Privileged Choice® **Flex** Application and Forms

Company Submission Materials Enclosed

Complete and return the following forms to Genworth Life Insurance Company:

- ☐ Coverage Selection for Privileged Choice Flex
- ☐ Payment Authorization (If Required)
- ☐ Application for Insurance
- ☐ Health Information Authorization (HIPAA Form)
- ☐ Notice and Consent for Testing
- ☐ Long Term Care Insurance Personal Worksheet
- ☐ Verification of Financial Non-Disclosure
- ☐ Potential Rate Increase Disclosure
- ☐ Couples Benefits Form (If Required)
- ☐ Replacement Notice (If Required)
- ☐ Authorization for Use or Disclosure of Patient Health Information

Genworth®

Underwritten by Genworth Life Insurance Company, Richmond, VA

115971MOD-C CAP 07/15/13

CALIFORNIA PARTNERSHIP FOR
LONG-TERM CARE

What Happens When Long-Term Care Costs Rise?

A Comparison of Costs and Benefit Amounts

2013

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

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

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

If a 55 year old purchases a policy in the year 2013 that provides $240 worth of daily benefits, the policy's benefits will cover a full days worth of care in a nursing home at the time of purchase.[2] As shown in **Chart 1**, care that costs $240 per day in the year 2013 is likely to cost $663 per day in twenty years. Without inflation protection, the $240 per day policy purchased today will still only pay $240 when the policyholder reaches age 75. That benefit amount will cover just over a third of the projected cost of care. The $423 difference between the value of the policy and the projected cost of care would have to be paid by the policyholder.

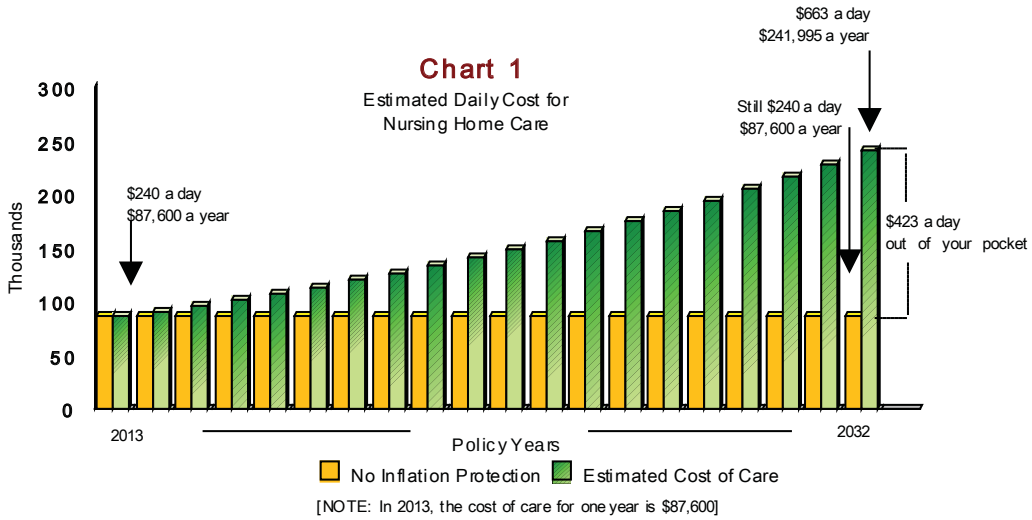
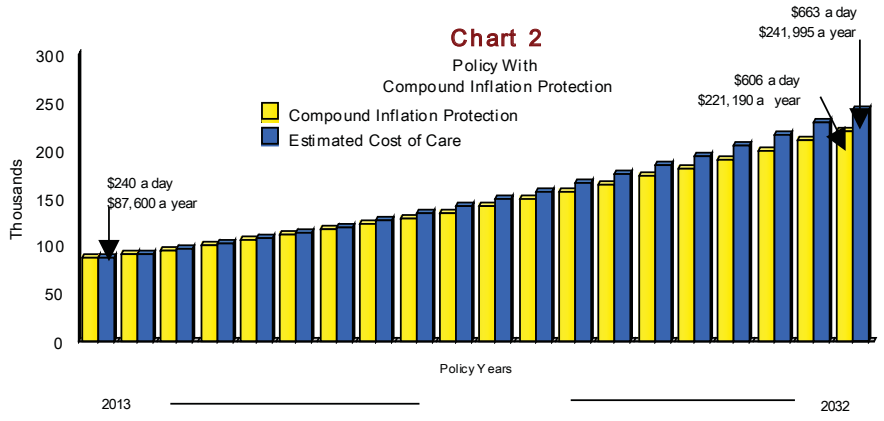


Chart 2 compares the anticipated increase in the cost for one day of nursing home care over the next twenty years with a long-term care policy that has a 5% compounded annual inflation protection benefit. The benefits of a policy that pays $240 in the year 2013 will grow by 5% each year. In twenty years, the policy will provide $606 in daily benefits. The actual cost for the care may be more or less than this projection, but **Chart 2** shows that a policy with inflation protection does much better at keeping up with the expected cost of care.

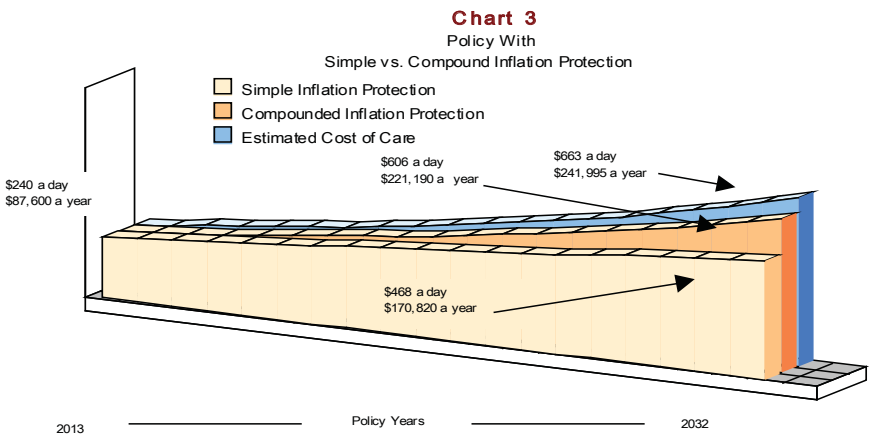


[NOTE: In 2013, the cost of care for one year is $87,600]

There are two types of inflation protection, Simple or Compounded:

Compounded increases: The policy daily benefits will grow by 5% compounded each year as described above. For example, an initial daily benefit of $240 will be worth $606 twenty years later. **Simple increases:** The policy daily benefits will grow by a fixed dollar amount each year. The amount of increase is equal to 5% of the policy's original daily benefit amount. For example, an initial benefit of $240 per day will be worth $468 twenty years later.

Chart 3 below compares how well these two types of inflation protection keep up with the expected future increases in the cost of one day and one year of nursing home care.



[NOTE: In 2013, the cost of care for one day is $240]

You should know that, if you are younger than 70 years of age, you automatically have 5% yearly compounded inflation protection with a Partnership policy.

If you are 70 years or older, you have a choice between the two types of inflation protection with a Partnership policy.

[1] No one can precisely predict future increases in the cost of care. This graph is based on an expected 5.5% annual increase in nursing home private pay rates.

[2] This estimate of the cost for one day of nursing home care is based on the California statewide average daily nursing home rate. Actual rates vary in different regions of the state.

IMPORTANT INSTRUCTIONS FOR AGENTS/PRODUCERS

Prior to soliciting new business, verify that your producer license is in good standing, you have completed all required CE, and you are in compliance with all applicable licensure requirements. Applications will be returned if all such requirements have not been met as of the date of the Application.

To avoid delays in processing your new business submission, carefully follow the instructions below.

1 Review Section A, Insurability Profile, with the Applicant(s). The Applicant(s) may be uninsurable if:
The Applicant(s) answers "Yes" to any question in this section; or
The Applicant(s) falls over or under the build limits.
You may want to contact the Pre-qualification hotline at 800 354.689 before submitting an Application.

2 Complete the entire Application to avoid returned Applications and processing delays. Do NOT use correction fluid. Corrections should be crossed out and initialed by the Applicant(s). Ensure all handwriting is legible.

3 The fully completed Application must be received at Genworth Life's Administrative Office within 30 days of the date the Application is signed by the Applicant(s).

4 If an initial premium check payment is being collected with the Application, please be sure to complete the Premium Receipt page in the Applicant Materials Booklet. An initial premium (one month; 9% of the annual premium) must be submitted per Applicant in order to be eligible for the Conditional Insurance Agreement (CIA). If using Electronic Funds Transfer (EFT) or Credit Card payments, be sure to complete the Payment Authorization form. If you have questions, call 800 309.0047.

5 Review and/or complete the forms in the Applicant Materials Booklet and leave it with the Applicant(s).

6 Confirm that the Application and all required forms have been signed where required and dated in all appropriate sections.

7 Prepare the Applicant(s) for the next steps.

MINIMUM UNDERWRITING REQUIREMENTS

Check the Applicant's height and weight to see if they meet basic eligibility requirements using the Build Tables provided in:

- Long Term Care Insurance Underwriting Guides

Provide Applicants with the "What to Expect Next" Brochure, which explains the health interviews and other medical requirements that may be needed to process the Application. Let the Applicant(s) know that all costs associated with the interviews are paid for by Genworth.

APPLICATION SUBMISSION CHECKLIST

Use this checklist to help ensure that you send in all necessary information.

- ◯ Fully completed Application and all required forms in the "Application and Forms" Company submission booklet.
- ◯ Check to be sure all signatures and dates are complete.
- ◯ If using Electronic Funds Transfer (EFT) for monthly premium deductions or initial Credit Card payments, be sure to complete and include the Payment Authorization Form.
- ◯ Include any optional forms needed (e.g., Requirements to Access Couples Benefits, replacement form or any state required forms).
- ◯ Health Information Authorization (HIPAA)
- ◯ Notice and Consent for Testing
- ◯ Suitability form (Long Term Care Insurance Personal Worksheet)
- ◯ Potential Rate Increase Disclosure Notice

Submit the entire completed Application and Forms Booklet (with any collected premium payment) to:

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

Provide the Applicant(s) with the Applicant Materials Booklet, which includes the Applicant's copies of any state required forms, as well as the Outline of Coverage.

IMPORTANT NOTES

- Certain eligibility requirements must be met to qualify for couples discounts. Couples Discounts may vary-see State Differences Matrix for discounts by state.
- In addition to married couples, Applicants who are not married but meet certain criteria may be eligible to apply for the Shared Benefit Rider or to receive a Couples Discount. Please refer to the "Requirements to Access Special (Couples) Benefits" form for an explanation of the state criteria and instructions on how to access these couples' benefits.
- When qualifying for CIA - If a request for Shared Benefits is made and we approve the Application, we will provide coverage under the policy for which the Application was made as of the latest date upon which the Application for Individual Long Term Care Insurance was signed by the Applicant or his/her Spouse or Partner.
- The Family History section of the Application for Insurance must be fully completed. Applications that omit Family History Information will be considered Not In Good Order (NIGO) and will be returned for completion prior to Underwriting Review.

Genworth

Administrative offices:
Genworth Life Insurance Company
3100 Albert Lankford Drive
Lynchburg, VA 24501

Coverage Selection for California Partnership Long Term Care Insurance

Coverage is intended to be federally tax-qualified long term care insurance within the context of Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191).

An Approved Participant In
CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

Applicant A *Print name*

.

Applicant B *Print name*

.

Coverage Selection

	Applicant A	Applicant B
Shared Coverage Benefit	◯ Yes ◯ No If Shared Coverage Benefit is chosen, both applicants must make identical selections below.	
Benefit Multiplier Months/Days Choose a Monthly or Daily benefit multiplier.	◯ 120/3650 ◯ 60/1825 ◯ 24/730 ◯ 96/2920 ◯ 48/1460 ◯ 12/365 ◯ 72/2190 ◯ 36/1095	◯ 120/3650 ◯ 60/1825 ◯ 24/730 ◯ 96/2920 ◯ 48/1460 ◯ 12/365 ◯ 72/2190 ◯ 36/1095
Monthly/Daily Maximum	$ ◯ Per Day ◯ Per Month	$ ◯ Per Day ◯ Per Month
	Choose a Daily or Monthly Maximum that meets the current CA Partnership Minimum but does not exceed $400 per day or $12,000 per month. Daily values are available in increments of $10 and monthly values are available in increments of $100.	
Elimination Period	◯ 30 days ◯ 90 days 90-Day Elimination Period not available with 12/365 Benefit Multiplier	◯ 30 days ◯ 90 days
Elimination Period Type	◯ Service days* ◯ Calendar days * Service days are days of Covered Care	◯ Service days* ◯ Calendar days
Waive Home and Community Care Elimination Period	◯ Yes ◯ No	◯ Yes ◯ No
Residential Care Facility Percentage of Monthly/Daily Maximum	◯ 100% ◯ 70%	◯ 100% ◯ 70%
Home and Community Care Percentage of monthly maximum	◯ 100% ◯ 50% Percentages based on the Monthly Maximum (or 30 times the Daily Maximum if a Daily Maximum is chosen)	◯ 100% ◯ 50%
Inflation protection / benefit increases Benefit increases not reduced by claims	Inflation Protection ◯ 5% Compound Mandatory unless 5% Simple applies. ◯ 5% Simple Must be age 70 or older and sign below. I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of a policy with and without inflation protection. Specifically, I have reviewed plans with 5% compound inflation protection and 5% simple inflation protection. I reject compound inflation protection and select equal inflation protection. Signature of Applicant A (Only when 5% Simple chosen) **X**	Inflation Protection ◯ 5% Compound Mandatory unless 5% Simple applies. ◯ 5% Simple Must be age 70 or older and sign below. I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of a policy with and without inflation protection. Specifically, I have reviewed plans with 5% compound inflation protection and 5% simple inflation protection. I reject compound inflation protection and select equal inflation protection. Signature of Applicant B (Only when 5% Simple chosen) **X**

Applicant A *Print name*

.

Applicant B *Print name*

.

Other choices

Transition Benefit

◯ Yes ◯ No ◯ Yes ◯ No

Transition Benefit not available with Waiver of Home and Community Care Elimination Period

Nonforfeiture Benefit

◯ Yes (Accept) ◯ No (Decline) ◯ Yes (Accept) ◯ No (Decline)

Discounts

Eligible for Couples Discount

Criteria must be met.
See "Application Instructions."

The second applicant on this form or the individual designated here will be the named individual for any Couples Discount or Shared Coverage Benefit, as applicable.

◯ Yes ◯ No

If YES and second applicant is applying on this application, no further information is needed.
If second applicant is not applying on this application, please provide the following.

Print spouse/partner name

.

Social Security Number

.

Existing coverage number

.

Modal Premium Disclosure

Although premiums are calculated on an annual basis, premiums may be shown on a monthly, quarterly or semi-annual basis. Annual premiums may be paid in advance at the beginning of each coverage year. However, your premiums may be paid on a more frequent basis throughout your coverage year. If you pay your premiums more frequently than annually (e.g., monthly, quarterly or semi-annually), there will be additional charges that apply. The more frequent the premium payment mode, the more charges you will incur. Please refer to the Modal Premium Disclosure in your policy.

Applicant A *Print name*

.

Applicant B *Print name*

.

Premium information

Full modal premium

$

Premium Payment mode

◯ Annual (1.0)
◯ Semi-annual (.51)
◯ Quarterly (.26)
◯ Monthly* (.09)

Full modal premium

$

Premium Payment mode

◯ Annual (1.0)
◯ Semi-annual (.51)
◯ Quarterly (.26)
◯ Monthly* (.09)

* Automatic draft of checking account required. Must complete Payment Authorization Form.

Request for an Effective Date later than the Date of Application: I hereby request that, if my application is approved, no insurance will take effect until the date set by the Company following its approval of my application. I understand that the Company's underwriting decision will consider any changes in my health status that take place after the Date of Application and that the Initial Premium will be applied as of the Effective Date set by the Company.

Signature of Applicant A

X

Signature of Applicant B

X

List bill

List bill ◯ Yes ◯ No

List bill number

.

List bill ◯ Yes ◯ No

List bill number

.

For Agent use only

Agent name

.

Agent producer code

.

State in which application is signed

.

App. folder No.

. 91005

Payment Authorization

Genworth® Financial

Genworth Life Insurance Company
Administrative Office
3100 Albert Lankford Dr.
Lynchburg, Virginia 24501-4948

Applicant A *Print name*

Applicant B *Print name*

Initial premium

Complete only if paying initial premium by EFT or Credit Card

$ $

Amount of initial premium should match full modal premium in application. For CIA, three months minimum required. Only one month is allowed in CA and in NH for applicants over age 65.

Select electronic funds transfer or credit card

For any initial premium payments, Your Bank or Credit Card Account will be charged for the requested amount promptly after receiving authorization.

◯ **Electronic Funds Transfer (EFT)**
- ◯ Initial payment
- ◯ Renewal payment only
- ◯ Initial & renewal payments

◯ Use same bank information for both applicants (optional)

Bank Name	Bank Name
Bank Account #	Bank Account #
Bank Routing #	Bank Routing #
Account Holder Name (if different from Applicant)	Account Holder Name (if different from Applicant)

◯ **Credit Card**
(Available for initial payment only)

Credit card payment NOT available in the following application states: AK, CA, MD, NJ, NY, NC and PA.

◯ Use same credit card for both applicants (optional)

◯ Visa ◯ MasterCard	◯ Visa ◯ MasterCard
Card Number	Card Number
Exp (mm/yy)	Exp (mm/yy)
Cardholder Name (if different from Applicant)	Cardholder Name (if different from Applicant)

Billing information

Complete only if Account/ Cardholder is not an Applicant

Account/Cardholder Name *Print*

Address	City
State	Zip

Terms and conditions

I authorize Genworth Life Insurance Company to collect the initial and/or recurring premiums as stated in this form from the Bank or Credit Card Account described in this form. I understand and agree that this Authorization is subject to the following conditions:

- This Authorization form must be completed in its entirety in order to be valid.
- Signing this Authorization does not mean that coverage is effective. Coverage is effective only as specified in the application or in the Conditional Insurance Agreement (CIA).
- Payment by EFT or Credit Card does not alter any contract issued by the Company.
- Any refund for coverage not taken or declinations will be made directly via check, not as a credit to the Bank or Credit Card Account. Otherwise, refunds will be applied in accordance with applicable laws.
- If the EFT or Credit Charge request is not honored, no further attempt to use the EFT or Credit Card to collect the premium will be made and Conditional Insurance Agreement (CIA) will not apply.
- Any refund of the premium will NOT include reimbursements for interest, fees or other obligations that the Financial Institution Credit Card company may impose.

Signatures

Applicant A Signature

X .....

Date (mm/dd/yyyy)

. .....

Account/Cardholder Signature
(if not an Applicant)

X .....

Date (mm/dd/yyyy)

. .....

Applicant B Signature

X .....

Date (mm/dd/yyyy)

. .....

Account/Cardholder Signature
(if not an Applicant)

X .....

Date (mm/dd/yyyy)

. .....

APPLICATION FOR INSURANCE

Genworth Life Insurance Company
Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits.

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CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

The benefits payable by this policy qualify for Medi-Cal Asset Protection under the California Partnership for Long Term Care. Eligibility for Medi-Cal is not automatic. If and when you need Medi-Cal, you must apply and meet the asset standards in effect at that time. Upon becoming a Medi-Cal beneficiary, you will be eligible for all medically necessary benefits Medi-Cal provides at that time, but you may need to apply a portion of your income toward the cost of your care. Medi-Cal services may be different than the services received under the private insurance.

A. INSURABILITY PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
○	○	**1**. Are you covered by Medi-Cal (not the same as Medicare)?	○	○

2A. Do you use or need assistance or supervision by another person in using or performing any of the following:

A		B
○	Walker	○
○	Hospital Bed	○
○	Kidney Dialysis	○
○	Dressing	○
○	Bowel/Bladder control	○

A		B
○	Wheelchair	○
○	Oxygen	○
○	Moving in/out of bed or chair	○
○	Eating	○
○	Walking	○

A		B
○	Quad Cane	○
○	Respirator	○
○	Bathing	○
○	Toileting	○

B. Have you been advised to:

A		B
○	Receive home care	○
○	Enter a residential care facility	○

A		B
○	Use an adult day care facility	○
○	Enter any other long term care facility	○

A		B
○	Enter a nursing home	○

3. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following:

A		B
○	ALS (Lou Gehrig's disease)	○
○	Alzheimer's Disease	○
	Congestive Heart Failure (CHF) *in combination* with any of the following:	
○	Heart Attack	○
○	Angina	○
○	Emphysema/Chronic Obstructive Pulmonary Disease (COPD)	○
○	Angioplasty	○
○	Heart Surgery	○
○	Asthma	○
○	Chronic Bronchitis	○

A		B
○	Cirrhosis of the Liver	○
○	Cystic Fibrosis	○
○	Dementia	○
○	Diabetes under treatment with Insulin	○
	Diabetes with a history of:	
○	TIA,	○
○	Heart Disease, or	○
○	Circulatory/Vascular Disease	○
○	Frequent or persistent forgetfulness or memory loss	○
○	Huntington's Chorea	○
○	Metastatic Cancer (spread from original site/location)	○

A		B
○	Multiple Sclerosis (MS)	○
○	Muscular Dystrophy	○
○	Organic Brain Syndrome	○
○	Parkinson's Disease	○
○	Senility	○
○	Stroke	○
○	Transient Ischemic Attack (TIA) within the past 5 years	○
	TIA *in combination* with:	
○	Diabetes or	○
○	Heart Surgery	○
○	TIA two or more times	○

4. In the past 4 years have you had Cancer of the:

A		B
○	Bone	○
○	Liver	○
○	Pancreas	○

A		B
○	Brain	○
○	Lung	○
○	Stomach	○

○	○	**5**. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○	○

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

Print Name of Applicant A _____ Print Name of Applicant B _____

B. PERSONAL PROFILE

Print Clearly - Use black ink.

Applicant A

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title: _____

Name _____
(As it should appear on your policy)

○ Married ○ Single ○ Widowed

Social Security Number _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone ( ) _____

Evening Phone ( ) _____

Best time to call _____ ○ a.m. ○ p.m.

Email Address _____

Applicant B

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title: _____

Name _____
(As it should appear on your policy)

○ Married ○ Single ○ Widowed

Social Security Number _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone ( ) _____

Evening Phone ( ) _____

Best time to call _____ ○ a.m. ○ p.m.

Email Address _____

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

City _____ State _____ Zip _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

C. MEDICAL PROFILE

6. In the past 5 years (10 years for cancer) have you: received medical advice or treatment; been medically diagnosed; or consulted with a health professional for any of the following conditions?
If 'YES,' please check appropriate circles for ***each applicant (A and B)*** and explain under the DETAILS section.

Applicant **A** YES	Applicant **A** NO		Applicant **B** YES	Applicant **B** NO
○	○		○	○

A		B
○	Alcoholism	○
○	Amputation	○
○	Angioplasty or	○
○	Heart Surgery	○
○	Asthma or	○
○	Chronic Bronchitis	○
○	Brain Disorder	○
○	Cancer (excl. Basal Cell of the Skin)	○
○	Carotid or other	○
○	Arterial Surgery	○
○	Congestive Heart Failure	○
○	CREST Syndrome	○
○	Depression	○
○	Diabetes not treated with Insulin	○
○	Disabling Back or Spine Condition	○
○	Drug Addiction	○
○	Emphysema/COPD	○

A		B
○	Epilepsy,	○
○	Seizures, or	○
○	Convulsions	○
○	Fainting Spells or Blacking Out	○
○	Fibromyalgia	○
○	Heart Attack,	○
○	Angina or	○
○	Atrial Fibrillation	○
○	Hodgkin's Disease	○
○	Immune System Disorders (excluding Human Immunodeficiency Virus (HIV) infection)	○
○	Injury due to Falls or Imbalance	○
○	Joint Replacement Surgery	○
○	Kidney Failure	○
○	Leukemia	○
○	Lupus	○

A		B
○	Mental Illness	○
○	Mental Retardation	○
○	Multiple Myeloma	○
○	Myasthenia Gravis	○
○	Organ Transplant	○
○	Osteoporosis	○
○	Post-Polio Syndrome	○
○	Paralysis	○
○	Rheumatoid Arthritis	○
○	Scleroderma	○
○	Skin Ulcers	○
○	Tremor	○
○	Other Conditions Causing Crippling or Limited Motion, or Requiring Adaptive Devices	○

Print Name of Applicant A _____ Print Name of Applicant B _____

If you need more space to answer the following questions, please use the DETAILS *section.*

Applicant **A** YES NO

7. Within the past 5 years, have you:

A. Smoked or used other tobacco products? Applicant **B** YES NO

B. Required assistance with:

A		B
○	Managing medications	○
○	Housekeeping/cooking	○

A		B
○	Shopping	○

A		B
○	Using transportation	○

C. Within the past 5 years, have you:

A		B
○	Received home health care	○

A		B
○	Used an adult day care facility	○

A		B
○	Been confined to a nursing home, residential care facility, or other long term care facility	○

D. Been medically advised to have surgery which has not been performed?

If YES, please provide the following information:

Applicant A	Applicant B	Date	Surgery Type	Name, address and phone number of advising physician.
○	○	_____	_____	_____
○	○	_____	_____	_____

E. Received Social Security Disability Insurance benefits?

F. Taken any prescription medications for:

A		B
○	High Blood Pressure	○

A		B
○	Any form of Arthritis	○

If YES, list each medication *and name of the prescribing physician:*

Applicant A	Applicant B	Medication	Name, address and phone number of prescribing physician.
○	○	_____	_____
○	○	_____	_____
○	○	_____	_____
○	○	_____	_____

8. Within the past 2 years, have you:

A. Received Disability Income, Worker's Compensation, or any state disability benefit?

B. Had another Long Term Care insurance application denied by us?

Print Name of Applicant A _____ Print Name of Applicant B _____

Applicant **A** YES NO ○ ○ Applicant **B** YES NO ○ ○

9. Within the past 3 years have you:

A. Taken *any* prescription medications (not previously listed in this application)?
If YES, list each medication *and the name of the prescribing physician:*

Applicant A	Applicant B	Medication	Name, address and phone number of prescribing physician.
○	○		
○	○		
○	○		
○	○		
○	○		

○ ○ B. Been medically advised to enter or been confined to a hospital or other health care facility? ○ ○
If YES, please provide the following information:

Applicant A	Applicant B	Date	Facility	Name, address and phone number of advising physician.
○	○			
○	○			
○	○			

10A. Who is your primary care physician with most of your medical records?

Applicant **A**

_____
Doctor's Name

_____
Address

_____
City, State, Zip

( ) _____ | _____
Phone No. | Date last seen (Mo/Day/Yr)

Applicant **B**

_____
Doctor's Name

_____
Address

_____
City, State, Zip

( ) _____ | _____
Phone No. | Date last seen (Mo/Day/Yr)

○ ○ B. Within the past 3 years have you consulted with or been treated by a licensed health care provider, ○ ○
other than your primary care doctor for any reason excluding eye doctors, podiatrists, and dentists?
If YES, please complete the following.

Applicant A	Applicant B	Physician's Name	City, State	Specialty
○	○			
○	○			
○	○			
○	○			

If you need more room to write, please provide details in Section D, Details.

Print Name of Applicant A _____ Print Name of Applicant B _____

D. DETAILS

Please provide the question number for the details being provided. Include name, address and phone # of Health Care Professional/ Facility and name of medication prescribed (if any).

Applicant A		**Applicant B**	
Ques.#		Ques.#	

Print Name of Applicant A _____ Print Name of Applicant B _____

E. FAMILY HISTORY PROFILE

Applicant A YES	Applicant A NO	Applicant A UNKNOWN		Applicant B YES	Applicant B NO	Applicant B UNKNOWN
○	○	○	**11**A. Is your mother living?	○	○	○
	_____		B. What is your mother's current age, or her age at death?		_____	
			C. Did/Does your mother have any of the following illnesses?			
○	○	○	• Diabetes	○	○	○
○	○	○	• Coronary Artery Disease or any other form of Vascular Disease	○	○	○
○	○	○	• Alzheimer's or any other form of Dementia	○	○	○
○	○	○	**12**A. Is your father living?	○	○	○
	_____		B. What is your father's current age, or his age at death?		_____	
			C. Did/Does your father have any of the following illnesses?			
○	○	○	• Diabetes	○	○	○
○	○	○	• Coronary Artery Disease or any other form of Vascular Disease	○	○	○
○	○	○	• Alzheimer's or any other form of Dementia	○	○	○

F. CLIENT PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
○	○	**13**A. Do you work 20 or more hours a week outside your home? *If YES*, list occupation. Applicant A: Occupation: _____ Applicant B: Occupation: _____	○	○
○	○	B. Do you perform volunteer work? *If YES*, list type of work and list hours worked per week. Applicant A: Type of work: _____ ____hrs/week Applicant B: Type of work: _____ ____hrs/week	○	○
○	○	C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? *If YES*, please describe. Applicant A: Activities: _____ Applicant B: Activities: _____	○	○
○	○	**14**. Do you drive an automobile? *If YES*, provide approximate annual mileage: Applicant A: Mileage: _____ Applicant B: Mileage: _____	○	○
○	○	**15**. Do you live in some form of a residential retirement community? *If YES*, list the specific services that are received (e.g., housekeeping, laundry, meals): Applicant A: Services: _____ Applicant B: Services: _____	○	○

Print Name of Applicant A _____ Print Name of Applicant B _____

G. OTHER COVERAGE AND REPLACEMENT

Applicant **A** YES ○ NO ○ | Applicant **B** YES ○ NO ○

16A. Do you have any accident and sickness or Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate (including health care service contract, health maintenance organization contract, or life insurance with Long Term Care coverage) in force or applied for?
If YES, provide DETAILS below.

Applicant A
Company: _____
Long Term Care? ○ No ○ Yes Daily Benefit: $_____

Applicant B
Company: _____
Long Term Care? ○ No ○ Yes Daily Benefit: $_____

B. If you have Long Term Care Insurance coverage with us, please list policy/certificate number(s):

Applicant A
Policy/certificate number(s): _____

Applicant B
Policy/certificate number(s): _____

C. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy/certificate in force during the last 12 months?
If YES, with which company?

Applicant A
Company: _____

Applicant B
Company: _____

If that insurance lapsed, when did it lapse?

Applicant A
Lapse Date: _____

Applicant B
Lapse Date: _____

D. Do you intend to replace ***any*** of your long term care, medical, or health insurance coverage with this policy?
If YES, name company being replaced:
Note: Under the rules of the California Partnership for Long-Term Care, you may have only one Partnership eligible policy in force.

Applicant A
Company: _____

Applicant B
Company: _____

Agent: *If YES*, be sure to fill out the Replacement Notice. Leave one copy with applicant; send one copy with application.

H. PROTECTION AGAINST UNINTENTIONAL LAPSE

*One of the circles **must be** checked.*

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A (Use for Individual and Shared Applications)

○ I elect NOT to designate any person to receive such notice.

○ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

If selecting this option, we recommend designating someone other than a spouse or agent.

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title:

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Relationship _____

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

Applicant B (Complete whenever there is a second applicant)

○ Same as applicant A.

○ I elect NOT to designate any person to receive such notice.

○ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

If selecting this option, we recommend designating someone other than a spouse or agent.

○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Other Title:

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Relationship _____

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

Print Name of Applicant A _____ Print Name of Applicant B _____

I. DECLARATIONS

No agent is authorized to: change, waive, or alter the terms and conditions of this application; accept risks; pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

AUTHORIZATION: I authorize Genworth Life Insurance Company, its insurance support organizations (such as EMSI), affiliates, and any reinsurers, to obtain information as to the diagnosis, treatment or prognosis of my physical and mental condition, other coverage and any other information needed to evaluate my application for insurance. Upon presentation of this authorization, or copy of it, they may obtain such information or records thereof from any physician, health professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, or insurance support organization which has such information. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This authorization includes information about drugs, alcoholism, and mental illness. I understand and agree that the Company or its representatives may conduct a phone or in-person interview as part of the underwriting process. I agree that this authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

AGREEMENT: I agree that:

1) the answers contained herein are full, complete and true to the best of my knowledge and belief; and
2) this application will be part of the insurance policy for which I am applying; and
3) if I qualify, and an Initial Premium is paid, the policy will take effect on the date I sign the application, or on a date set by the Company if I request a later policy effective date.

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long term care insurance policy to the State of California for the purpose of documenting my Medi-Cal asset disregard under the Medi-Cal program, evaluating the California Partnership for Long-Term Care, and meeting Department of Health Care Services or Department of Insurance audit or quality control requirements. As part of the evaluation of the California Partnership for Long-Term Care, the State is trying to determine how well this program is reaching people with varying amounts of income and assets. You will therefore be asked to fill out a brief survey, prepared by the State, and indicate what range your income and assets fall into. I understand that the information contained in these records will be used for no purpose other than stated above, and will be kept strictly confidential by the State of California.

X _____ _____ X _____ _____

Signature of Applicant **A** | Date Signed | Signature of Applicant **B** | Date Signed

NOTICE TO APPLICANT REGARDING MEDI-CAL ELIGIBILITY

I understand that eligibility for Medi-Cal is not automatic; an application is necessary. Once my long term care insurance begins paying benefits, the insurer will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any other asset exemptions available to a Californian applying for Medi-Cal. I understand that should I want to apply for Medi-Cal it is my responsibility to complete the application process. I further understand that before receiving Medi-Cal I will first have to use any additional assets I have not protected. If I become a Medi-Cal beneficiary, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medi-Cal services at that time may not be the same services I was receiving under my private long term care insurance. Note: The Medi-Cal program does not include a residential care facility benefit. Medi-Cal will not pay for any continuing care which may be required if the total benefits of private long term care insurance are exhausted while residing in a residential care facility.

X _____ _____ X _____ _____

Signature of Applicant **A** | Date Signed | Signature of Applicant **B** | Date Signed

REQUEST FOR A LATER POLICY EFFECTIVE DATE:

*Check circle **only** to request your policy become effective at a date later than the date you sign this application.*

INDIVIDUAL PLANS:	○* Applicant **A**	○* Applicant **B**
SHARED PLANS:	○*	

* By checking this circle I acknowledge that, if my application is approved, the effective date of my coverage will be a later date to be set by the Company. I understand that the Company will consider any changes to my health *after* the Date of this Application in their underwriting decision, and that the Initial Premium will begin as of the Effective Date set by the Company.

CAUTION: If your answers on this application are misstated or untrue, Genworth Life Insurance Company may have the right to deny benefits or rescind your insurance.

X _____ Signature of Applicant **A**	X _____ Signature of Applicant **B**	X _____ Signature of Licensed and Appointed Insurance Producer/Agent/Representative
Date Signed	Date Signed	

Print Name of Applicant A _____ Print Name of Applicant B _____

CHECKLIST: (Check the appropriate boxes below for items received at the time of application.)

☐ The Privacy Notice which I have read.

☐ Before You Buy a complete description of the California Partnership For Long-Term Care as prepared by the Department of Health Care Services, including an explanation of how Medi-Cal Asset Protection is achieved.

☐ Taking Care of Tomorrow - A Consumer's Guide to Long Term Care prepared by the California Department of Aging.

☐ The notice entitled "Things You Should Know Before You Buy Long Term Care Insurance".

☐ A Long Term Care Insurance Personal Worksheet for completion and to return to the insurer.

☐ Information on the State of California Health Insurance Counseling and Advocacy Program (HICAP) and the name, address and telephone number of the local HICAP Program and the statewide HICAP number, 1-800-434-0222.

☐ The Outline of Coverage which includes graphic comparisons showing the projected increase in the cost of nursing facility care over a twenty (20) year period between a policy or certificate that does not increase benefits and: (1) a policy or certificate that increases benefits, but not premiums over the policy or certificate period; and (2) a policy or certificate that increases premiums and benefits over the policy or certificate period.

☐ A copy of What Happens When Long-Term Care Costs Rise?

☐ I read and signed the Consent and Authorization to Release Information and the Notice to Applicant Regarding Medi-Cal Eligibility.

☐ A Shopper's Guide to Long Term Care Insurance.

☐ A copy of the Notice to Applicant Regarding Replacement of Accident and Sickness or Long Term Care Insurance if Question 16D indicates that this is a replacement.

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

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

Agent Certification: I delivered the documents checked above to the applicant(s):

X _____ _____
Signature of Licensed and Appointed Agent Date Signed

Print Name of Applicant A _____ Print Name of Applicant B _____

J. AGENT'S REPORT *To ensure against delays in processing please provide details.*

Applicant **A** YES	Applicant **A** NO		Applicant **B** YES	Applicant **B** NO
○	○	**1**. Did you personally interview the applicant face to face and witness his or her signature? *If NO*, give details. Applicant **A**: _____ Applicant **B**: _____	○	○
○	○	**2**. Did you observe any physical or mental impairments with walking or talking, or any form of tremor? *If YES*, please explain. Applicant **A**: _____ Applicant **B**: _____	○	○
		3. List other health insurance policies sold by you to the applicant. Applicant **A**: _____ Applicant **B**: _____		
		4. List health insurance policies sold by you to the applicant in the last five years that are no longer in force. Applicant **A**: _____ Applicant **B**: _____		

AGENT INFORMATION

_____ Name of Licensed and Appointed Agent (Please print)

_____ Street Address

_____ Social Security No. or Tax ID of Licensed and Appointed Agent

_____ City, State, Zip

X _____ Signature of Licensed and Appointed Agent

( ) _____ Phone No.

( ) _____ Fax No.

_____ Email Address of Licensed and Appointed Agent

Genworth

Health Information Authorization

from Genworth Life Insurance Company

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

This is a HIPAA Compliant Authorization

Company Copy - Complete and return a signed copy with your application.

Authorization

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

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive or previously received; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, Human Immunodeficiency Virus (HIV) antibodies, Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC).

Who May Request or Use Information: This information may be disclosed to and used and/or disclosed by: Genworth Life, including its producers, agents, and representatives (collectively, "Representatives"); its vendors, including, but not limited to, ReleasePoint, Examination Management Services, Incorporated (EMSI) and APS Workflow, Inc.; its insurance support organizations; its affiliates and reinsurers; and MIB, Inc. ("MIB"). A copy of my application may also be attached to any policy/certificate of a co-applicant who is issued coverage as a result of the same application.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; medical practitioners; health professionals; hospitals; clinics; the Veterans Administration; pharmacy benefits managers; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations; and MIB. In addition, I authorize Genworth Life, or its reinsurers, to make a report of my protected health information to MIB.

Statements of Understanding and Acknowledgement of Release of Certain Health Related Information: I understand that:

- I, or any person authorized to act on my behalf, will receive a copy of this Authorization; and the copy is as valid as the original.
- If I do not sign this Authorization, or revoke it by writing to Genworth Life Insurance Company at its Administrative Office, Genworth Life may decline my application.
- In the event coverage is declined, information related to the declination may be provided to my Representative, including certain medical information. However, information regarding sensitive medical histories will not be released or made available to my Representative. This includes, but is not limited to, HIV, alcohol or drug abuse, mental and psychiatric disorders, cognitive impairments or medical information that may be restricted by state law. All medical information provided to my Representative will also be provided to me, as the applicant(s) for coverage.
- Some health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if health information is disclosed to persons or organizations that are not subject to federal health information privacy laws, such persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of the information.
- This Authorization is valid for 24 months from the date signed unless revoked in writing prior thereto. However, my revocation is not effective for any information that might have been used or disclosed in reliance upon this Authorization prior to such revocation.

Signature

Printed Name of Applicant A	Date of Birth	Last 4 Digits of SSN
⚠ Signature of Applicant A **X**		Date Signed
Printed Name of Applicant B	Date of Birth	Last 4 Digits of SSN
⚠ Signature of Applicant B **X**		Date Signed

Other Important Information

Producer Compensation: When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy/certificate, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy/certificate is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy/certificate. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy/certificate premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed agent is authorized to sell insurance polices from other insurance carriers, those carriers may pay compensation that differs from ours.

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

from Genworth Life Insurance Company

Company Copy - Complete and return a signed copy with your application.

Insurability

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

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

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
   (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

(over)

Signatures

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result 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. Test results may be maintained in a file or a data bank.

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

I have read and I understand this Notice and Consent For Testing Which May Include HIV Antibody/ Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

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

Applicant *(Please Print)*	Date of Birth
	.

Name and address of designated Physician:

Signature of Applicant or Parent/Guardian	Date	State of Residence
X	.	.

Genworth Life Insurance Company

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

Genworth

Genworth Life
Administrative Offices:
3100 Albert Lankford Drive
Lynchburg, VA 24501

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

from Genworth Life Insurance Company

Company Copy - Complete and return a signed copy with your application.

Insurability

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

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

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
   (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

(over)

Signatures

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result 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. Test results may be maintained in a file or a data bank.

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

I have read and I understand this Notice and Consent For Testing Which May Include HIV Antibody/ Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

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

Applicant *(Please Print)*	Date of Birth
	.

Name and address of designated Physician:

Signature of Applicant or Parent/Guardian	Date	State of Residence
X	.	.

Genworth Life Insurance Company

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

Company Copy

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medi-Cal. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ***ask*** you to fill out the rest to help you and the company decide if you should buy this policy.

SECTION A

Premium Information

Policy Form #: ◯ **7052CA** ◯ **7037D Partnership** ***Select One***

The premium for the coverage you are considering will be: (Complete ***only*** the premium for the desired payment frequency.)

$ annually $ semi-annually $ quarterly $ monthly

Type of Policy Guaranteed renewable.

The Company's Right to Increase Premiums The company has the right to increase premiums based on premium class; provided it raises premiums for all similar policies issued in the same state and on the same form as this policy.

Rate Increase History The company has sold long-term care insurance since 1974 and has sold this policy since 2013. The company has not raised its rates on this policy form in this or any other state, but in the past 10 years it has raised or requested to raise its rates on similar policy forms that are no longer available for sale. ***Following is a summary of the rate increases:***

Policy Form Series - Not every series was available in every state	**Years Available For Sale**	**States**	**Effective Year(s) of Increase[1]: Percentage of Increase[2]**
6465, 6026, 6318, 6322, 6328, 6394, 6395	1974-1989	All states except CA, CT, MA, MN, NV, NJ, NY, NC, VT, & VA	2007-2015: 8-10%
6484, 6667, 7003, 7012, 7021, 50000, 50001, 50003, 50004, 50013, 50018, 50020, 50021, 50022, 50023, 50024, 50029, 50100, 50107, 51000	1988-2003	All states except MA, MN, NJ, & NY	2007-2015: 9-14%
		AK, MI; pending in other states	2012-2015: 35-88%
7000, 7002, 7011, 7020, 7022, 50024, 50027, 50109, 50110, 51001, 51002	1993-2005	All states except MA, MN, & NV	2007-2010: 12%
		All states except MA, NY, & VT	2011-2015: 12-30%
		AK, MI; pending in other states	2012-2015: 60-95%
7011, 7012, 7030, 7031, 7032, 7033, 7034, 51005, 51006, 51007	1997-2004	All states except MA, MN, & NY	2007-2010: 11%
		All states except IN, MA, NM, NY, & VT	2011-2015: 15-29%
		AK, MI; pending in other states	2012-2015: 63-78%
7025, 7035, 7037, 51010, 51001	2001-2006	AK, MI; pending in other states	2012-2015: 44-60%
7040	1999-2012	Pending	2013-2015: 35%

[1] Future effective dates reflect increases requested, but not yet implemented.

[2] The amount of the increase may vary by state; policy form series; or policy type. The actual effective increase may be higher as a result of the compounding effect of prior rate increases.

SECTION A *(continued)*

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

Questions Related to Your Income

How will you pay each year's premium? ◯ From my Income ◯ From my Savings/Investments ◯ My Family will Pay ◯ Other (friends, entities, etc.)

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?
◯ Yes ◯ No — ***If you have not considered this possibility, please do not proceed with the application until doing so.***

SECTION B (If you elect to fill out Section B, all questions must be answered.)

What is your annual income? (check one)
◯ Under $10,000 ◯ $10,000-$20,000 ◯ $20,001-$50,000 ◯ Over $50,000

How do you expect your income to change in the next 10 years? (check one)
◯ No change ◯ Increase ◯ Decrease
If you will be paying with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ◯ Yes ◯ No

If not, how will you pay for the difference between future costs and your daily benefit amount?
◯ From my Income ◯ From my Savings/Investments ◯ My Family will Pay ◯ Other (friends, entities, etc.)
The national median annual cost of care in a private room in a nursing home in 2012 was $81,030 ($222 per day), but this figure varies across the country. In ten years the national median annual cost would be about $132,000, if costs increase 5% annually.

Select Elimination Period you are considering. The approximate cost of care for that period (based on a national median cost of $222/day) is shown for each elimination period choice.
◯ 30 Days ($6,660) ◯ 90 Days ($19,980)

How are you planning to pay for your care during the Elimination Period? (check one)
◯ From my Income ◯ From my Savings/Investments ◯ My Family will Pay ◯ Other (friends, entities, etc.)

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
◯ Under $20,000 ◯ $20,000-$30,000 ◯ $30,001-$50,000 ◯ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
◯ Stay about the same ◯ Increase ◯ Decrease
If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET *continued*

DISCLOSURE STATEMENT

Check one: ◯ The answers to the preceding questions in sections A and B accurately describe my financial situation.
◯ I choose not to complete this information (in section B on the prior page), and I have signed the Verification of Financial Non-Disclosure.
NOTE: Section A must be completed even if you do not disclose your financial information.

CHECK THE CIRCLE TO ACKNOWLEDGE YOU HAVE READ THE FOLLOWING STATEMENT AND SIGN BELOW.

◯ **(This Circle Must Be Checked)** I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures.
I understand that the rates for this policy may increase in the future.

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

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

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

Complete this section ONLY if your agent has advised you that this policy may not be suitable for you.
My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

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

In order for us to process your application, please return this signed statement to Genworth Life Insurance Company, along with your application. The company may contact you to verify your answers.

VERIFICATION OF FINANCIAL NON-DISCLOSURE

Please check below and return this form with your signed Personal Worksheet.

◯ Yes, I wish to purchase this coverage. I still choose not to complete the financial information required in the **Long Term Care Insurance Personal Worksheet**. Please resume your review of my application.

◯ No, I have decided not to buy a policy at this time.

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

An approved policy WILL NOT BE ISSUED until the Long Term Care Insurance Personal Worksheet (and if applicable, the Verification of Financial Non-Disclosure) has been fully completed and received by the company.

Complete and submit this form with the application to:
Genworth Life Insurance Company
Long Term Care Insurance Division
3100 Albert Lankford Drive
Lynchburg, Virginia 24501-4948

LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

1. The **annual premium rate** that is applicable to you and that will be in effect until a request is made and approved for an increase is $ _____.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective on the next policy anniversary date.

4. **Potential Rate Revisions:** *This policy is Guaranteed Renewable.* This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:
   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

I have read the above information concerning "Potential Rate Increases."

Applicant A Signature	Date
Applicant B Signature	Date

CONTINGENT NONFORFEITURE

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care insurance coverage, if:
- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose the Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:
- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500, for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

(over)

Company Copy – Complete and return a signed copy with your application to Genworth Life Insurance Company.

CONTINGENT NONFORFEITURE

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the following chart:

   Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days after the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will also change in the following ways:

a. The total lifetime amount of benefits your reduced paid-up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

REQUIREMENTS TO ACCESS COUPLES BENEFITS

California

Married couples are eligible to receive a couples discount on our Individual plans. If you are not married but meet the criteria below, you may be eligible to receive a couples discount on an Individual plan.

Criteria to Access Couples Benefits: Two people who

- are registered by the Secretary of State as Domestic Partners in California, **or**
- are named in a legal union other than marriage validly formed in another jurisdiction, that is substantially equivalent to a domestic partnership in California regardless of whether it bears the name domestic partnership

or, all of the following:

- are and have been living together for the past three consecutive years in a committed relationship as partners or family members, sharing basic living expenses, and
- are not married to each other, or to anyone else; and
- if related, must belong to the same generation of the same family, (e.g., brothers, sisters, cousins)

If you meet the criteria listed above, both applicant signatures are required below.

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

This form MUST be submitted with the application(s) for couples discount eligibility consideration.

Genworth Financial

Replacement Notice

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with long term care insurance coverage issued by Genworth Life Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.

(1) Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas similar claims might have been payable under your present coverage.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

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

COMPARISON TO YOUR PRESENT COVERAGE: I have reviewed your current long term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

☐ Additional or different benefits (please specify) _____
☐ No change in benefits, but lower premium.
☐ Fewer benefits and lower premium.
☐ Other (please specify) _____

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

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

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

Company Copy - Complete and return a signed copy with your application to Genworth Life Insurance Company

Genworth

Authorization for use or disclosure of patient health information: KAISER

Getting Health Information Quicker: Submitting a Clean Authorization Form

Saves Time

You won't have to bother clients with additional questions or signatures

6 Easy Steps

Make sure your authorization is completed correctly to avoid delays

See next page for 6 easy ways to make sure your authorization is squeaky clean.

Did You Know?

Authorizations received "not in good order" is a main driver for delays in obtaining history from the medical facilities.

Genworth

Authorization for use or disclosure of patient health information: KAISER

6 Easy Steps to Getting Health Information Quicker

1 Complete patient's (proposed insured's) name, date of birth, address and telephone number.
Please provide Kaiser number.

2 Enter the name of the Medical Center from which records are required.

3a Enter the period for which medical office records and hospital records are required.
For LTCi, we require medical records for the three (3) year period from the authorization sign date.

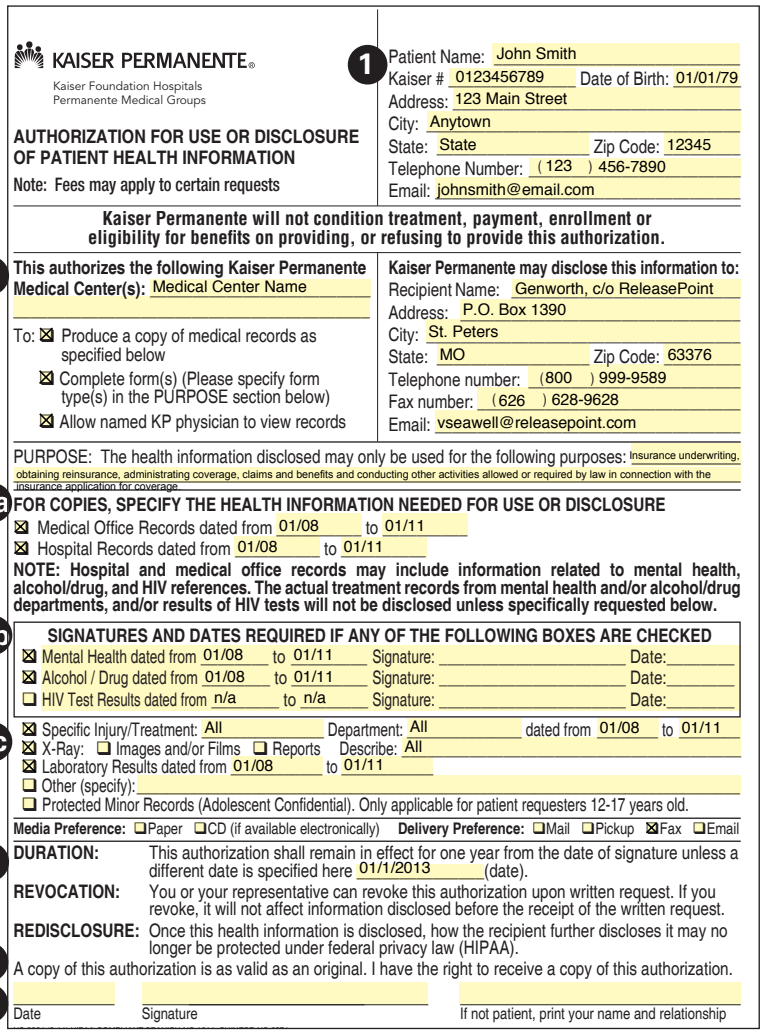
3b Enter the same (3 year) period for mental health and alcohol/drug records and sign and date where indicated.

3c Enter the same (3 year) period for Specific Injury/Treatment and Laboratory Results.

4 Enter the duration for which the authorization will remain valid.
We require 24 months from the date of application.

5 Have the proposed insured sign and date the form.

6 Make a copy of the authorization and provide the copy to the applicant.



KAISER PERMANENTE®
Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION
Note: Fees may apply to certain requests

1 Patient Name: John Smith
Kaiser # 0123456789 Date of Birth: 01/01/79
Address: 123 Main Street
City: Anytown
State: State Zip Code: 12345
Telephone Number: (123) 456-7890
Email: johnsmith@email.com

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

2 **This authorizes the following Kaiser Permanente Medical Center(s):** Medical Center Name

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

Kaiser Permanente may disclose this information to:
Recipient Name: Genworth, c/o ReleasePoint
Address: P.O. Box 1390
City: St. Peters
State: MO Zip Code: 63376
Telephone number: (800) 999-9589
Fax number: (626) 628-9628
Email: vseawell@releasepoint.com

PURPOSE: The health information disclosed may only be used for the following purposes: Insurance underwriting, obtaining reinsurance, administrating coverage, claims and benefits and conducting other activities allowed or required by law in connection with the insurance application for coverage.

3a **FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE**
☒ Medical Office Records dated from 01/08 to 01/11
☒ Hospital Records dated from 01/08 to 01/11
NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

3b **SIGNATURES AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED**
☒ Mental Health dated from 01/08 to 01/11 Signature: _____ Date: _____
☒ Alcohol / Drug dated from 01/08 to 01/11 Signature: _____ Date: _____
☐ HIV Test Results dated from n/a to n/a Signature: _____ Date: _____

3c ☒ Specific Injury/Treatment: All Department: All dated from 01/08 to 01/11
☒ X-Ray: ☐ Images and/or Films ☐ Reports Describe: All
☒ Laboratory Results dated from 01/08 to 01/11
☐ Other (specify): _____
☐ Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12-17 years old.

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

4 **DURATION:** This authorization shall remain in effect for one year from the date of signature unless a different date is specified here 01/1/2013 (date).
REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.
REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

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

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

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

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

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

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

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

Kaiser Permanente may disclose this information to:
Recipient Name: Genworth, c/o ReleasePoint
Address: P.O. Box 1390
City: St. Peters
State: MO Zip Code: 63376
Telephone number: (800) 999-9589
Fax number: (626) 628-9628
Email: vseawell@releasepoint.com

PURPOSE: The health information disclosed may only be used for the following purposes: Insurance underwriting, obtaining reinsurance, administrating coverage, claims and benefits and conducting other activities allowed or required by law in connection with the insurance application for coverage.

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

☒ Medical Office Records dated from _____ to _____
☒ Hospital Records dated from _____ to _____

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

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

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

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

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

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

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

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

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

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

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

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

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

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

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

Kaiser Permanente may disclose this information to:
Recipient Name: Genworth, c/o ReleasePoint
Address: P.O. Box 1390
City: St. Peters
State: MO Zip Code: 63376
Telephone number: (800) 999-9589
Fax number: (626) 628-9628
Email: vseawell@releasepoint.com

PURPOSE: The health information disclosed may only be used for the following purposes: Insurance underwriting, obtaining reinsurance, administrating coverage, claims and benefits and conducting other activities allowed or required by law in connection with the insurance application for coverage.

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

☒ Medical Office Records dated from _____ to _____
☒ Hospital Records dated from _____ to _____

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

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

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

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

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

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

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

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

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

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

Insurance and annuity products:	• Are not deposits. • May decrease in value.	• Are not insured by the FDIC or any other federal government agency. • Are not guaranteed by a bank or its affiliates.