Application for Life Insurance

Genworth Life Insurance Company ***Genworth Life and Annuity Insurance Company***

For use in Florida. Please complete this application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. If special mailing envelopes have been provided, submitting the application in such an envelope will help avoid delays in processing your client's application. We sincerely appreciate your business.

LICENSED INSURANCE AGENT CHECKLIST

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

DO

- Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- Make sure that the circle for the appropriate Insurer is marked in item 4.a. on Page 1.
- Ask all questions and fully and accurately record all answers given — the application will be part of any policy issued.
- Enter each beneficiary's SSN — it will help us locate the beneficiary at claim time.
- Print in dark ink.
- Obtain all the necessary signatures.
- Complete and sign the Licensed Insurance Agent's Report.
- Promptly schedule any required medical exam.
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- If you accept payment with the application:
  - Accept payment only in the form of a currently dated check or money order made payable to the selected Insurer.
  - Enter the full amount accepted in Section 7.f. on Page 1.
  - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered "No."
  - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
  - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
  - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
  - Promptly send the payment and the Application – Part I, including the ORIGINAL of the TIAA to the Insurer marked in item 4.a. on Page 1.
- Check for these most often missed minimum requirements for smooth In Good Order processing:
  - For Payment Method Missing in Section 7.a. on page 1
  - For Annual Income and Bankruptcy Question in Section 9.a. on page 2
  - For Agent Code in Agent Report Section 1.b. and 3

DO NOT

- DO NOT use pencil or correction fluid.
- DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- DO NOT promise or imply that we will provide insurance.
- DO NOT accept payment in the form of cash/currency or Traveler's checks.
- DO NOT accept a check or money order made payable to you or with the payee left blank.
- DO NOT do the following:
  - Do not accept payment when the amount applied for plus existing insurance with the Insurer exceeds $1,000,000.
  - Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.
  - Do not accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.

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/ 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/ 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 Ad- | 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, in the next 2 years, 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, in the next 2 years, 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].)	◯	◯

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 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.

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 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.

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.**

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

_____ _____

License No. | License No.

1. Licensed Insurance Agent's Report (Not part of the Application)

a. Full Name (Please print)	b. Agent's Company Code No.*	c. SSN or Tax ID No.	d. Phone and FAX Numbers
			Phone: FAX:

e. 1. Does the proposed insured have any existing life insurance or annuity? ..... ◯ Yes No ◯

2. Is this insurance applied for intended to replace, end or change any existing insurance or annuity? ..... ◯ Yes No ◯

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods may apply.

f. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? ◯ Yes No ◯

g. Has a medical or paramedical exam been scheduled? If "Yes," give date and Provider with whom scheduled..... ◯ Yes No ◯

Date (Mo. Day Yr.): Provider's Name:

h. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: $ Reason:

i. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father	Mother	Siblings (Name and Amount)
$	$	

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Signature(s) of Licensed Insurance Agent(s) Date

2. Managing Agency/Brokerage Report (Not part of the Application)

a. Managing Agency/Brokerage Name (Please print)	b. Managing Agency/Brokerage No.	c. Date
e-mail:		

3. Licensed Insurance Agents to Receive Commission (Please print)

Complete for each licensed agent to receive commission.

Total Commission Share(s) to equal 100%. Each licensed agent will share equally unless otherwise indicated.

a. Full Name, Address, and SSN or TIN (Please print) e-mail:	b. Agent's Commission Share %	c. Agent's Company Code No.*
d. Full Name, Address, and SSN or TIN (Please print) e-mail:	e. Agent's Commission Share %	f. Agent's Company Code No.*
g. Full Name, Address, and SSN or TIN (Please print) e-mail:	h. Agent's Commission Share %	i. Agent's Company Code No.*
j. Full Name, Address, and SSN or TIN (Please print) e-mail:	k. Agent's Commission Share %	l. Agent's Company Code No.*
m. Full Name, Address, and SSN or TIN (Please print) e-mail:	n. Agent's Commission Share %	o. Agent's Company Code No.*

***The code number assigned by the Insurer selected in item 4.a. on Page 1 of the application.**

Notice to Proposed Insured and Owner

Genworth Life Insurance Company • Genworth Life and Annuity Insurance Company
700 Main Street • Lynchburg, VA 24504

Thank you for your application. We greatly appreciate your completing each part truthfully and accurately. This notice tells you what to expect after completing the Application - Part I. If you have any questions, please ask the soliciting licensed insurance agent (licensed agent). The licensed agent should gather information about your personal situation, insurable needs and financial objectives and explain how the insurance recommendations are appropriate to fulfill those needs and objectives. When deciding insurance needs, consider the following: the losses you want to protect against; the kind of insurance; how long you will need the coverage; your future liquidity needs, e.g., college funding; your ability to pay the planned premium; taxes; and your other financial assets, e.g., Social Security, pension plans.

Policies Available Only in English

Our insurance applications, illustrations, disclosures and our insurance policies are available only in English. In addition, all of our servicing to our policyholders is only in English. You are responsible for fully understanding these English materials. We do not permit our insurance agents to translate these materials to a different language and you may not rely on any translation by our insurance agent.

What Happens Next

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may seek information from other sources to help us in our evaluation. During underwriting we may find that we are unable to insure you, to give you the amount of insurance you have applied for, or that we are only able to give insurance to you on a modified basis or at a rate that is greater than our lowest rate. Some of the factors we take into account in the underwriting process include medical history, driving history, history of tobacco use, activities such as aviation, any criminal history, and financial information. Available premium classifications are indicated below. Not all premium classifications are available with all products.

Preferred Best No Nicotine
Preferred No Nicotine
Select No Nicotine
Standard No Nicotine
Preferred Nicotine
Standard Nicotine
Substandard - Tables B – P (2 – 16)
(Table rated cases are issued as either No Nicotine or Nicotine, as appropriate. Flat extra premiums may also be applied.)

Physical Exam

Virtually all Proposed Insureds are required to take a physical exam. The exam is done by a qualified examiner and takes approximately 30 minutes. During the exam, you should expect the following: to provide your medical history; to be weighed and measured; to have an EKG (not always required); to provide a blood or saliva sample and a urine sample; to have your blood pressure and pulse taken.

Here are some of the ways you can help with the exam process:

- Schedule your exam within 24 hours after you complete the Application - Part I
- Have a list of the names and addresses of all licensed health care providers and facilities seen during the past 20 years and be prepared to provide reasons, dates and any treatments received as a result of those visits
- Do not eat or drink (except water) for 12 hours prior to your scheduled exam time
- Have a list of all medications taken in the past five years
- Have a photo ID ready, e.g., driver's license, passport, or greencard

Important Information

Contestability

Because your application will be our primary source of information, we strongly urge you to review the completed application closely for accuracy. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. In addition, you may be violating state law if you knowingly conceal material facts or submit an application that contains materially false information.

Replacement of Existing Coverage

If you have existing coverage, answer "yes" to this question in the application. If you intend to replace existing coverage, tell the licensed agent of your intention and answer "yes" to the replacement question in the application. State law may require the licensed agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, answer the replacement question "yes." Doing so may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. Stopping premium payments, surrendering, or borrowing from an existing policy as a result of applying for this policy could be considered replacement. State law may define replacement to include other situations. Ask the licensed agent if you are unsure about replacement.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, and also the right to receive upon request a copy of any investigative consumer report. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to P.O. Box 461, Lynchburg, Virginia 24505-0461.

Federal Fair Credit Reporting Act

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics, as well as information obtained from other data sources. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) Disclosure

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc. MIB, Inc. is a non-profit membership organization of life insurance companies. It operates an information exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. To contact MIB, Inc., you may: write 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; phone toll free (866) 692-6901 (TTY 866 346-3642 for hearing impaired); or use the website http://www.mib.com.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Free Look Period

If we deliver a policy to you, you will have a brief period of time to examine the policy and, if you desire, to return the policy to us for a full refund of any premium you paid. This period – known as the "free look period" – is usually 20 days from our delivery of the policy to you, but it may be a slightly longer period in some states. To return the policy, simply mail or deliver the policy to the Company or any of its agents within the free look period for your state. The policy will then be made void from the beginning.

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased, renewed or when you exercise certain policy rights, such as increasing the premiums you pay, lengthening your coverage, increasing your death benefit or adding an optional rider. This compensation may also include fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, 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. Intermediaries may also pay compensation directly to the licensed agent. If the licensed agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

FRAUD WARNINGS

ARKANSAS and LOUISIANA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA and WASHINGTON
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA
Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Temporary Insurance Application and Agreement (TIAA)

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

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within [90] days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

Temporary Insurance Application (Answer all Questions.)

Insurer The Insurer designated in Section 4.a. of the Application - Part I.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

	Yes	No
1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA?	◯	◯
2. Is the Policy applied for a joint life insurance policy?	◯	◯
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed [$1,000,000]?	◯	◯
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test that was not completed?	◯	◯
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse?	◯	◯
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C?	◯	◯
7. Has the Proposed Insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	◯	◯

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Proposed Insured | Date of this TIAA | Signature of Owner (if other than Proposed Insured)

Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.

Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) [$1,000,000] minus the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date - [90] Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) [45] days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines; (3) the date the Owner refuses to accept any policy issued or offered; (4) the date the Insurer sends notice to the Owner at the address shown in the Application - Part I that the Insurer has declined to issue insurance; and (5) [90] days after the Start Date.

Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

Licensed Insurance Agent's Statement

Amount Remitted $ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

Signature(s) of Licensed Insurance Agent(s) | Licensed Insurance Agent Number(s)

Temporary Insurance Application and Agreement (TIAA)

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

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within [90] days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

Temporary Insurance Application (Answer all Questions.)

Insurer The Insurer designated in Section 4.a. of the Application - Part I.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

	Yes	No
1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA?	◯	◯
2. Is the Policy applied for a joint life insurance policy?	◯	◯
3. Does the total amount of insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, or temporary insurance agreements exceed [$1,000,000]?	◯	◯
4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test that was not completed?	◯	◯
5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse?	◯	◯
6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C?	◯	◯
7. Has the Proposed Insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	◯	◯

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

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Signature of Proposed Insured | Date of this TIAA | Signature of Owner (if other than Proposed Insured)

Temporary Insurance Agreement

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Signature(s) of Licensed Insurance Agent(s) | Licensed Insurance Agent Number(s)

Authorization for Release of Health-Related Information

Original to Insurer

◯ **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

◯ **Genworth Life Insurance Company of New York***
P.O. Box 10717
Lynchburg, VA 24505

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, Genworth Life Insurance Company, or Genworth Life Insurance Company of New York, 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.

Continued on next page

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

This Authorization shall remain in force for 24 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 Lankford 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

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

Authorization for Release of Health-Related Information

Copy to Applicant

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P.O. Box 320
Lynchburg, VA 24505-0320

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Signature of Proposed Insured/Patient or Personal Representative	Date

Description of Personal Representative's Authority or Relationship to Patient

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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)*

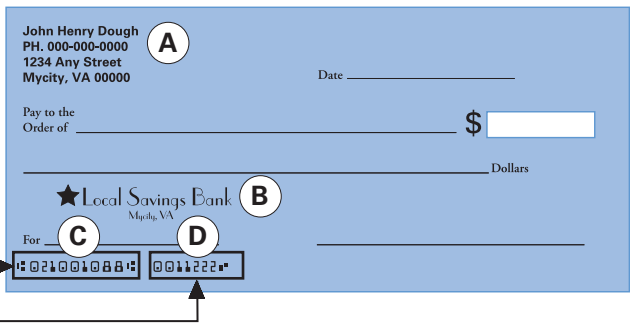
Bank routing number *(see "C" below)*

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 .

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.

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 body fluid samples.

Unless precluded by law, 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 that we perform 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 involved solely in the underwriting process such as its affiliates, reinsurers, employees, or agents. 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. 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, you shall be notified by a physician designated by you or, in the absence of such designation, by the Tallahassee Florida Department of Health and Rehabilitation Services. The Insurer may contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer will ask you for the name of a physician 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 of Consent For Testing Which May Include HIV Antibody/ Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Please Print) _____ Date of Birth _____

Name and address of designated Physician:

_____

_____

_____

Signature of Proposed Insured or Parent/Guardian _____ Date _____ State of Residence _____

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

Original to Insurer

◯ **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

◯ **Genworth Life Insurance Company of New York***
P.O. Box 10717
Lynchburg, VA 24505

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, Genworth Life Insurance Company, or Genworth Life Insurance Company of New York, as shown above

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Signature of Proposed Insured/Patient or Personal Representative	Date

Description of Personal Representative's Authority or Relationship to Patient

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Authorization for Release of Health-Related Information

Copy to Applicant

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