Application for Life Insurance – Part I

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

1. Proposed Insured

Please print all answers.

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Sex ◯F ◯M	c. Date of Birth Mo. Day Yr.	d. State of Birth	e. Social Security Number
f. Home Address (Number, Street, City, State, and Zip Code.) e-mail:			How Long At Address?	g. Legal Residency ◯U.S. ◯Other (Specify):
h. Driver's License Number/State	i. Marital Status ◯M ◯S ◯W ◯D	j. Home Phone Number		k. Work Phone Number
l. Occupation (Include duties.)	m. Employer Name and Address			How Long w/ Employer?

2. Ownership (Complete if Owner is other than Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address) e-mail:	b. Rel. to Prop. Ins.	c. SSN or TIN	d. Date of Birth/Trust Mo. Day Yr.
e. Owner is: ◯Individual ◯Partnership ◯Corporation ◯Trust ◯Other (Specify):			
f. Contingent Owner: (Full Name and Address) e-mail:	g. Rel. to Prop. Ins.	h. SSN or TIN	i. Date of Birth/Trust Mo. Day Yr.
j. Contingent Owner is: ◯Individual ◯Partnership ◯Corporation ◯Trust ◯Other (Specify):			

3. Beneficiary (If percentage shares are not given, they will be equal. Use REMARKS to name additional Beneficiaries.)

a. Primary: (Full Name and Address)	b. % Share	c. Rel. to Prop. Ins.	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr.
f. Primary: (Full Name and Address)	g. % Share	h. Rel. to Prop. Ins.	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr.
k. Contingent: (Full Name and Address)	l. % Share	m. Rel. to Prop. Ins.	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr.
p. Contingent: (Full Name and Address)	q. % Share	r. Rel. to Prop. Ins.	s. SSN or TIN	t. Date of Birth/Trust Mo. Day Yr.

4. Insurer, Plan and Amount of Insurance

a. Insurer: (Select one) ◯**GLIC** ◯**GLAIC**

b. Plan of Insurance:

c. Amount of Insurance: $

5. Death Benefit Option (Universal Life only)

◯Level (Specified Amount only)
◯Increasing (Specified Amount plus cash value)
◯Scheduled Increases (if available):
◯Simple _____% ◯Compound _____%

6. Riders (If available with Plan)

◯Waiver
◯Children's Term Ins.: Units ☐
◯Other (Amount and Description):

7. Premiums

a. Payment Method: ◯Pre-Arranged Withdrawal (PAW) ◯Direct Bill ◯Other (Specify):

b. Payment Mode: ◯Monthly (PAW only) ◯Quarterly ◯Semiannual ◯Annual ◯Single

c. Automatic Premium Loan: ◯Yes No ◯ (if available)

d. Send Premium Notices to: ◯Insured (Section 1.f.) ◯Owner (Section 2.a.) ◯Other (Specify):

e. Premium Source: ◯Salary ◯Investments ◯Savings ◯Gifts/Inheritance ◯Other (Specify):

f. Amount Remitted in Exchange for Temporary Insurance: $

8. Proposed Insured's Tobacco and Nicotine Use

a. Mark the **one** item that best describes your history of tobacco and other nicotine product use: ◯ Never Used ◯ Totally Stopped ◯ Use Now

b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in **REMARKS.**

◯ Less than 1 ◯ 1 or more/less than 2 ◯ 2 or more/less than 3 ◯ 3 or more/less than 5 ◯ 5 or more

9. Proposed Insured's Insurance Needs (Complete either the Personal or Business section. Explain "Yes" answers in REMARKS.)

a. ◯ **Personal:** ◯ Income Replacement ◯ Debt Repayment ◯ Estate Conservation ◯ Other

1. Personal Finances: Gross Annual Income $ Total Assets $ Total Liabilities $
2. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? ◯ Yes No ◯

b. ◯ **Business**: ◯ Buy-Sell ◯ Key Employee ◯ Secure Credit ◯ Other

1. Business Finances: Total Assets $ Total Liabilities $ Net Worth $
2. What percentage of the business do you own? % 3. Your Gross Annual Salary (include bonus) $
4. Is business insurance applied for or in force on other key members of the business? (Explain either answer in **REMARKS.**) ◯ Yes No ◯
5. Within the past 5 years, has the business filed for bankruptcy or had any lien or judgments filed against it? ◯ Yes No ◯

10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)

a. Do you have existing life insurance or annuities? ◯ Yes No ◯

b. If "Yes," to Question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities? ◯ Yes No ◯
(If "Yes," you may be required to review and sign additional forms.)

c. If "Yes," to Question 10.a., list all existing life insurance policies and annuity contracts. For additional policies/contracts, use **REMARKS**.

Full Name of Company	To Be Replaced?	Amount	Year Issued	Beneficiary(ies)
	◯ Yes No ◯	$		
	◯ Yes No ◯	$		
	◯ Yes No ◯	$		
	◯ Yes No ◯	$		

11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)

	Yes	No
a. Do you have any other application or informal inquiry for life insurance pending in any company or society?	◯	◯
b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?	◯	◯
c. Have you ever been convicted of a misdemeanor or felony?	◯	◯
d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment?	◯	◯
e. In the past 5 years, has your driver's license been suspended or revoked?	◯	◯
f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs?	◯	◯
g. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.)	◯	◯
h. In the past 2 years have you engaged in, or do you intend to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? (If "Yes," complete appropriate activities Supplement[s].)	◯	◯
i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks other than for vacation? (If "Yes," complete Foreign Residence/Travel Supplement.)	◯	◯

12. REMARKS (For explanations and special requests. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

Authorization to Collect and Disclose Information

Information Information means facts about the Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation. The following statements apply to Information being collected in the states named: **New Jersey** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. **Vermont** Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS. In Vermont, the Company will not forward the results of any new tests it requests to any other entity.

Source Medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; facilities or offices staffed or run by care providers; insurers; reinsurers; MIB; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Genworth Life Insurance Company, and Genworth Life and Annuity Insurance Company

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured's behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

In all states except Rhode Island and Vermont, this Authorization will be valid for thirty (30) months after the date this Application – Part I is signed. In Rhode Island and Vermont, this Authorization will be valid for twenty-four (24) months after the date this Application – Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

Representations

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner's insurance needs.

I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

State in which Owner Signed Application _____

State in which Policy will be Delivered _____

_____ _____ _____

Signature of Proposed Insured | Date | Owner (if not Proposed Insured: Signature and any Title)

_____ _____

Signature of Licensed Insurance Agent | Signature of Licensed Insurance Agent

_____ _____

Licensed Insurance Agent's Printed Name | Licensed Insurance Agent's Printed Name

_____ _____ _____ _____ _____ _____

Social Security No. | License No. | Managing Agency/ Brokerage No. | Social Security No. | License No. | Managing Agency/ Brokerage No.

Genworth® Financial

Genworth Life Insurance Company
Genworth Life and Annuity Insurance Company
700 Main Street, Lynchburg, VA 24504
Phone: 888 325.5433

Electronic funds transfer (EFT) authorization

for Life Insurance new business

- Complete, sign, date and return this form to us with your application materials
- Keep a copy of the form for your records

Application information

Proposed Insured's name

File or application number(s) (if available)

Premium payment

For most products, frequencies other than annual include an additional cost. In those cases, the year's total premiums will be higher than if you paid one annual premium.

If you have a question about your product, contact your agent.

Select payment frequency:

○ **Monthly*** ○ **Quarterly** ○ **Semi-Annually** ○ **Annually**

We will withdraw the scheduled premium amount based on the frequency you select.

**If you choose monthly payment frequency, you need to authorize two months of premium payment. This amount will be drafted only for the initial premium payment.*

Payment amount authorized

$

Account information

If you do not check the initial payment selection, you must submit another form of payment to cover the initial premium payment, and we will use this electronic funds transfer for subsequent premiums only.

○ I want my initial payment to be made via EFT.

Note: We will draft your account when we receive your application if the Temporary Insurance Application and Agreement (TIAA) is properly completed, signed and dated. If we do not receive the TIAA, or if the TIAA is not properly completed, signed and dated, we will draft your account when we receive all delivery requirements.

Account owner name *(if different from proposed insured above – see "A" below)*

Account owner street address *(see "A" below)*

Account owner City, State, ZIP *(see "A" below)*

Financial institution name *(see "B" below)*

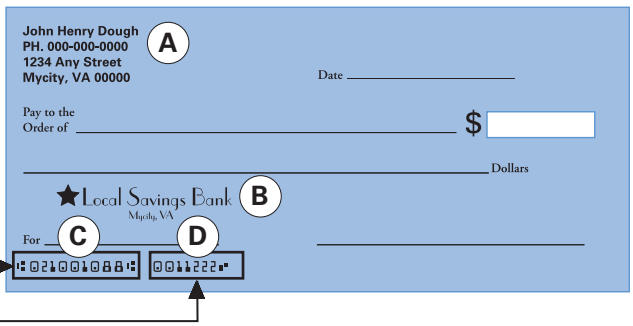
Bank routing number *(see "C" below)*

Checking account number *(see "D" below)*

This is an example of a personal check. A business check may be different. The circled letters show you where on the check to find the information required to process your electronic funds transfer.

The nine-character bank routing number appears between the ⑆ symbols, usually at the bottom left corner of the check.

The account number is 5-22 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.



Acknowledgement

By signing below, I (the policyowner) understand and accept these terms and conditions (if applicable):

- Signing the Electronic funds transfer authorization does not mean that insurance is effective. Insurance is effective only as stated in the Application for Life Insurance or in the Temporary Insurance Application Agreement (TIAA).
- We will not provide coverage if the financial institution does not honor the withdrawal, even if we receive all other requirements.
- We will initiate payment of the first premium only after:
  (1) we receive the completed and signed Application – Part I and a TIAA has been properly issued; or
  (2) we receive and review for proper dates and signatures the Policy Delivery and Acknowledgement form and all requirements we requested when we delivered the policy to you.
- We may issue the policy at a premium rate different from the rate for which you applied. In that case, we will give the payer advance notice of the new premium amount before we withdraw premiums, if there was a TIAA. After the first withdrawal, we will withdraw premiums on the day of the month that corresponds to the policy's effective date. The policy effective date is the date the policy owner signs the TIAA, or the Policy Delivery and Acknowledgement form.
- Coverage is effective under the TIAA only if the premium amount withdrawn equals one premium for the plan and payment frequency (two premium payments must be withdrawn if the premium frequency is monthly).
- If TIAA coverage ends as described in the TIAA's 'Stop Date,' we will return the amount withdrawn to the bank account shown on page 1.

Authorization

By signing below, I (the bank account owner) understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay your insurance premiums.
- If your financial institution does not honor a withdrawal request, we will NOT consider your premium paid.
- We have the right to end withdrawals at any time and bill you directly either quarterly or less frequently for premiums due.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.

Signatures

Signature of premium payer *(bank account owner)* Date

X .

Signature of policyowner *(if different from premium payer)* Date

X .

REPLACEMENT NOTICE
REPLACING YOUR LIFE INSURANCE POLICY?

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at anytime. Ask the company or agent that sold you your existing policy to give you information about it.

Cover page contains a checklist of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

☐ If you wish to receive a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing its policy.

List below the identification of policies you intend to replace.

Name of Existing Insurer	Contract or ID* Number	Insured

* If the existing insurer has not assigned a policy number, list alternative identification such as an application or receipt number.

Name of Proposed Insured

Applicant (if different)

Applicant's Address

Applicant's Signature

Date

Replacing Agent

License Number

Agent's Address

Telephone Number

Agent's Signature

Date

○ **Genworth Life and Annuity Insurance Company**
Fixed Life: P.O. Box 320 • Lynchburg, VA 24505-0320

Fixed Annuities: 6610 West Broad Street • Richmond, VA 23230
Fax: 804 281.3022

○ **Genworth Life Insurance Company**
Fixed Life: P.O. Box 461 • Lynchburg, VA 24505-0461

Fixed Annuities: 6610 West Broad Street • Richmond, VA 23230
Fax: 804 281.3022

Application – Part II Medical History

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

Professional health care provider (care provider) means persons licensed as: medical physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Professional health care treatment facility (treatment facility)** includes: hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and facilities or offices staffed or run by care providers.

1. Proposed Insured — Please print all answers

a. Full Name	b. Date of Birth (Mo. Day Yr.)	c. Social Security Number	d. Height ft. in.	e. Weight lbs.

2. Primary Care Provider (If none, state NONE.)

Name and Address **(For the past 5 years, give dates and reasons consulted and any treatments or medications prescribed in DETAILS.)**

3. Medical Questions (Explain "Yes" Answers in DETAILS.)

a. In the past 10 years, have you had, been treated for, or been medically advised to be treated for, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
(1) Alcoholism or Drug Use	◯	◯	(13) Depression	◯	◯	(24) Lupus (SLE)/Scleroderma	◯	◯	(36) Shortness of Breath	◯	◯
(2) Angina	◯	◯	(14) Diabetes	◯	◯	(25) Mental Illness	◯	◯	(37) Skin Disorder	◯	◯
(3) Asthma	◯	◯	(15) Dizziness/Fainting	◯	◯	(26) Muscular Dystrophy	◯	◯	(38) Sleep Apnea	◯	◯
(4) Blood Disorder	◯	◯	(16) Gastrointestinal Bleeding	◯	◯	(27) Neurologic Disorder	◯	◯	(39) Stroke	◯	◯
(5) Bronchitis	◯	◯	(17) Headaches	◯	◯	(28) Palpitations/Arrhythmia	◯	◯	(40) Sugar, Protein, or Blood in Urine	◯	◯
(6) Cancer	◯	◯	(18) Heart Attack	◯	◯	(29) Pancreatitis	◯	◯			
(7) Chest Pain	◯	◯	(19) Heart Murmur	◯	◯	(30) Paralysis	◯	◯	(41) Suicide Attempt	◯	◯
(8) Cirrhosis	◯	◯	(20) Hepatitis	◯	◯	(31) Peripheral Vascular Disease	◯	◯	(42) Thyroid Disorder	◯	◯
(9) Clotting Disorder	◯	◯	(21) High Blood Pressure	◯	◯	(32) Pituitary Disorder	◯	◯	(43) Tuberculosis	◯	◯
(10) Colitis/Ileitis	◯	◯	(22) Human Immunodeficiency Virus (HIV) Infection	◯	◯	(33) Prostate Disorder	◯	◯	(44) Tumor, Mass or Lump	◯	◯
(11) Coughing Up of Blood	◯	◯				(34) Rheumatoid Arthritis	◯	◯	(45) Ulcer/Gastritis	◯	◯
(12) Chronic Lung Disorder	◯	◯	(23) Kidney Disorder	◯	◯	(35) Seizures/Convulsions	◯	◯			

b. For reasons other than those given in answering Question 3.a., in the past 5 years have you: Yes No
(1) consulted with or received treatment from a care provider or treatment facility? ..... ◯ ◯
(2) had an EKG, X-ray, or other diagnostic test, other than an AIDS-related test? ..... ◯ ◯
(3) been advised to have any diagnostic test, other than an AIDS-related test, hospitalization or surgery that was not completed? ..... ◯ ◯
(4) had medication prescribed for a physical or mental disorder? ..... ◯ ◯

c. In the past 6 months, has your weight changed more than 15 pounds? ..... ◯ ◯

d. Other than as prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? ..... ◯ ◯
If "Yes," also give name, form, amount, frequency and length of use, and date last used in **DETAILS**.

e. (1) Mark the **one** item that best describes your history of alcoholic beverage use.
◯ Never Used ◯ Totally Stopped ◯ Use Now
(2) If you have "Totally Stopped," indicate number of years since you totally stopped and give date and reason in **DETAILS.**
(3) If you "Use Now," answer the following.
(a) How often do you drink alcoholic beverages? ◯ Occasionally ◯ 3 or less days per week ◯ 4 or more days per week
(b) When you drink, how many drinks do you consume per day? ◯ 3 or less ◯ 4-6 ◯ 7 or more

f. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, alcoholism, mental illness, or suicide in your family? ..... Yes ◯ No ◯

Father ☐	Age if Alive:	Age at Death: Cause	Siblings	No. Alive	Age(s)	No. Dead:	Age(s):	
Mother ☐	Age if Alive:	Age at Death: Cause				Cause(s)		

4. DETAILS (For explanations and requested information. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

State condition and give diagnoses, dates, durations, treatments, tests, medications prescribed and names and addresses of all care providers and treatment facilities.

I represent that the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

Signature of Proposed Insured | Date | Signature of Examiner

Application – Part II Medical History, Overflow Form

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

Proposed Insured **Please print all answers**

a. Full Name | b. Date of Birth (Mo. Day Yr.) | c. Social Security Number

4. DETAILS (Provide explanations and requested information.)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

I represent that the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

Overflow Page _____ of _____

Signature of Proposed Insured | Date | Signature of Licensed Insurance Agent or Examiner

NOTICE AND CONSENT FOR TESTING
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, oral fluid or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw a blood sample, collect oral fluid or urine samples, and order laboratory tests only in regard to your present application for insurance. In order to perform all testing procedures, it may be necessary for you to provide more than one of these bodily fluid samples.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant test result abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me, the collection of an oral fluid or urine sample, the testing of the sample, and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

Proposed Insured (Please Print)		Date of Birth
Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

Name and address of licensed Physician to whom you authorize disclosure of other than normal test results:

Examiner's Name and Address:

○ **Genworth Life and Annuity Insurance Company**

New Business: P.O. Box 320
Lynchburg, VA 24505-0320

○ **Genworth Life Insurance Company**

New Business: P.O. Box 461
Lynchburg, VA 24505-0461

Authorization for Release of Health-Related Information

○ **Genworth Life and Annuity Insurance Company**
P.O. Box 320 • Lynchburg, VA 24505-0320

○ **Genworth Life Insurance Company**
P.O. Box 461 • Lynchburg, VA 24505-0461

This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)	Date of birth

Authorization

This Authorization for Release of Health-Related Information to the Life Insurer

Life Insurer

Genworth Life and Annuity Insurance Company, or Genworth Life Insurance Company, as shown above

Protected Health Information

Protected Health Information is my entire medical record and other health information. It includes information such as: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, sexually transmitted diseases and mental illness; prescription drug use; other insurance coverage; hazardous activities; character; and the use of alcohol, drugs, and tobacco. It excludes psychotherapy notes.

My Providers

My Providers are: any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy database; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf.

I authorize My Providers to disclose my Protected Health Information to the Life Insurer and its agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I made that restrict my Protected Health Information do not apply to this Authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the Life Insurer may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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 the Life Insurer.

This Authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that:1) I have the right to revoke this Authorization in writing, at any time, by sending a written notice to the Life Insurer at 3100 Albert Langford Drive, Lynchburg, VA 24501, Attention: Privacy Official; and 2) written revocation is not effective if any of My Providers has relied on this Authorization or if the Life Insurer has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any Protected Health Information disclosed pursuant to this Authorization may be redisclosed and no longer covered by the federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Protected Health Information, the Life Insurer may not be able to perform the underwriting necessary to process my life insurance application. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative	Date

Description of Personal Representative's Authority or Relationship to Patient