

APPLICATION For Insurance

Genworth Life Insurance Company

Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501

THE GROUP POLICY/CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THE GROUP POLICY/CERTIFICATE IS AN APPROVED LONG TERM CARE INSURANCE POLICY/CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705.

A. INSURABILITY PROFILE

Applicant A			Applicant B	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	1. Are you covered by Medicaid (<u>not</u> the same as Medicare)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2A. Do you use a Walker, Wheelchair or Quad Cane; Hospital Bed; Oxygen, Respirator or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair, Bathing, Dressing, Eating, Toileting, Bowel/Bladder control, or Walking?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	B. Have you been advised to: receive home care, use an adult day care facility, enter a nursing home, enter an assisted care facility, or enter any other long term care facility?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following: <ul style="list-style-type: none"> •ALS (Lou Gehrig's disease) •Alzheimer's Disease •Congestive Heart Failure (CHF) <i>in combination</i> with any of the following: Heart Attack or Angina; Emphysema/Chronic Obstructive Pulmonary Disease (COPD); Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis •Cirrhosis of the Liver •Cystic Fibrosis •Dementia •Diabetes under treatment with Insulin or with a history of TIA, Heart Disease, or Circulatory/Vascular Disease •Frequent or persistent forgetfulness or memory loss •Huntington's Chorea •Metastatic Cancer (spread from original site/location) •Multiple Sclerosis (MS) •Muscular Dystrophy •Organic Brain Syndrome •Parkinson's Disease •Senility •Stroke •Transient Ischemic Attack (TIA) within the past 5 years •TIA <i>in combination</i> with Diabetes or Heart Surgery •TIA two or more times 	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, or Stomach?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection, or other sickness or condition derived from such infection, or tested positive for HIV or exposure to the HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>

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

B. PERSONAL PROFILE

Print clearly - Use black ink

APPLICANT A

Mr. Mrs. Miss Ms. Other Title:

Name _____
(As it should appear on your Coverage documents)

Married/Legal Couple Single Widowed

Social Security Number _____

Employee Number _____

Employer/Group Name _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ a.m. p.m.

E-mail address _____

I am eligible as: Actively at work Employee Spouse/Partner
 Other _____

APPLICANT B

Mr. Mrs. Miss Ms. Other Title:

Name _____
(As it should appear on your Coverage documents)

Married/Legal Couple Single Widowed

Social Security Number _____

Employee Number _____

Employer/Group Name _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ a.m. p.m.

E-mail address _____

I am eligible as: Actively at work Employee Spouse/Partner
 Other _____

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

City _____ State _____ Zip _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

LONG TERM CARE INSURANCE APPLICATION INSTRUCTIONS

The information included below is intended to assist you in completing the application and other documents required to apply for LTCI coverage with Genworth Life Insurance Company. If an agent is not involved in the preparation of this application and other forms please disregard any reference to agent sections or agent signatures. Employee Advantage and their spouses are direct bill unless otherwise noted.

Step 1 – Ensure basic underwriting eligibility.

- Check height and weight to see if you meet the Basic Eligibility Requirements in the table below.
- Complete the Insurability Profile section on page A-1.

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

BASIC ELIGIBILITY REQUIREMENTS

If over or under limits below, we recommend that you do not submit an application. If the applicant has diabetes or osteoporosis, please see the underwriting guide.

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

DISCOUNTS

With Long Term Care Business Solutions, a Couples Discount is available in one of two situations if the applicant meets the Insurability Profile criteria in his or her application:

- Both persons submit valid applications at the same time; or
- One person submits a valid application within 12 months of the effective date of his or her partner's insurance.

If coverage for one applicant is under a different group policy, a Couples Discount is available only when similar underwriting criteria apply. If coverage is issued to both applicants, a 40% discount will apply. If coverage is issued to one applicant, a 25% will apply.

	COUPLES DISCOUNT	PREFERRED HEALTH DISCOUNT (if available)		TOTAL DISCOUNT APPLICANT	
		1	2	1	2
1 Applicant with Preferred Health	n/a	20%	–	20%	–
2 Applicants/ 1 Issued with Preferred	25%	10%	–	35%	–
2 Applicants/ Both Issued / Both Preferred	40%	10%	10%	50%	50%

COUPLES

In addition to married couples, applicants who are not married but meet certain criteria may be eligible to receive a Couples Discount. Please refer to the "Requirements to Access Couples Discount" form for an explanation of the criteria and instructions on how to access the discount.

AGENT'S REPORT

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

FAMILY HISTORY PROFILE

Information obtained in Section E "Family History Profile" will not be used to decline an application or deny a Preferred Health Discount.

OUTLINE OF COVERAGE

Applicant(s) should retain the outline of coverage.

PHONE AND IN-PERSON HEALTH INTERVIEW REQUESTS

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

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 20 minutes.

CHECKLIST

Use this checklist to help ensure that you send in all necessary information. If you have any questions regarding any of these materials please call the phone number below.

- Application (*fully completed*)
- EFT/Credit Card Authorization (*if paying by either method*)
- A check for Full Modal Premium (*if applicable*)
- Health Information Authorization
- Replacement Notice (*when coverage is being replaced*)
- Personal Worksheet (if applicable)
- State required forms
- Requirements to Access Couples Discount form (*when required*)

Please complete the above forms, provide agent, if applicable, and applicant signatures, date all forms, and mail (*with any required premium payment made payable to*):

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