

<i>SERFF Tracking Number:</i>	<i>FRCS-125925881</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Genworth Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41108</i>
<i>Company Tracking Number:</i>	<i>5105</i>		
<i>TOI:</i>	<i>LTC03I Individual Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03I.001 Qualified</i>
<i>Product Name:</i>	<i>Long-Term Care Application</i>		
<i>Project Name/Number:</i>	<i>Genworth-2/61/61</i>		

Filing at a Glance

Company: Genworth Life Insurance Company

Product Name: Long-Term Care Application

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form

SERFF Tr Num: FRCS-125925881

SERFF Status: Closed

Co Tr Num: 5105

Co Status: None

Authors: Michael Cochran, Kevin Wiggs, LaToya Osborn

Date Submitted: 12/12/2008

State: ArkansasLH

State Tr Num: 41108

State Status: Approved-Closed

Reviewer(s): Marie Bennett

Disposition Date: 12/31/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Genworth-2/61

Project Number: 61

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/31/2008

State Status Changed: 12/31/2008

Corresponding Filing Tracking Number:

Filing Description:

Our fee of \$50 has been sent by EFT on this same date. This fee is based on the Company's state of domicile.

This form is new and is not intended to replace any previously approved form.

The application form is being filed on a general use basis and will be marketed in the individual life market by the Company's licensed agents. The issue ages for the forms are 18 -79 years inclusive.

SERFF Tracking Number:	FRCS-125925881	State:	Arkansas
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This application will be utilized with previously approved flexible premium adjustable life insurance policy number ULPLTCIPGLI AR (11/05), approved by your department effective 8/17/2006 [under SERFF filing number SERT-6HHV7D137].

The forms are submitted in final printed format except for slight font and formatting variations that may occur due to the Company's production printers. Further, the Company reserves the right to change the font and format of the forms, colors, logos, and paper type. Distribution and access may also be via hard copy or electronic media. In all cases, the forms will meet or exceed the minimum standards of your applicable state insurance form readability requirements.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

(This filing was made by a third party - FC01)

LaToya Osborn, Technician	latoya.osborn@firstconsulting.com
1020 Central	(800) 927-2730 [Phone]
Kansas City, MO 64105	(816) 391-2755[FAX]

Filing Company Information

Genworth Life Insurance Company	CoCode: 70025	State of Domicile: Delaware
401 Parkway Place Dr.	Group Code: 4011	Company Type:
Little Rock, AR 72211	Group Name: Genworth Financial, Inc.	State ID Number:
(501) 476-0960 ext. [Phone]	FEIN Number: 91-6027719	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	DE fee of \$50 per filing=\$50
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Genworth Life Insurance Company	\$50.00	12/12/2008	24519828

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	12/31/2008	12/31/2008

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Project Name/Number: *Genworth-2/61/61*

Disposition

Disposition Date: 12/31/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FRCS-125925881* *State:* *Arkansas*
Filing Company: *Genworth Life Insurance Company* *State Tracking Number:* *41108*
Company Tracking Number: *5105*
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Product Name: *Long-Term Care Application*
Project Name/Number: *Genworth-2/61/61*

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Total Living Coverage Application for Life Insurance		Yes

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Form Schedule

Lead Form Number: 43881 TLC App FW(24) 0608

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	43881 TLC App FW(24) 0608	Application/Total Living Enrollment Form	Coverage Application for Life Insurance	Initial		54	43881 TLC App FW(24) 0608.pdf

Proposed Insured information *Continued*

Employment status *Select one*

Employed Disabled Retired Other

If employed, enter employer information below

Occupation Employer name Type of business

.....

Address

.....

City State Zip

.....

3. Couples discount

If "Other" selected, complete the appropriate Couples form to determine eligibility for discount.

All discount forms, (i.e. Couples form(s), Spouse/other application forms if they are applying for coverage) need to be completed and submitted **at time of application** to determine total discounts.

a. With whom does the Proposed Insured live?

Live alone With spouse Other

b. Does the Proposed Insured's spouse or other household member have long term care benefits inforce or applied for with Genworth Life?

Yes No

If "Yes" to the question above, enter spouse/other household member information

Name *First, M.I., Last* Policy/contract number

.....

Birth date *mm/dd/yyyy* Social Security Number

.....

4. Owner information

Complete ONLY if Owner is someone other than the Proposed Insured. Otherwise, skip to section 5, Beneficiary information.

If Corporation/Partnership, complete Business Owner Supplement Information form and skip to section 5.

If Trust, complete Certification of Trustee Powers form and skip to section 5.

Owner type *Select one*

Individual Corporation Partnership Trust

Other *Describe*

Owner name *First, M.I., Last* Trustee name

.....

Birth/trust date *mm/dd/yyyy* Social Security/Tax ID Number

.....

Relationship to Proposed Insured

.....

Address

.....

City State Zip

.....

If Owner type above is an individual, complete citizenship information below.

Is the Owner a United States citizen?

Yes No State/country of birth

.....

If "No" to the question above, does the Owner have a Permanent Resident Card?

Yes No If "Yes," enter Owner Permanent Resident Card number

.....

If "No," enter Owner Visa number

.....

5. Beneficiary information

If more than one primary beneficiary is named, the death benefit will be paid in equal shares to surviving beneficiaries unless requested otherwise. If no primary beneficiary survives and more than one contingent beneficiary is named, any death benefit they receive will be paid in equal shares unless requested otherwise.

Additional beneficiary space is available in section 10, "Remarks" or on the overflow form.

Primary beneficiary type *Select one*

Individual Corporation Partnership Trust

Other *Describe*

Primary beneficiary/trust name

Trustee name

.

.

Birth/trust date *mm/dd/yyyy*

Social Security/Tax ID Number

.

.

Relationship to Proposed Insured

.

Address If different from Proposed Insured

.

City

State

Zip

.

.

.

Beneficiary share

100%

50%

25%

Equally

Other

%

Beneficiary *Select one*

Primary beneficiary

Contingent beneficiary

Beneficiary type *Select one*

Individual

Corporation

Partnership

Trust

Other *Describe*

Beneficiary/trust name

Trustee name

.

.

Birth/trust date *mm/dd/yyyy*

Social Security/Tax ID Number

.

.

Relationship to Proposed Insured

.

Address If different from Proposed Insured

.

City

State

Zip

.

.

.

Beneficiary share

100%

50%

25%

Equally

Other

%

Beneficiary *Select one*

Primary beneficiary

Contingent beneficiary

Beneficiary type *Select one*

Individual

Corporation

Partnership

Trust

Other *Describe*

Beneficiary/trust name

Trustee name

.

.

Birth/trust date *mm/dd/yyyy*

Social Security/Tax ID Number

.

.

Relationship to Proposed Insured

.

Address If different from Proposed Insured

.

City

State

Zip

.

.

.

Beneficiary share

100%

50%

25%

Equally

Other

%

6. Proposed Insured history

a. Has the Proposed Insured ever used tobacco or any other product that contains nicotine?

Yes No

Date last used

.

b. Other than as prescribed by a physician, has the Proposed Insured ever used marijuana, narcotics, stimulants, sedatives or hallucinogens?

For any type used, indicate frequency of use

Yes No

Name of substance

Date last used

.

Name of substance

Date last used

.

Additional space for details is available in section 10, "Remarks."

c. Is there any other application for life insurance, long term care insurance, life insurance with a long term care rider or annuity contract with a long term care rider pending in any company?

Yes No

Company name

Life/annuity amt.

Long term care amt.

.

\$

\$

d. Has Proposed Insured ever submitted an application or requested a reinstatement of life insurance, long term care insurance, nursing home or health coverage or life insurance/annuity contract with long term care coverage that was not issued or reinstated as applied for?

Yes No

If "Yes," what was the outcome?

Refused

Postponed

Limited

Withdrawn

Cancelled

Asked to pay a higher premium

Details:

Date

.

.

Additional space for details is available in section 10, "Remarks."

e. In the past 5 years, has the Proposed Insured requested or received Workers' Compensation, Social Security disability or any other disability payments?

Yes No

Reason:

Date

.

.

f. Has Proposed Insured ever been convicted of a misdemeanor or felony?

Yes No

Type of conviction

Felony

Misdemeanor

Date conviction occurred

Convicted of:

.

.

Current status

Incarcerated

Discharged

Await sentencing

Parole/probation

Parole/probation satisfied

g. In the past 5 years, has the Proposed Insured been convicted of or pled guilty or no contest to reckless driving, multiple moving violations, driving under the influence of alcohol or drugs, or had his/her driver's license suspended or revoked?

Yes No

If "Yes," indicate all that apply and provide most recent date of occurrence

Reckless driving Provide date

Multiple moving violations Provide date

Suspended license Provide date

Driving under the influence of alcohol Provide date

Revoked license Provide date

Driving under the influence of controlled substance Provide date

Other Provide detail and date

For each item checked, list offense and most recent date of occurrence.

Proposed Insured history Continued

If "Yes," complete aviation supplement

h. In the past 5 years has the Proposed Insured flown, or does he/she intend to fly as a pilot, student pilot, or crew member other than on a scheduled commercial airline?
Yes No

Check "None," or indicate all that apply and complete appropriate supplement.

i. Which of the following activities does the Proposed Insured intend to engage in, or has engaged in within the past 2 years?
None Hang gliding Ultra-light flying Hot air ballooning Scuba diving
Mountain, ice or rock climbing Motor vehicle and/or boat racing Sky diving

If "Yes," complete foreign resident and travel supplement.

j. Within the next 2 years, does the Proposed Insured intend to travel or reside outside of the U.S. for more than four consecutive weeks other than for vacation?
Yes No

7. Proposed Insured medical history

a. Height b. Weight
ft in pounds

c. Has there been a weight change of ten pounds or more in the past year?
Yes No

If "Yes," indicate pounds gained or lost and the reason
Gained Reason
Lost

d. Proposed Insured's personal physician name Telephone
Address
Date and reason last seen

If physician is different from the one identified in Section 7d, provide physician's name, address and phone number.

e. Is the Proposed Insured applying for preferred life rates?
Yes No

f. Has the Proposed Insured had a complete physical exam within the past 6 months (including a blood profile)?
Yes No

Physician name Telephone
Address

Explain "Yes" answers in section 10, "Remarks."

g. Within the past 12 months, has the Proposed Insured used or been advised by a health care professional to use any of the following:
1. Assistance or supervision with moving in or out of a bed or chair, bathing, dressing, eating, toileting, bowel or bladder control or walking
2. Home health care services, adult day care services, or care in a nursing home, assisted living facility, or any other long term care facility
3. A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen, or kidney dialysis

Proposed Insured medical history *Continued*

Explain "Yes" answers in section 10, "Remarks."

h. Has the Proposed Insured had, been treated for, or been diagnosed by a health care professional as having any of the following:

- | | |
|--|---|
| <p>1. Cirrhosis of the Liver
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>2. Muscular Dystrophy
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>3. Cystic Fibrosis
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>4. Parkinson's Disease
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>5. Multiple Sclerosis
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>6. Stroke
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>7. Huntington's Chorea
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>8. ALS (Lou Gehrig's Disease)
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>9. Alzheimer's Disease, dementia, senility or frequent or persistent forgetfulness or memory loss
 <input type="radio"/> Yes <input type="radio"/> No</p> | <p>10. Diabetes under treatment with Insulin, or with a history of Transient Ischemic Attack (TIA), heart disease, or circulatory/vascular disease
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>11. Cancer of the following within the past 4 years: bone, brain, lung, liver, ovary, pancreas, stomach or any metastatic cancer
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>12. TIA within the past 5 years or more than one TIA
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>13. Organ Transplant, other than kidney or cornea
 <input type="radio"/> Yes <input type="radio"/> No</p> <p>14. Schizophrenia or other forms of psychosis
 <input type="radio"/> Yes <input type="radio"/> No</p> |
|--|---|

i. Has the Proposed Insured ever tested positive for the HIV (Human Immunodeficiency Virus) or been treated or diagnosed by a health care professional as having Acquired Immune Deficiency Syndrome (AIDS)?

- Yes No

Explain "Yes" answers in section 10, "Remarks."

j. In the past 10 years has the Proposed Insured had, been treated for, or been advised by a health care professional to be treated for:

1. Chest pain, angina, heart attack, angioplasty, heart surgery, coronary artery disease, congestive heart failure, heart murmur, atrial fibrillation, palpitations, or any other disease or disorder of the heart or circulatory system
 Yes No
2. High blood pressure, carotid artery or peripheral vascular disease, aneurysm, or disease or disorder of the blood or arteries
 Yes No
3. Diabetes, disease or disorder of the thyroid, pancreas, endocrine glands or immune system
 Yes No
4. Asthma, chronic bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), sleep apnea, or other disease or disorder of the lungs or respiratory system
 Yes No
5. Crohn's Disease, Ulcerative colitis, hepatitis or other disease or disorder of the stomach, liver, colon, rectum or intestines
 Yes No
6. Cancer, tumor, polyp, cyst, lymphoma, Hodgkin's Disease, leukemia, Multiple Myeloma, or other malignant disorder
 Yes No

9. Existing insurance/replacement

If "Yes" to questions "a," "c," or "d," complete (sign and date) and submit **all necessary life / annuity and long term care replacement forms**.

- a. Are there existing life insurance or annuity contracts, including those with benefits for long term care, in-force on the life of the Proposed Insured? *If "Yes," provide details in "e" below.*
 Yes No
- b. Are there existing accident and sickness or long term care insurance contracts (including health care service contracts and health care maintenance organization contracts) in-force for the Proposed Insured? *If "Yes," provide details in "e" below.*
 Yes No
- c. Does the Owner intend to replace, end or change, with respect to the Proposed Insured, any life insurance or annuity contracts (including those with benefits for long term care) with this policy?
 Yes No
- d. Does the Owner intend to replace, end or change with respect to the Proposed Insured, any long term care, medical or health insurance coverage with this policy?
 Yes No

Please list all existing life insurance, annuities, and long term care policies on the Proposed Insured.

Remember, a long term care replacement form is required if replacing any life or annuity coverage that includes benefits for long term care.

e. Company name			Policy/contract number	
.				
Type	Contract amount	Issue year	Replacing	LTC benefit
.	\$.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Company name			Policy/contract number	
.				
Type	Contract amount	Issue year	Replacing	LTC benefit
.	\$.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Company name			Policy/contract number	
.				
Type	Contract amount	Issue year	Replacing	LTC benefit
.	\$.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Company name			Policy/contract number	
.				
Type	Contract amount	Issue year	Replacing	LTC benefit
.	\$.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

- f. Has there been any other long term care insurance coverage or life insurance or annuity contract that accelerates benefits for long term care in force on the Proposed Insured in the past 12 months? *If "Yes," provide details*
 Yes No

Company name	If insurance lapsed, when did it lapse?
.	.
Company name	If insurance lapsed, when did it lapse?
.	.

- g. Is the Proposed Insured covered by Medicaid? *Not Medicare*
 Yes No

10. Remarks

Please use this section to provide full details to all "Yes" answers from previous sections. Include question number, section letter/number, dates, results of any tests, medications, names and addresses and phone number of physician/hospital.

If beneficiaries are needed beyond those listed in section 5, please provide full details here.

Dotted lines for handwritten remarks.

11. Payment selection

If requesting temporary insurance, complete the appropriate Temporary Insurance Application and Agreement (TIAA) and submit it with this application along with the full Initial Premium.

Form for payment selection including options for frequency (Monthly, Quarterly, Semiannual, Single, Annual), method (EFT, Check, Direct bill, Credit card), notices (Insured, Owner, Other), source (Salary, Investments, Savings, 1035 Transfer, Gifts/inheritance), and amount remitted.

12. Representations and agreement

For the protection against unintentional lapse, a notice will be given only if at the beginning of a policy month, the net cash surrender value is less than the monthly deduction for the month or the policy loan balance exceeds the cash surrender value.

Protection Against Unintentional Lapse: I, the Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Life Insurance policy that provides long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Name <i>First, M.I., Last</i>	Relationship	
•	•	
Address	Telephone number	
•	•	
City	State	Zip
•	•	•

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

Rejection of the 5% Compound Optional Inflation Benefit:

Check below if the 5% Compound option was not selected in section 1.

I, the Owner, have reviewed the Outline of Coverage and the graphs or charts that compare the benefits and premiums of the long term care coverage with and without inflation protection. Specifically, I have reviewed plans offering compound, simple and no increases, and I reject the 5% Compound option.

Proposed Insured and Owner Agreement

By signing on the next page, I, the Proposed Insured and Owner (if different), agree that this application for insurance, and any amendment(s) and supplement(s) to the application that are attached to any policy delivered to the Owner will be referred to herein as the "Application."

I further represent, understand, and agree that:

- All statements in this Application are true, complete, and correctly recorded to the best of my knowledge and belief.
- I will notify the Insurer in writing prior to policy delivery if any statement or answer given in any part of this Application changes prior to delivery.
- The insurance being applied for is suitable for the Owner's insurance needs and financial objectives.
- Insurance is not being applied for as part of a plan or arrangement to transfer the policy to another party.
- Only the Insurer's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of Application, receipt or policy.
- The initial premium will be set forth on the policy's schedule pages, and payment of premiums will be subject to the terms and conditions of the policy.
- I, the Owner, have received the Notice to Proposed Insured and Owner, Consumer Privacy Notice, Outline of Coverage, Long Term Care Insurance Potential Rate Increase Disclosure Form, applicable Shoppers or Buyers Guide and the Accelerated Benefits Rider for Long Term Care Services Disclosure Notice.

13. Conditions for starting coverage

By signing on the next page, I, the Owner, agree that, except as stated on date of delivery in a TIAA, no insurance will take effect until a policy is delivered to and accepted by the Owner and

- Each person to be insured is alive and in the same condition of health and insurability as stated in this Application, and
- No person to be insured has received any medical advice or treatment from a health care provider or facility since the date of this Application, and
- The initial premium is paid.

14. Authorization to collect and disclose information

The Genworth Financial insurance companies listed on page 1 of this document are referred to as "we," "us," and "our" on this page.

The Proposed Insured is referred to as "you" and "your" on this page.

This Authorization complies with the HIPAA Privacy Act. Our reinsurers, the medical information bureau known as MIB Inc. (MIB), consumer-reporting agencies, and all authorized representatives of these parties and we may collect Information regarding your application for insurance. The Information collected may only be disclosed as allowed or required by law to the following: other insurers to which you have applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them.

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. Our reinsurers and we will use the Information to evaluate the requested policy change.

Definition of terms. Information means facts about the Proposed Insured. It includes facts about the following topics: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, and sexually transmitted diseases; prescription drug database; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation.

Source means 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; medical prescription drug database; insurers; reinsurers; MIB, consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

15. Signature

A fiduciary or representative must sign in capacity or with title and provide documentation of authority.

By signing below, the Owner and Proposed Insured agree to the representations made in this application, and the Proposed Insured agrees to:

- Authorize each Source to give Information when this authorization is presented
• Accept that a copy of this authorization is as valid as the original
• Understand that he/she may revoke this authorization by sending us written notice
• Understand that he/she may request a copy of this authorization
• Acknowledge that failing to sign, changing or revoking this authorization may delay or prevent processing of the application and may result in the application being denied
• Understand that this authorization is valid for twenty-four months from the date of signing

Caution: If the answers on this application are incorrect or untrue, Genworth Life Insurance Company has the right to deny benefits or rescind the policy.

FRAUD WARNING: A PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, CONCEALS MATERIAL FACTS OR SUBMITS AN INSURANCE APPLICATION OR A CLAIM STATEMENT CONTAINING MATERIALLY FALSE INFORMATION COMMITS A CRIME OF INSURANCE FRAUD.

Complete both "State where application signed," and "State to be delivered" even if they are the same state.

Delivery of policy issued will occur in the resident state of the Owner.

Signature of Owner is required if different from Proposed Insured.

State where application signed

State in which policy will be delivered

Proposed Insured signature Date of signature

Printed name of Proposed Insured

Owner signature Include title if officer of firm or corporation Date of signature

Printed name of Owner

Licensed insurance producer signature Date of signature

Licensed insurance producer name printed

SERFF Tracking Number: *FRCS-125925881* *State:* *Arkansas*
Filing Company: *Genworth Life Insurance Company* *State Tracking Number:* *41108*
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TOI: *LTC03I Individual Long Term Care* *Sub-TOI:* *LTC03I.001 Qualified*
Product Name: *Long-Term Care Application*
Project Name/Number: *Genworth-2/61/61*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-125925881

State: Arkansas

Filing Company: Genworth Life Insurance Company

State Tracking Number: 41108

Company Tracking Number: 5105

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Product Name: Long-Term Care Application

Project Name/Number: Genworth-2/61/61

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

12/01/2008

Comments:

Attachments:

Auth 11-08.pdf

AR Coc.pdf

AR Fee Schedule.pdf

AR RDB.pdf

Statement of Variability - 43881 TLC App 06-2008.pdf

Review Status:

Bypassed -Name: Application

12/01/2008

Bypass Reason: Not applicable to this filing.

Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification

12/01/2008

Bypass Reason: Not applicable to this filing.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage

12/01/2008

Bypass Reason: Not applicable to this filing.

Comments:



Date: 11/18/2008

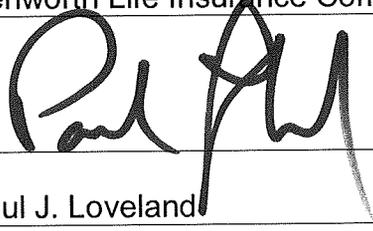
To: The Insurance Commissioner

Authorization

This Authorization, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters related to forms and rates before the Insurance Department.

This Authorization shall be valid for a period of one year and renewable for a like period at the end of each term until terminated by the Company.

Company Name: Genworth Life Insurance Company

Signature: 

Name: Paul J. Loveland

Title: Vice President, Product Compliance

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Genworth Life Insurance Company

Form Title(s): Total Living Coverage application for life insurance.

Form Number(s): 43881 TLC App FW(24) 0608

I hereby certify that to the best of my knowledge and belief, the above form and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Paul J. Loveland
Vice President, Product Compliance

December 10, 2008

Date

ARKANSAS FEE SCHEDULE

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Genworth Life Insurance Company

NAIC Code: 70025

Contact Person & Telephone: LaToya Osborn, Compliance Technician
1-800-927-2730 Ext. 2836

First Consulting & Administration, Inc., 1020 Central, Suite 201, Kansas City, MO 64105

INSURANCE DEPARTMENT USE ONLY

ANALYST: _____ **AMOUNT:** _____ **ROUTE SLIP:** _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* x \$50 = \$
**Retaliatory = \$

Life and/or Disability - filing and review of each rate filing or loss ratio guarantee filing per each insurer.

* x \$50 = \$
**Retaliatory = \$

Life and/or Disability Policy, Contract or Annuity Form: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the base form.

* x \$20 = \$
**Retaliatory = \$50.00

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* x \$25 = \$
**Retaliatory = \$

AMENDED CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.

* x \$400 = \$

Filing to amend Certificate of Authority

*** x \$100 = \$

* **THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

** **THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*** **THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SECTION 23-61-401.**

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Genworth Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
43881 TLC App FW(24) 0608	53.4



Paul J. Loveland
Vice President, Product Compliance

December 10, 2008

Date

GENWORTH LIFE INSURANCE COMPANY
6610 WEST BROAD STREET
RICHMOND, VIRGINIA 23230

STATEMENT OF VARIABILITY

Form Description

Form Number

Application for Life Insurance

43881 TLC App 0608

Brackets

Hard Brackets [] – Denote that provision or text is variable.

- The Company's name, addresses and telephone numbers appearing on the forms are variable and may be changed as appropriate. The Company's logo(s) or trademarks may be added as appropriate.
- Section 1 – Plan of insurance, rider, benefit and premium selections are variable based upon coverage offered.
- Section 4 – County where signed and delivered applicable only in the State of Florida.
- Section 11 – Payment selection options are variable based upon coverage offered.
- Section 15 – Fraud statement may be variable based upon state-specific requirements. State where signed and delivered may vary subject to state-specific requirements.