



Genworth®
Financial

IGO App Quickcheck Guide

Receive a faster response with an
“In Good Order” (IGO) Application

Page 1

1. Proposed Insured

- Full Name
- Gender
- Date of Birth
- State of Birth
- Social Security Number
- Home Address (No abbreviations in the city, state and zip code.) If home address is different than the mailing address, please include mailing address.
- Legal Residency (If State of Birth is outside the U.S., please indicate if PI is a U.S. Citizen, Permanent Resident Alien or Temporary Visa Holder. For Permanent Resident Aliens and Temporary Visa Holders, please complete the Resident Alien Supplement, including all Visa information.)
- Driver’s License # and State (If no driver’s license, state “None.”)
- Phone Numbers (With area codes)

2. Ownership

- Owner Full Name (If trust, give full name of the trustee(s), the trust and date of the trust agreement.)
- Owner’s complete address
- Relationship to Proposed Insured
- Social Security Number or TIN
- Date of Birth/Trust Date (required prior to issue in CA and MN)

3. Beneficiary

If percentage shares are not given, they will be equal.

- Full Name (If trust, give full name of the trustee(s), the trust and date of the trust agreement.)
- Full Address
- % Share
- Relationship to Proposed Insured
- Social Security Number or TIN
- Date of Birth/Trust

4. Insurer Plan and Amount of Insurance

- Insurer (select one): Genworth Life Insurance Company (GLIC) or Genworth Life and Annuity Insurance Company (GLAIC)
- Plan of Insurance (Use complete plan name, i.e., use “ColonySM Term UL 10,” not “Colony Term UL” or use GenGuardSM UL, not “UL” - **A signed illustration or waiver is required with all UL products other than the Colony Term UL series.***)

Before submitting the application:

Check it for these most often missed minimum requirements for smooth IGO processing.

Prior to soliciting the application:

Check that you are licensed (and appointed, if applicable) in the appropriate state. Please be sure that you are using the appropriate state’s specific version based on the policy’s state of delivery.

* Waiver of illustration is not applicable in MI. Universal life insurance is not available in MS.

Page 1

Application for Life Insurance – Part I

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
100 Main Street • Lexington, MA 02424

1 Proposed Insured Please print all answers.
 a. Full Name (First, Middle, Last. Include maiden name in parentheses.)
 b. Sex: M F
 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: _____
 g. How Long at Address:
 h. Driver's License Number/State
 i. Marital Status: W M D O
 j. Home Phone Number
 k. Work Phone Number
 l. Occupation (include duties)
 m. Employer Name and Address
 n. 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. Contingent (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: \$ _____
 d. Payment Method: Pre-Arranged Withdrawal (PAW) Direct Bill Other (Specify): _____
 e. Payment Mode: Monthly (PAW only) Quarterly Semiannual Annual Single
 f. Automatic Premium Loan: Yes No (if available)
 g. Send Premium Notices to: Insured (Section 1.1) Owner (Section 2.1) Other (Specify): _____
 h. Premium Source: Salary Investments Savings Gifts/Inheritance
 i. Amount Permitted in Exchange for Temporary Insurance: \$ _____

5 Death Benefit Option (Universal Life or Level)
 a. Level (Specified Amount only)
 b. Increasing Specified Amount plus cash value
 c. Scheduled Increases (if available)
 d. Other (Specify): _____
 e. Waiver Yes No
 f. Riders Term Ins. Units: _____
 g. Other (Amount and Description): _____

6 Riders (If available with Plan)

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 1.1) Owner (Section 2.1) Other (Specify): _____
 e. Premium Source: Salary Investments Savings Gifts/Inheritance
 f. Amount Permitted in Exchange for Temporary Insurance: \$ _____

Form No. GEFA-509 Page 1 1/2007

4. Insurer Plan and Amount of Insurance (continued)

- Colony Term UL - Unless you inform us otherwise, we assume your client desires a planned premium sufficient to provide coverage for the number of years associated with the product name, e.g. 10 years for Colony Term UL 10 and 20 years for Colony Term UL 20.
- Amount

5. Death Benefit Option

If left blank, “Level” will be given for applicable plans.

6. Riders (if available with plan)

- Waiver (for Waiver of Specified Premium, please include amount of monthly waiver benefit; amount cannot exceed the planned premium.)
- Children’s Term Ins.: Units ____ (Complete CIR application. If “Units” is blank, will be given 10 units.)
- Other (Amount and Description)

7. Premiums

- Payment Method (If blank and other than monthly, will be “Direct Bill.”)
- Payment Mode (If blank, will be “Annual.”) Direct Monthly is not available.

Are all questions answered?

Omission of any of these answers could result in amendments at the time of delivery.

Did everyone sign?

Money

All checks must be payable to the insurer selected on the application. Neither Third Party Checks or cash will be accepted. The TIAA date, application date and check date must all match.

Another company's exam

A completed Form No. GEFA-504 Nonmedical Part II is required if another company's exam is accepted. Please be sure that you are using the appropriate state-specific version based on the policy's state of delivery.

Minors

A completed Form No. GEFA-504 Nonmedical Part II is required on all minors. Please be sure that you are using the appropriate state-specific version based on the policy's state of delivery.

HIV consent

All HIV consent forms should be obtained for the Proposed Insured's resident state. Exception: if policy is to be delivered in CA or TX, use a CA or TX form, respectively.

Page 2

8. Proposed Insured's Tobacco, Nicotine, and Nicotine Substitute Use

- Mark One: Never Used, Totally Stopped, Use Now
- Totally Stopped (Complete "b" and give date and reason in remarks.)

9. Proposed Insured's Insurance Needs – Required for All Applications

Must select Business or Personal and answer all questions.

10. Proposed Insured's Existing Insurance/ Replacement

- This must be fully completed in accordance with the state in which the policy will be delivered. If NAIC state and yes to existing insurance (10a), complete appropriate replacement form(s); if non-NAIC state and yes to replacement (10b), complete appropriate replacement form(s).
- All existing coverage, whether being replaced or not, must be listed.

11. Proposed Insured's History – Supplemental Forms May be Required

- If answered yes, provide details and complete supplement.

Page 3

A. Representations

- State in Which Owner Signed Application
- State in Which Policy Will Be Delivered
- Proposed Insured Signature (Parent or legal guardian must sign for child on Part I and nonmed form)
- Date
- Owner Signature and Title
- All Trustee Signatures, if applicable
- Agent Signature

Page 4

B. Licensed Insurance Agent's Report

- Must answer existing insurance and replacement question #1e
- If Proposed Insured is married, please complete #1h
- If Proposed Insured is a Minor, please complete #1i
- Agent must sign

C. Managing Agency/Brokerage Report

- Managing Agency/Brokerage Name
- Managing Agency/Brokerage No.

TIAA

D. Temporary Insurance Application

- TIAA - All questions answered
- TIAA - Money cannot be accepted if any questions are answered "yes" or "left blank" (if collected, money will be returned).
- Insured and owner signature

E. Licensed Insurance Agent's Statement

- Agent signature

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Page 2

8. Proposed Insured's Tobacco and Nicotine Use
Have you ever used tobacco or any nicotine product use? (Owner/Insured) Never Used Totally Stopped Use Now
If you have "Totally Stopped," indicate number of years since you totally stopped and give date and reason in REMARKS.
a. 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.)
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
Business: Buy-Sell Key Employee Secure Credit Other _____
1. Business Finances: Total Annual \$ _____ Total Liabilities \$ _____ Net Worth \$ _____
2. What percentage of the business is owned by? _____ 3. Your Gross Annual Salary (includes 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 judgments or liens filed against it? Yes No

10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)
Do you have existing life insurance or annuities? Yes No
a. If "Yes," to Question 10a, 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 10a, 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)
	<input type="radio"/> Yes <input type="radio"/> No	\$		
	<input type="radio"/> Yes <input type="radio"/> No	\$		
	<input type="radio"/> Yes <input type="radio"/> No	\$		
	<input type="radio"/> Yes <input type="radio"/> No	\$		

11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)
a. Do you have any other application or informal inquiry for life insurance pending in any company or society? Yes No
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? Yes No
c. Have you ever been convicted of a misdemeanor or felony? Yes No
d. Have you ever received or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment? Yes No
e. In the past 5 years, has your driver's license been suspended or revoked? Yes No
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? Yes No
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.) Yes No
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).) Yes No
i. In the next 2 years, do you intend to travel or reside outside of the U.S. for more than a consecutive weeks other than for vacation? (If "Yes," complete Foreign Residence/Travel Supplement.) Yes No

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

Form No. GEFA-509 Page 2 1/2007

Page 3

Authorization to Collect and Information
I, the undersigned, authorize the insurance carrier to collect and use information for the purpose of underwriting, rating, and issuing life insurance policies and annuities. This authorization is given to the insurance carrier and its agents, brokers, and service providers. I understand that this information may be shared with other insurance carriers and service providers. I agree to provide true and accurate information and to keep the information current. I understand that providing false information may result in denial of coverage or cancellation of a policy. I agree to provide true and accurate information and to keep the information current. I understand that providing false information may result in denial of coverage or cancellation of a policy.

Insurer The Proprietary Insurer is the Insurer. The Authority MIB is the Insurer.

Representations
The application includes the Application - Part I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application. I agree to provide true and accurate information and to keep the information current. I understand that providing false information may result in denial of coverage or cancellation of a policy. I agree to provide true and accurate information and to keep the information current. I understand that providing false information may result in denial of coverage or cancellation of a policy.

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

Form No. GEFA-509 Page 3 1/2007

Page 4

A. Representations
The application includes the Application - Part I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application. I agree to provide true and accurate information and to keep the information current. I understand that providing false information may result in denial of coverage or cancellation of a policy. I agree to provide true and accurate information and to keep the information current. I understand that providing false information may result in denial of coverage or cancellation of a policy.

B. 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 apply.

C. 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) 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.*

D. Temporary Insurance Application
The code number assigned by the Insurer selected in item 4.a. on Page 1 of the application.
Form No. GEFA-509 Page 4 1/2007

E. 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) _____
Form No. GEFA-509 (TIAA) ORIGINAL Return with the application and the payment. 1/2007

Application for Life Insurance

Genworth Life Insurance Company Genworth Life and Annuity Insurance Company

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 1.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 1.a. on Page 1.
- ▶ For Term and Excess Interest Whole Life plans — explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided on request.

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. Insurer, Plan and Amount of Insurance Please print all answers.

a. Insurer (Select One): <input type="radio"/> Genworth Life Insurance Company <input type="radio"/> Genworth Life and Annuity Insurance Company	b. Plan of Insurance:	c. Amount of Insurance: \$
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2. Proposed Insured

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Sex <input type="radio"/> F <input type="radio"/> 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 <input type="radio"/> U.S. <input type="radio"/> Other (Specify):
h. Driver's License Number/State	i. Marital Status <input type="radio"/> M <input type="radio"/> S <input type="radio"/> W <input type="radio"/> D	j. Home Phone Number		k. Work Phone Number
l. Occupation (Include duties.)	m. Employer Name and Address			How Long w/ Employer?

3. 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: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> 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: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			

4. 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.

5. Death Benefit Option (Universal Life only) 6. Riders (If available with Plan)

<input type="radio"/> Level (Specified Amount only) <input type="radio"/> Increasing (Specified Amount plus cash value) <input type="radio"/> Scheduled Increases (if available): <input type="radio"/> Simple _____% <input type="radio"/> Compound _____%	<input type="radio"/> Waiver <input type="radio"/> Children's Term Ins.: Units <input style="width: 50px;" type="text"/> <input type="radio"/> Other (Amount and Description):
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7. Premiums

a. Payment Method: <input type="radio"/> Pre-Arranged Withdrawal (PAW) <input type="radio"/> Direct Bill <input type="radio"/> Other (Specify):	
b. Payment Mode: <input type="radio"/> Monthly (PAW only) <input type="radio"/> Quarterly <input type="radio"/> Semiannual <input type="radio"/> Annual <input type="radio"/> Single	c. Automatic Premium Loan: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> (if available)
d. Send Premium Notices to: <input type="radio"/> Insured (Section 2.f.) <input type="radio"/> Owner (Section 3.a.) <input type="radio"/> Other (Specify):	
e. Premium Source: <input type="radio"/> Salary <input type="radio"/> Investments <input type="radio"/> Savings <input type="radio"/> Gifts/Inheritance <input type="radio"/> 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)
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		

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? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| c. Have you ever been convicted of a misdemeanor or felony? | <input type="radio"/> | <input type="radio"/> |
| d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment? | <input type="radio"/> | <input type="radio"/> |
| e. In the past 5 years, has your driver's license been suspended or revoked? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| 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.) | <input type="radio"/> | <input type="radio"/> |
| 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].) | <input type="radio"/> | <input type="radio"/> |
| 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.) | <input type="radio"/> | <input type="radio"/> |

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 as indicated on Page 1 of the application

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.

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:
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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) e-mail: _____	b. Managing Agency/Brokerage No.	c. Date
---	----------------------------------	---------

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 1.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

Custom No Nicotine

Preferred Nicotine

Standard Nicotine

Custom 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.

Premium Payments on Term

For premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided on your request. Ask the licensed agent for this information.

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 and TENNESSEE 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

Insurer

Insurer (Select one): Genworth Life Insurance Company
 Genworth Life and Annuity Insurance Company

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.)

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? | <input type="radio"/> | <input type="radio"/> |
| 2. Is the Policy applied for a joint life insurance policy? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| 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 (excluding an AIDS-related test) that was not completed? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| 6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? | <input type="radio"/> | <input type="radio"/> |

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.

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

Insurer

Insurer (Select one): Genworth Life Insurance Company
 Genworth Life and Annuity Insurance Company

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.)

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? | <input type="radio"/> | <input type="radio"/> |
| 2. Is the Policy applied for a joint life insurance policy? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| 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 (excluding an AIDS-related test) that was not completed? | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> |
| 6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? | <input type="radio"/> | <input type="radio"/> |

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.

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

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Signature(s) of Licensed Insurance Agent(s)

Licensed Insurance Agent Number(s)



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

Page 1 of 2

- 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.

John Henry Dough
PH. 000-000-0000
1234 Any Street
Mycity, VA 00000

Date _____

Pay to the
Order of _____ \$ _____ Dollars

★ Local Savings Bank
Mycity, VA

For _____

⌘ C ⌘ D ⌘

Labels A, B, C, and D are circled on the check. A points to the payee name, B points to the bank name, C points to the routing number, and D points to the account number.

Electronic funds transfer (EFT) authorization
for Life Insurance new business

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

.



**NOTICE AND CONSENT FOR TESTING
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
AND
AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

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. You may withdraw such consent at any time. In order to perform all these procedures, it may be necessary for you to provide more than one body fluid sample.

HIV ANTIBODY/ANTIGEN TEST. 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.

PRE-TEST COUNSELING. Due to the serious nature of HIV and HIV-related illnesses, you may want to obtain counseling before undergoing this test for HIV antibodies and antigens. Alternative HIV testing and counseling is available through the Commonwealth of Pennsylvania Department of Health and your local health department. You may obtain additional information on such alternative testing and counseling by contacting the Department at (717) 783-0479.

CONFIDENTIALITY. 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 contractors. 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.

NOTIFICATION OF TEST RESULTS – AUTHORIZATION TO DISCLOSE. If your HIV test results are normal, no routine notification will be sent to you unless you indicate otherwise. 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 will 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. If you do not designate a physician to receive any abnormal test results, the results will be disclosed to the Commonwealth of Pennsylvania Department of Health or to your local health department.

SIGNIFICANCE OF POSITIVE TEST RESULTS AND AFFECT ON APPLICATION FOR INSURANCE. 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.

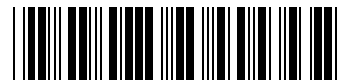
I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of that sample, and the disclosure of test results as described. I understand that this consent will be valid for twenty-four (24) months following the date shown below. I understand that I may revoke this consent at any time, but that the consent will remain valid to the extent that any person has acted in good faith reliance on the consent.

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

I wish to be informed of a negative test result.



I request that abnormal test results be sent to the following (I must choose one):

Name and address of designated Physician:

or

The Commonwealth of Pennsylvania Department of Health; or

One of the following Health Departments or Bureaus:

Allegheny County Health Department
Pittsburgh, PA 15213

Allentown Health Bureau
Allentown, PA 18102

Bethlehem Bureau of Health
Bethlehem, PA 18018

Bucks County Department of Health
Doylestown, PA 18901

Chester County Health Department
West Chester, PA 19380-0990

Erie County Department of Health
Erie, PA 16507

Montgomery County Health Department
Norristown, PA 19404-0311

Philadelphia Department of Public Health
Philadelphia, PA 19146

Wilkes Barre City Health Department
Wilkes Barre, PA 18701

York City Bureau of Health
York, PA 17401

IF YOU DO NOT CHOOSE A RECIPIENT, WE WILL SEND ANY ABNORMAL TEST RESULTS TO THE COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH.

Signature of Proposed Insured
or Parent/Guardian

Date

State of Residence

Examiner's Name and Address:

For assistance in understanding the meaning of the HIV antibody/antigen testing and test results, please contact:

The Commonwealth of Pennsylvania Department of Health
Bureau of Communicable Diseases, Division of HIV/AIDS
Counseling and Testing Section
PO Box 90, Room 912
Harrisburg, PA 17108-0090
Phone: (717) 783-0479

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

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

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

THIS DISCLOSURE IS REQUIRED WHEN APPLYING FOR THE COLONY TERM UL PRODUCTS.

Name of Proposed Insured _____ Age _____ Sex _____

Name of Agent preparing disclosure _____

Agent home or agency address _____

Telephone number of Agent _____

INSURER INFORMATION (Home Office Address. Please send all correspondence to the addresses listed above, respectively.)

Insurer Name:	GENWORTH LIFE & ANNUITY INSURANCE COMPANY	GENWORTH LIFE INSURANCE COMPANY
Home Office:	700 Main Street Lynchburg, VA 24504-1412	700 Main Street Lynchburg, VA 24504-1412
Correspondence To:	P.O. Box 320 Lynchburg, VA 24505-0320	P.O. Box 461 Lynchburg, VA 24505-0461

POLICY AND RIDER INFORMATION

	Descriptive Title of Coverage (i.e., "Colony Term UL 10," "Colony Term UL 15.")	Face Amount of Coverage If not applicable, Description of Coverage	Planned Periodic Premium and Mode
Policy			
Rider(s)			
Supplemental Benefit(s) (built into policy)			

Total (Initial) (annual, monthly, etc.) planned premium for the policy and rider will be _____ .

Amount and Timing of Paying Planned Premiums: Paying planned premiums earlier in a policy year in larger amounts results in lower total charges for insurance for the year and allows the death-benefit guarantee to last longer than if the same total planned premiums were paid more frequently during the year in smaller amounts.

COLONY TERM UL:

Complete the section below:

Number of Years Policy Has Been in Force	5	10	20	age 65
Total Accumulated Cash Surrender Value*				

* For any year that the Total Accumulated Cash Surrender Value is zero, the actual value may be less than zero.

You may borrow against the cash value stated above at an annual policy loan interest rate for preferred loans (if applicable) of _____% payable in advance, and for non-preferred loans of _____% payable in advance.

Please Note: the values shown above are for the specified amount of coverage and are based on the following assumptions:

- 1) that premium payments are made in the frequency specified by the Owner and received at the beginning of the applicable modal period(s);
- 2) the guaranteed interest rate is credited; and
- 3) the guaranteed maximum cost of insurance is deducted.

Current interest (if higher than guaranteed) and current cost of insurance (if lower than guaranteed) may cause cash surrender values to be greater than those shown. Current interest and cost of insurance rates are not guaranteed and are subject to change at any time. Rates will not be changed on an individual basis, but instead will be applied uniformly to a class of insureds. Any change will be due to a re-evaluation by the company of expected future mortality, interest, expenses, and/or persistency.

The values shown are based on the following assumption: that the premiums are paid in order to keep the coverage in force. Rates will not be changed on an individual basis, but instead will be applied uniformly to a class of insureds. Any change will be due to a re-evaluation by the company of expected future mortality, interest, expenses, and/or persistency.

SURRENDER COMPARISON INDEX

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. If requested earlier than delivery, the index disclosure will be provided as soon as reasonably possible. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured has has not requested an earlier delivery of the Index.

Upon request, either the Insurer or the agent will furnish you with additional information about the insurance described.

NOTICE AND CONSENT TO EMPLOYER'S APPLICATION FOR LIFE INSURANCE



Genworth Life Insurance Company
P.O. Box 461, Lynchburg, VA 24505-0461
888.325.5433

Genworth Life and Annuity Insurance Company
P.O. Box 320, Lynchburg, VA 24505-0320
888.325.5433

1. EMPLOYEE (PROPOSED INSURED) INFORMATION

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)		b. Gender <input type="radio"/> F <input type="radio"/> M	c. Date of Birth	d. Social Security Number
e. Street Address	f. City	g. State	h. Zip Code	
i. Occupation				

2. EMPLOYER (OWNER) INFORMATION

a. Full Legal Name				
b. Street Address	c. City	d. State	e. Zip Code	

3. NOTICE BY EMPLOYER (OWNER)

- a. Employer intends to apply for insurance on the life of the Employee (Proposed Insured).
- b. The maximum face amount the Employee (Proposed Insured) could be insured for at the time the contract is issued is \$ _____
- c. The Employer will be the Owner of any policy issued and a beneficiary of any proceeds payable upon the Employee's (Proposed Insured's) death.
- d. State and federal law may limit the right of an Employer to buy life insurance on employees and former employees. Employer certifies that it has independently determined that the purchase of life insurance covered by this form complies with applicable laws and regulations.

4. CONSENT OF EMPLOYEE (PROPOSED INSURED)

- a. I consent to being an insured under the life insurance policy for which my Employer intends to apply.
- b. I consent to my Employer continuing coverage, after my employment ends, under any policy issued.
- c. I understand that my Employer will own the policy. Unless provided in a separate agreement, my Employer will receive all of the death proceeds and my personal representative, next of kin, and heirs at law will have no beneficial interest in the policy or its death proceeds.

AGREEMENT AND AUTHORIZATION

This form is provided as a convenience to the employer and to obtain information that may be needed for information reporting services. By providing this form, the Company makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefits of certain employer-owned life insurance contracts will not be completely excluded from federal gross income of the employer unless notice-and-consent requirements and other requirements specified in the law are fulfilled.

The Genworth Financial companies and their representatives and distributors do not provide tax or legal advice. We did not create this form for use by any taxpayer to avoid any Internal Revenue Service penalty. You should ask your independent tax and legal advisors for advice based on your particular situation.

A photocopy of this form shall be as valid as the original.

Signature of Employee (Proposed Insured) _____
Date

Signature of Employer (Owner) _____
Date

Title



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

DISCLOSURE STATEMENT AGENT CERTIFICATION

Insured _____

I hereby certify that a completed Disclosure Statement (Form DISCLPA1) was given no later than the time the application was signed by the applicant.

Date

Agent Signature



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

SURRENDER COMPARISON INDEX DISCLOSURE AGENT CERTIFICATION

Insured _____

Policy Number _____

I hereby certify that the surrender comparison index was given upon delivery of the policy or earlier upon request of the applicant.

Date

Agent Signature



Disclosure Statement For Accelerated Death Benefit Rider

Genworth Life and Annuity Insurance Company
Home Office: P.O. Box 320
Lynchburg, Virginia 24505-0320

RIDER BENEFIT

This Rider provides for the early payment of part of the Policy's death benefit. We will make this accelerated death benefit payment to the Owner of the Policy upon receiving proof that the Insured's life expectancy does not exceed six months.

The Owner may make only one request for an accelerated payment. We must receive written approval from any irrevocable beneficiary, as well as the full release of any collateral assignment of the Policy, before making any payment.

There is no premium or cost of insurance charge for this Rider; however, an administrative fee is deducted before payment.

CONSEQUENCES OF RECEIVING ACCELERATED DEATH BENEFIT PAYMENT

An accelerated death benefit payment may be considered taxable income. A payment may also adversely affect the recipient's eligibility for Medicaid benefits or other state or federal government benefits or entitlements. The Owner should contact a qualified tax advisor and the appropriate government agencies before electing to receive a payment.

AMOUNT OF BENEFIT AVAILABLE

The Owner requests the amount of accelerated death benefit. Generally, the largest amount available is the benefit maximum minus the amount of outstanding policy loan. This benefit maximum is the lesser of (a) and (b) where (a) is the amount equal to the loan value of the Policy plus 75% of the difference between the death benefit of the Policy and the loan value and (b) is \$500,000. The benefit maximum can vary by state, however, and is defined by the Rider.

We will deduct an administrative fee from the accelerated death benefit prior to payment to the Owner.

EFFECT OF AN ACCELERATED DEATH BENEFIT PAYMENT

The accelerated death benefit will be treated as a lien against the death benefit of the Policy. This lien will limit the availability of any surrender benefit and of any future policy loans or partial withdrawals (surrenders) under the Policy.

We will charge interest on the lien. We will charge interest at the policy loan interest rate(s) stated in the Policy on the portion of the lien amount equal to the difference between the loan value and any outstanding policy loan. We will charge interest on the portion of the lien amount that exceeds this difference at a rate no greater than the greater of: (a) the current yield on a 90-day treasury bill; and (b) the current maximum adjustable policy loan interest rate allowed by law.

Policy and rider premiums will not be reduced after an accelerated death benefit payment and will remain payable.

No matter how long the Insured lives, the Policy will not terminate as a result of a payment unless the lien equals or exceeds the death benefit. The Owner may repay all or part of the lien at any time. Partial repayments are subject to the terms of the Rider.

ACKNOWLEDGEMENT

I acknowledge that: (a) I have received and read this Disclosure Statement, including the sample illustration on the back, and (b) I understand that only the actual provisions of the Rider will control payment of an accelerated death benefit.

Signature of (Proposed) Insured

Date

Signature of Owner (if different)

Date

Signature of Broker

Date

Below is a sample illustration of the effect of an accelerated death benefit payment. This illustration shows the effect on the death proceeds immediately after the accelerated death benefit payment has been made and 3 months after payment of the accelerated death benefit.

This sample illustration assumes: (1) \$400,000 death benefit; (2) \$100,000 loan value; (3) no policy loans; (4) the maximum accelerated death benefit is elected; (5) the policy loan interest rate is 6.00%; and (6) the lien interest rate is 8.00%.

Sample Illustration

Before Accelerated Death Benefit Payment:

Death Benefit	\$ 400,000
less: Loan Value	\$ 100,000
	\$ 300,000
	x 75%
	\$ 225,000
plus: Loan Value	\$ 100,000
	\$ 325,000
Maximum Accelerated Death Benefit Available	\$ 325,000
less: Administrative Fee	\$ 250
	\$ 324,750
Amount of Accelerated Death Benefit Payment	

Immediately After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	\$ 324,750
plus: Administrative Fee	\$ 250
	\$ 325,000
Lien Amount	
Death Benefit	\$ 400,000
less: Lien Amount	\$ 325,000
	\$ 75,000
Death Proceeds Payable at Insured's Death	

3 Months After Payment of Accelerated Death Benefit:

Amount of Accelerated Death Benefit Payment	\$ 324,750
plus: Administrative Fee	\$ 250
plus: Accrued Lien Interest (3 months)	\$ 5,838
	\$ 330,838
Lien Amount	
Death Benefit	\$ 400,000
less: Lien Amount	\$ 330,838
	\$ 69,162
Death Proceeds Payable at Insured's Death	



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



1035 Exchange Agreement

from Genworth Life and Annuity Insurance Company, Genworth Life Insurance Company and Genworth Life Insurance Company of New York†

Page 1 of 5

All 5 pages must be returned.

This Agreement is between the Company selected below and the Owner. The laws of the state in which the new policy is delivered govern this Agreement.

Policy information

The selected Genworth Financial company is referred to as “The Company,” “us,” and “we” in this Agreement.

Please provide the full name of the Insured and prospective Owner. Insured and/or Owner’s names must be the same for all Original Contracts and for the new policy. If the Insured or Owner’s name has changed since the Original Contract was issued, please attach an additional page with an explanation.

Please select the appropriate Genworth Financial Company.

- Genworth Life and Annuity Insurance Company
- Genworth Life Insurance Company
- Genworth Life Insurance Company of New York

Insured full name

•

Insured Social Security Number Date of birth *mm/dd/yyyy*

•

Owner name *If different from the Insured*

•

Owner Social Security/Tax ID Number

•

Original Contracts and Insurers *List each contract the Owner wishes to exchange*

Estimated surrender value is the value net of loans.

Service location refers to the city and state to which you send your premium payments.

Contract number	Original insurer <i>Exchanged carrier</i>	Lost contract?
•	•	<input type="radio"/> Yes <input type="radio"/> No
Estimated surrender value	Estimated loan amount	Transfer loan?
•	•	<input type="radio"/> Yes <input type="radio"/> No

Service location

•

Contract number	Original insurer <i>Exchanged carrier</i>	Lost contract?
•	•	<input type="radio"/> Yes <input type="radio"/> No
Estimated surrender value	Estimated loan amount	Transfer loan?
•	•	<input type="radio"/> Yes <input type="radio"/> No

Service location

•

Contract number	Original insurer <i>Exchanged carrier</i>	Lost contract?
•	•	<input type="radio"/> Yes <input type="radio"/> No
Estimated surrender value	Estimated loan amount	Transfer loan?
•	•	<input type="radio"/> Yes <input type="radio"/> No

Service location

•

The Owner wishes to secure reporting of the exchange of each Original Contract as a tax-free exchange described in Section 1035 of the Internal Revenue Code (IRC Section 1035).

Statement by Owner – Do not conserve Original Contracts

Do not attempt to conserve any Original Contract.

By selecting this option and signing this Agreement, the Owner specifically directs each Original Insurance Company not to attempt to conserve any Original Contract.



Conserve refers to when the Original Insurer tries to convince you to keep your Original Contract.

1035 Exchange Agreement

Page 2 of 5

Terms and conditions of all exchanges *Please review this document and sign on page 5*

By executing this Agreement, you:

The Owner is referred to as “you” in this Agreement.

- Represent that no Original Contract is subject to a prior assignment, bankruptcy proceedings, federal or state tax levy or other legal action;
- Specifically request that we participate in this Agreement and related transactions, and agree and understand that we have made no representations and have no responsibility or liability concerning the tax treatment of any Original Contract under IRC Section 1035, the tax reporting of the exchange transaction by any Original Insurer or any other tax matter related to this Agreement and related transactions.
- Assign and transfer, without limitation, all right, title, and interest in each Original Contract to us in exchange for a new policy. This assignment specifically includes and does not limit, the right to surrender and receive the surrender value for each Original Contract.

At the same time this Agreement is executed, you:

- Apply to us for a new life insurance policy with the same Insured as the Insured on each Original Contract;
- Designate us as the beneficiary of each Original Contract; and
- Agree to deliver to us each Original Contract not designated “Lost” in the Original Contracts and insurers section on page 1.
 - If an Original Contract is designated “Lost” in the Original Contracts and insurers section above, you certify that you are the sole Owner of the contract, have searched diligently for it, believe that it is lost beyond recovery, and agree to protect us from any claims that may arise from the contract and to forward it to us for cancellation if it is found.
- Agree to remain responsible for any premiums due under each Original Contract from the date of this Agreement until the date each Original Contract is surrendered.

We will not surrender any Original Contract and no insurance will be in effect with us if:

- We decline to issue a new policy (we will assign each Original Contract back to you).
- We are notified that the Insured has died.
- We do not receive the Surrender Requirements defined in this Agreement.

You understand and agree that:

Please refer to the **Coverage Start Date** section on page 3 for non-linked benefit products, and the **Start date of new policy** section on page 4 for linked benefit products.

- Once we mail or fax a surrender request to each Original Insurer, each Original Contract will no longer provide life insurance in the event of the Insured’s death and that if you return the new policy to us under the “free look” provision, we will pay you only the surrender value received from each Original Contract and that such return may have income-tax consequences for you.
- Interest does not accrue on surrender values from the date the Original Contract is surrendered to the date we credit the values to the new policy.
- When we return any surrender values to you or pay them to a beneficiary, we will report the return or payment to the Internal Revenue Service on Form 1099-R, as required by law. We will only return surrender values as stated in this Agreement.
- If after mailing or faxing a surrender request to the Original Insurer, we are notified that the surrender is ineffective because the death benefit of the Original Contract is payable or has been paid, no insurance will be in effect with us, except:
 - as may become effective because of surrender values received from other Original Contracts;
 - as stated in any Temporary Insurance Application and Agreement (TIAA) issued in connection with the application for the new policy.
- We have made no representations and have no responsibility or liability concerning:
 - tax treatment of any Original Contract under IRC Section 1035;
 - tax reporting of the exchange by any Original Insurer;
 - any other tax matter associated with this Agreement and related transactions.
- We are not responsible for the accuracy of the Original Contract’s cost basis provided to us by the Original Insurer or for any inaccurate tax reporting caused by receipt of incorrect cost basis.

Terms and conditions for exchange to a policy without linked-benefits

Except as stated in a TIAA issued in connection with the application for the new policy, if the total amount of the surrender value of all Original Contracts, reduced by the amount of any loans transferred, is not enough to keep the amount of insurance applied for in effect for the first policy month, coverage will not begin even if we have already mailed or faxed the surrender request to each Original Insurer.

In this situation, we will immediately mail notice to you. You will have 30 days from the date the notice was mailed to pay premium or make a loan repayment to us to make up the insufficiency. If we do not receive the additional funds by the end of the 30-day period, we will return any surrender value received to you, and we will have no further liability.

Surrender Requirements

We will mail or fax a surrender request for each Original Contract to each Original Insurer once all these conditions have been met:

- we approve your application for a new policy.
- we receive all requirements necessary to issue the new policy.
- for policies designated by us as those to be illustrated, we receive an illustration **signed** by you for the new policy at the approved premium class. A signed illustration is not needed if:
 - we approved your application at the standard no nicotine use premium class or better (less costly) no nicotine use premium class; or
 - we approved your application at the premium class you requested or at a better (less costly) premium class.
- for policies designated by us as not to be illustrated, we receive a projection **signed** by you for the new policy at the approved premium class.
- when our approval is at a premium class not requiring an illustration, we receive authorization to mail or fax the surrender request.
- the information in the application and the proposed insured's insurability, as determined by us, have not changed since the date of the application.

Coverage prior to delivery of the new policy

Please note the Coverage Start Date information, and contact your agent if you have any questions.

- **Coverage Start Date:** If a TIAA is issued, the Coverage Start Date is the date specified in the TIAA, and coverage is subject to the terms of the TIAA.
If a TIAA was not issued, coverage subject to the terms of the new policy starts when we mail or fax a surrender request to each Original Insurer provided that all Surrender Requirements are satisfied and surrender values reduced by the amount of indebtedness being transferred and sufficient to keep the insurance applied for in effect for the first policy month.
- **Coverage End Date:** If coverage starts prior to policy delivery it will end on the earliest of the following dates:
 - the date you refuse delivery of the new policy;
 - the last day of the delivery period, if all delivery requirements for the new policy are not satisfied by the end of the delivery period; or
 - if a TIAA was issued, the End Date specified in the TIAA.
- **Coverage Amount:** If a TIAA is issued, we will start coverage for the limited amount of insurance stated in the TIAA. If a TIAA is not issued, we will provide the amount of insurance applied for in the new policy.

Policy Date of the new policy

- **Policy Date of the new policy:** If a TIAA is issued, the Policy Date of the new policy will be the date specified in the TIAA. If a TIAA is not issued and the conditions specified in the Coverage Start Date section above are met, the Policy Date of the new policy will be the "Coverage Start Date."
- **Coverage Amount of new policy:** You may, based on the amount of surrender value received, request that the amount of insurance of the new policy be greater than the amount of insurance applied for. If we approve such a request, the Insured will be covered only for the original amount applied for from the Coverage Start Date to the date we approved the higher amount of insurance. However, the cost for the new policy will be determined as if the Insured had been covered for the new higher amount from the Coverage Start Date.

Terms and conditions for exchange to the linked-benefit policy combining life insurance and long-term care insurance under the initial-premium plan

In this linked-benefit policy, the surrender values of all of the Original Contracts become the Initial Premium of the linked-benefit policy, which in turn, determines the amount of insurance that can be issued. Therefore, we cannot issue a new linked-benefit policy and no coverage will take effect until we receive the surrender value from each Original Contract.

Surrender Requirements

- We will mail or fax a surrender request for each Original Contract to each Original Insurer once all these conditions have been met:
 - We approve your application for the linked-benefit policy.
 - We receive all underwriting requirements necessary to issue the new policy.
 - We receive an illustration **signed** by you for the new policy at the approved premium class and rider rate classification.
- A new illustration is not needed if both the premium classification for the life insurance portion and the rider rate classification of the long-term care portion are the same as applied for. If either or both are different from those applied for we must receive an illustration **signed** by you showing the approved classes before we will mail or fax the surrender request.

If the Insured dies before the linked-benefit policy is issued

- If the Insured dies after we request the surrender values but before we receive all surrender values, we will contact each Original Insurer to collect any death proceeds. We will pay those proceeds according to the beneficiary designations in effect under each Original Contract immediately prior to the Date of this Agreement.
- If an Original Insurer pays surrender values instead of death proceeds, we will apply the surrender values as an initial premium and provide the amount of life insurance benefit that could have been issued, had the Insured not died based on this initial premium. The amount of insurance will not exceed the maximum life insurance benefit as defined in the "Coverage Amount" section below. No long-term care insurance benefit will be provided.

The new linked-benefit policy

- **Coverage Amount:** The maximum life insurance benefit we will provide under any circumstance is the lesser of the following:
 - the amount calculated based on the life insurance and long-term care insurance benefits applied for and the premium class and rider risk classification approved by us; and
 - \$1,200,000.If the surrender values we receive would purchase a life insurance benefit greater than \$1,200,000, we will issue the policy at the maximum amount and refund any excess surrender values to you. After that, we have no further liability regarding the values returned.
- **Start date of new policy:** Coverage under the new policy will begin on its Date of Issue.
- **When there is no coverage:** We will not issue a new policy if:
 - we do not receive all expected surrender values within 180 days of the date we start the surrender process; or
 - the total surrender values received purchase a life insurance benefit less than \$25,000.

In either situation, we will return all surrender values received to you.

Additional terms and conditions if a policy exchange includes loan transfers

In a policy exchange, we will transfer a loan from an Original Contract to help you obtain favorable tax reporting from the Original Insurer. In this situation, we will issue a new life insurance policy subject to an indebtedness equal to the sum of the loan amounts transferred from each Original Contract. The Original Contract(s) will be the sole security for the loan.

You understand and acknowledge that:

Not all products can include a loan transfer. Please discuss this option with your licensed insurance agent to see whether this feature is available.

- This Agreement authorizes us to make any adjustments necessary to the policy's amount of insurance in order to assume the indebtedness (We reserve the right to require additional evidence of insurability if an adjustment results in an increase in the amount of insurance of the new policy).
- We may determine the plan of insurance for which we will issue a new policy subject to a loan.
- Your answering "Yes" to the Loan Transfer question and signing this Agreement does not require us to issue a new life insurance policy with a loan even though this Agreement states "Accepted by the selected Genworth Financial Company;"
- As of the Policy Date of the new policy, the new policy will have a loan equal to the sum of the loan amount transferred from each Original Contract.
- The benefits and values of the new policy will be reduced by the total loan transferred.

Required signatures

By signing, you are confirming that you have received, read and understand all five pages of this agreement.

Signature of Owner(s) Date mm/dd/yyyy
X .

Signature of Owner(s) Date mm/dd/yyyy
X .

Signature of irrevocable beneficiary *If applicable* Name of irrevocable beneficiary
X .

Witness to sign here. Signature of witness
X .

Signature of spouse *If Owner is a resident of a community property state*
X .

Printed Name of the Insured
 .

Accepted by the selected Genworth Financial Company

Mailing instructions

Send all pages of the completed form with all Original Contracts to:

Genworth Life & Annuity
 Attn: New Business
 P.O. Box 461
 Lynchburg, VA 24505-0461

Genworth Life of New York
 Attn: New Business
 P.O. Box 10717
 Lynchburg, VA 24506-0717

Genworth Life
 Attn: New Business
 P.O. Box 461
 Lynchburg, VA 24506-0461

For Express Mail only:
 Genworth Financial
 Attn: New Business
 3100 Albert Lankford Drive
 Lynchburg, VA 24501



SUPPLEMENT TO LIFE APPLICATION PART I – ADDITIONAL INSURABLE INTEREST QUESTIONS

Select one: Genworth Life Insurance Company Genworth Life and Annuity Insurance Company

Proposed Insured:

Full name (first, middle, last, suffix or maiden)	Social Security Number	Date of Birth (MM/DD/CCYY)
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1. Will or has the Proposed Insured, Owner, and/or any other person:
 - a. Receive(d) a cash advance or other inducement, such as "free insurance", in connection with this application for life insurance? Yes No
If "Yes", provide details in #4 below.
 - b. Borrow(ed) money to pay premiums for this policy? Yes No
If "Yes", provide details in #4 below.
 - c. Enter(ed) into a finance agreement that entitles a lender or investor to a portion of the death benefit above and beyond the repayment of principal and interest on the loan? Yes No
If yes, please provide a copy of the finance agreement.
2. Will the Proposed Insured and/or Owner transfer the policy for value? Yes No
If "Yes", provide details in #4 below.
3. If the policy is issued, does the Owner intend to transfer it by gift or otherwise? Yes No
If "Yes", provide details in #4 below.
4. Detail Section for "Yes" answers to questions above:

Representations

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 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 insurance 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
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Signature of Owner (if other than Proposed Insured)	Date
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