YES	Applicant B 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**.	☐	☐
☐	☐	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?	☐	☐

Applicant A		Applicant B	
A	**B**	**A**	**B**
☐	☐ Alcoholism	☐	☐ Convulsions
☐	☐ Amputation	☐	☐ Depression
☐	☐ Angina	☐	☐ Diabetes not treated with Insulin
☐	☐ Angioplasty	☐	☐ Disabling Back Condition
☐	☐ Asthma	☐	☐ Drug Addiction
☐	☐ Atrial Fibrillation	☐	☐ Emphysema/COPD
☐	☐ Blacking Out	☐	☐ Epilepsy
☐	☐ Brain Disorder	☐	☐ Fainting Spells
☐	☐ Cancer (excluding basal cell of skin)	☐	☐ Heart Attack
☐	☐ Chronic Bronchitis	☐	☐ Heart Surgery
☐	☐ Congestive Heart Failure (CHF)	☐	☐ Hodgkin's Disease

Applicant A		Applicant B	
A	**B**	**A**	**B**
☐	☐ Injury due to Falls or Imbalance	☐	☐ Skin Ulcers
☐	☐ Joint Replacement Surgery	☐	☐ Spine Condition
☐	☐ Leukemia	☐	☐ Tremor
☐	☐ Lymphoma	☐	☐ Tuberculosis (TB)
☐	☐ Mental Illness	☐	☐ Other Conditions causing Crippling
☐	☐ Osteoporosis	☐	☐ Other Conditions causing Limited Motion
☐	☐ Paralysis	☐	☐ Other Conditions requiring Adaptive Devices
☐	☐ Rheumatoid Arthritis		
☐	☐ Seizures		
☐	☐ Shortness of Breath		

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** _____

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

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

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

X _____ _____
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 telephone 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 indicates 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:.....	☐	☐
☐	☐	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.

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

61221

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 received 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><td colspan="4">COVERAGE SELECTION</td></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: $
	High Limit Residential Care: $
Premium Payment Mode (Adjustment Factor) ☐ Annual (1.0) ☐ Semi-Annual (.51) ☐ Quarterly (.26) ☐ Monthly (.09) - requires Electronic Funds Transfer	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 80 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.

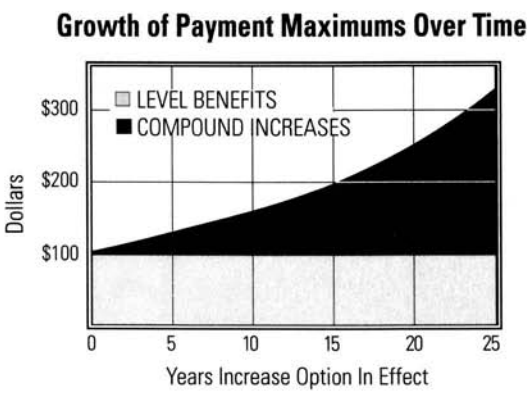
13. INFORMATION AND COUNSELING

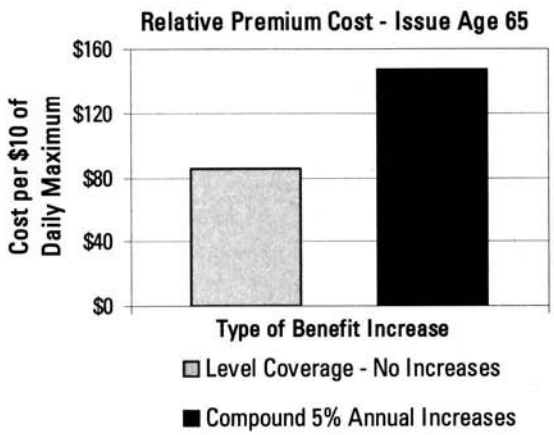
The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) 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 received 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><td colspan="4">COVERAGE SELECTION</td></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: $
	High Limit Residential Care: $
Premium Payment Mode (Adjustment Factor) ☐ Annual (1.0) ☐ Semi-Annual (.51) ☐ Quarterly (.26) ☐ Monthly (.09) - requires Electronic Funds Transfer	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 80 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.

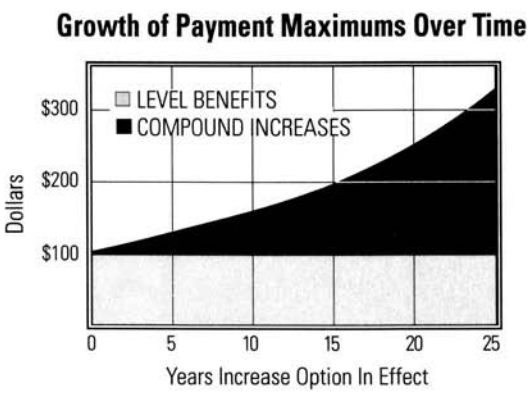
13. INFORMATION AND COUNSELING

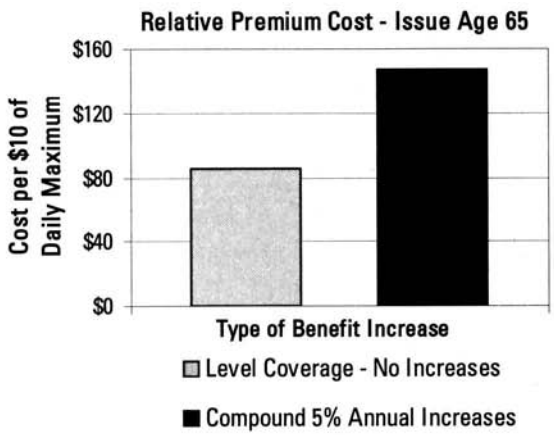
The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) 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.

Genworth®
Financial

LONG TERM CARE INSURANCE FORMS BOOK

California Underwritten by Genworth Life Insurance Company

List of Contents:

38778CA 11/01/11

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.

Purpose: My health information may be disclosed under this Authorization so that Genworth Life Insurance Company may (1) underwrite my application for coverage, make eligibility, risk rating, policy/certificate issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or provide coverage and benefits; (4) administer coverage; and (5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with Genworth Life Insurance Company.

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, Human Immunodeficiency Virus (HIV) antibodies, Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC).

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company; its vendors including but not limited to, Western Field Investigations (WFI), Examination Management Services, Incorporated (EMSI) and APS Workflow, Inc.; its insurance support organizations; its affiliates and reinsurers. A copy of my application may also be attached to any policy/certificate 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; Pharmacy Benefits Manager; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Statements of Understanding: I understand that:

- I will receive a copy of this Authorization; and that a copy of it is as valid as the original.
- 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.
- 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.
- Some health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if health information is disclosed to persons or organizations that are not subject to health information privacy laws, such persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of the information.
- This Authorization will be valid for 24 months from the date signed.

Printed Name of Applicant A	Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN
Signature of Applicant A		Date Signed
Printed Name of Applicant B	Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN
Signature of Applicant B		Date Signed

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/certificate, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy/certificate 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/certificate. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy/certificate 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 agent can sell insurance polices from other insurance carriers, those carriers may pay compensation that differs from ours.

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.

Purpose: My health information may be disclosed under this Authorization so that Genworth Life Insurance Company may (1) underwrite my application for coverage, make eligibility, risk rating, policy/certificate issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or provide coverage and benefits; (4) administer coverage; and (5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with Genworth Life Insurance Company.

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, Human Immunodeficiency Virus (HIV) antibodies, Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC).

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company; its vendors including but not limited to, Western Field Investigations (WFI), Examination Management Services, Incorporated (EMSI) and APS Workflow, Inc.; its insurance support organizations; its affiliates and reinsurers. A copy of my application may also be attached to any policy/certificate 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; Pharmacy Benefits Manager; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Statements of Understanding: I understand that:

- I will receive a copy of this Authorization; and that a copy of it is as valid as the original.
- 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.
- 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.
- Some health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if health information is disclosed to persons or organizations that are not subject to health information privacy laws, such persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of the information.
- This Authorization will be valid for 24 months from the date signed.

Printed Name of Applicant A	Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN
Signature of Applicant A		Date Signed
Printed Name of Applicant B	Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN
Signature of Applicant B		Date Signed

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/certificate, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy/certificate 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/certificate. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy/certificate 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 agent can sell insurance polices from other insurance carriers, those carriers may pay compensation that differs from ours.

Genworth Financial

Genworth Life Insurance Company

Please print using black ink.

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 2010. 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	2007-2010: 9%
50024D	IN	1993-2002	2008: 9%
7030AP	IN	1998-2001	2011-2013: 11%[2]
7000	All states except, MA, MN & NV	1994-1998	2007-2010: 10%-12%[1] 2011-2013: 18%[2]
7020	All states except, MA, MN & NV	1996-1999	2007-2010: 10%-12%[1] 2011-2013: 18%[2]
7021	All states except, MA, MN, NJ & NY	1996-1998	2007-2010: 9%-11%[1]
7030-7032	All states except, MA, MN, NV & NY	1997-2003	2007-2010: 10%-11%[1] 2011-2013: 18%[2]
7033	CT	1998-2002	2008: 11% 2011-2013: 18%[2]
7034 & 7034A	CA	1998-2001	2008-2009: 11% 2011-2013: 18%[2]

[1] Percentage may vary by state

[2] Future effective date reflects rate increases requested, but not yet implemented

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	Printed Name	Date *mm/dd/yyyy*
X		
Applicant B Signature	Printed Name	Date *mm/dd/yyyy*
X		

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

Agent's Signature	Agent's Printed Name	Date *mm/dd/yyyy*
X		

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	Date *mm/dd/yyyy*	Applicant B Signature	Date *mm/dd/yyyy*
X		**X**	

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	Printed Name	Date *mm/dd/yyyy*
X		
Applicant B Signature	Printed Name	Date *mm/dd/yyyy*
X		

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

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%

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.

H REPLACEMENT NOTICE

– 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**	The above "Notice to Applicant" was delivered to me on:	Date
X _____		/ /

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

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**	Date
X _____	/ /

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

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

– APPLICANT COPY –
Keep this copy for your records.

H REPLACEMENT NOTICE

– COMPANY COPY –

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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(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**	The above "Notice to Applicant" was delivered to me on:	Date
X _____		/ /

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

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**	Date
X _____	/ /

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

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

– COMPANY COPY –

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser # _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone Number: ( ) _____
Email: _____

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

This authorizes the following Kaiser Permanente Medical Center(s): _____

To:
- ❑ Produce a copy of medical records as specified below
- ❑ Complete form(s) (Please specify form type(s) in the PURPOSE section below)
- ❑ Allow named KP physician to view records

Kaiser Permanente may disclose this information to:

Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone number: ( ) _____
Fax number: ( ) _____
Email: _____

PURPOSE: The health information disclosed may only be used for the following purposes: _____

FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

- ❑ Medical Office Records dated from _____ to _____
- ❑ Hospital Records dated from _____ to _____

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

- ❑ Mental Health dated from _____ to _____ Signature: _____ Date: _____
- ❑ Alcohol / Drug dated from _____ to _____ Signature: _____ Date: _____
- ❑ HIV Test Results dated from _____ to _____ Signature: _____ Date: _____

- ❑ Specific Injury/Treatment: _____ Department: _____ dated from _____ to _____
- ❑ X-Ray: ❑ Images and/or Films ❑ Reports Describe: _____
- ❑ Laboratory Results dated from _____ to _____
- ❑ Other (specify): _____
- ❑ Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

Media Preference: ❑Paper ❑CD (if available electronically) **Delivery Preference:** ❑Mail ❑Pickup ❑Fax ❑Email

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____
Date Signature If not patient, print your name and relationship

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser # _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone Number: ( ) _____
Email: _____

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

This authorizes the following Kaiser Permanente Medical Center(s): _____

To:
- ❑ Produce a copy of medical records as specified below
- ❑ Complete form(s) (Please specify form type(s) in the PURPOSE section below)
- ❑ Allow named KP physician to view records

Kaiser Permanente may disclose this information to:

Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone number: ( ) _____
Fax number: ( ) _____
Email: _____

PURPOSE: The health information disclosed may only be used for the following purposes: _____

FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

- ❑ Medical Office Records dated from _____ to _____
- ❑ Hospital Records dated from _____ to _____

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

- ❑ Mental Health dated from _____ to _____ Signature: _____ Date: _____
- ❑ Alcohol / Drug dated from _____ to _____ Signature: _____ Date: _____
- ❑ HIV Test Results dated from _____ to _____ Signature: _____ Date: _____

- ❑ Specific Injury/Treatment: _____ Department: _____ dated from _____ to _____
- ❑ X-Ray: ❑ Images and/or Films ❑ Reports Describe: _____
- ❑ Laboratory Results dated from _____ to _____
- ❑ Other (specify): _____
- ❑ Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

Media Preference: ❑Paper ❑CD (if available electronically) **Delivery Preference:** ❑Mail ❑Pickup ❑Fax ❑Email

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____
Date Signature If not patient, print your name and relationship

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.

Genworth Financial

Genworth Life
Genworth Life & Annuity
Genworth Life of New York

Transfer and exchange authorization

Genworth Life Insurance Company,
Genworth Life and Annuity Insurance Company and
Genworth Life Insurance Company of New York*

*Only Genworth Life Insurance Company of New York is licensed in the state of New York

- For use with all annuity products.
- Use this form to authorize an exchange or transfer to a new or existing annuity contract.
- In this form, Genworth Life Insurance Company, Genworth Life and Annuity Insurance Company and Genworth Life Insurance Company of New York are referred to individually as the Insurer.

Existing contract or account information

Current institution information

Additional forms may be required if the transaction is a replacement or a change to an existing life insurance policy or annuity contract.

Institution name

Street address

Telephone number

City, state, zip

Plan/account type *Annuity, life account, other*

Policy/contract number

Owner information

Owner name

Social Security/Tax ID number

Joint owner name *if any*

Social Security/Tax ID number

Annuitant name

Joint annuitant name *if any*

Conservation

○ I request that no efforts be made by the current institution to keep my current contract, policy or account.

Existing policy statement

Does not apply to a mutual fund or certificate of deposit.

Select one:

○ I certify that the existing policy/contract to be exchanged/transferred has been lost or destroyed, and to the best of my knowledge and belief, is not in anyone's possession.

○ The original policy/contract is attached.

Transaction detail

Processing date for releasing institution

Any date you specify must be within 30 days of our receipt of this form.

Please process the transaction specified herein *select one*

○ Immediately

○ Before date of:

○ After date of:

Transfer to an existing contract

Confirm your existing contract allows additional purchase payments before marking "Yes."

Is the transfer or exchange to an existing annuity contract?

○ Yes

○ No

If yes, enter existing contract number:

Transfer options *Select one of the three options on the left and complete the corresponding information*

○ **Non-qualified funds, 1035 tax-free exchange**

The surrendering company must provide the cost basis in accordance with the Tax Equity and Fiscal Responsibility Act of 1982.

○ **Full transfer**

I am assigning all rights, title and interest in my contract to the Insurer to whom I have submitted an application.

I hereby assign and transfer without exception, limitation, or reservation to the Insurer, all assignable benefits, interest, property and rights in the policy/contract referenced herein. I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the assigned policy/contract.

I understand that if the Insurer approves the application, it will surrender the assigned policy/contract and request the proceeds. If and when received, the proceeds will be applied as all or part of the premium/purchase payment for the new policy or contract. I understand that the Insurer will not treat this assignment as the equivalent of a cash payment. I further understand that no part of the value of the assigned policy/contract will be treated as a premium/purchase payment until it is received by the Insurer.

With this assignment, I revoke any existing beneficiary designations under the assigned policy/contract. I designate the Insurer, its successors or assigns as beneficiary of any death benefits that may become payable under the assigned policy/contract.

○ **Partial transfer**

Liquidation amount *select one*

○ Partial transfer of $ .....

○ Maximum amount without surrender charge

I wish to execute a partial withdrawal from the policy/contract listed on page 1 of this form for the amount specified above. I understand that surrender charges may apply. I expressly represent that the sole purpose of this transaction is to effect a partial exchange of a life insurance policy or annuity contract under section 1035(a) of the Internal Revenue Code.

The Insurer has made no representation concerning the tax treatment of this transaction. I understand that the Insurer has no responsibility or liability for the validity of this transaction or for my tax treatment related to this transaction.

Other than the owner(s) mentioned herein, no person, firm or corporation, other than myself and the issuing insurer, has an interest in said policy/contract. No proceedings in insolvency or bankruptcy have been instituted by or against me.

○ **Non-qualified funds, transfer from mutual fund or certificate of deposit**

If liquidating a mutual fund, a signature guarantee is required on page 3.

Liquidation amount *select one*

○ Full liquidation ○ Partial liquidation of $ .....

○ Maximum amount without surrender charge

I authorize the liquidation specified above and the transfer of the net proceeds to the Insurer. I am aware that surrender or withdrawal penalties may apply to this liquidation, and that income tax consequences may result. I have been advised to contact my tax advisor.

○ **Qualified Funds**

Type of plan being surrendered *select one*

○ IRA ○ SEP-IRA ○ Simple IRA ○ Roth IRA ○ TSA/403(b)

○ 401(a) ○ 401(k) ○ Keogh ○ 457(b) governmental

Liquidation type *select one*

○ Direct transfer ○ Eligible rollover distribution

Liquidation amount *select one*

○ Full liquidation ○ Partial liquidation of $ .....

○ Maximum amount without surrender charge

I hereby direct you to liquidate the qualified funds I have indicated and to remit the proceeds to the Insurer. This liquidation constitutes either a direct transfer or an eligible rollover distribution as noted above. Subject to minimum premium and all other in good order requirements, the Insurer will accept the funds as premium for the qualified contract that I have applied for as referenced in the Insurer's Letter of Acceptance. I am aware that surrender or withdrawal penalties may apply to this liquidation, and that tax consequences may result. I have been advised to contact my tax advisor.

Signature

If you are a Trustee, Attorney-in-Fact, Guardian, Conservator or other Fiduciary, you must sign in your capacity (e.g. Jane Smith, Trustee) and attach relevant legal documentation.

Signature of joint owner, if any, is required.

I authorize the transaction described herein and affirm that the Insurer is participating in this transaction at my request. I confirm the elections made herein. All statements made in this form are true to the best of my knowledge and belief.

Owner signature *Sign in capacity* Date

X .

Joint owner signature *Sign in capacity* Date

X .

If liquidating a mutual fund, apply Signature Guarantee below.

Insurer representative authorized signature

The authorized signature below certifies the Insurer's acceptance of the requested funds as instructed by the owner of the contract or account referenced herein. The Insurer is a duly licensed insurance company and has received a favorable determination letter from the IRS.

Genworth Life/Genworth Life & Annuity/Genworth Life of New York signature Date

X .

Mailing instructions

Regular First Class Mail:
P.O. Box 40011
Lynchburg, VA 24506

Overnight delivery:
3100 Albert Lankford Dr.
Lynchburg, VA 24501-4996

For questions call:
Variable Annuities: 800 352.9910
Fixed Annuities: 800 221.9501
Single Premium Immediate Annuities: 888 325.5433