

SERFF Tracking Number: GEFA-125277086 State: Arkansas
Filing Company: Genworth Life Insurance Company State Tracking Number: 36931
Company Tracking Number: ANCILLARY FORMS
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
Product Name: Group LTC Ancillary Forms
Project Name/Number: Group LTC Ancillary Forms/37616 8/17/07

Filing at a Glance

Company: Genworth Life Insurance Company

Product Name: Group LTC Ancillary Forms

TOI: LTC03G Group Long Term Care

Sub-TOI: LTC03G.001 Qualified

Filing Type: Form

SERFF Tr Num: GEFA-125277086

SERFF Status: Closed

Co Tr Num: ANCILLARY FORMS

Co Status:

Authors: Marcia Chalfant, June

Lipscomb, Jeanette Mai, Kathleen

Hamby

Date Submitted: 09/19/2007

State: ArkansasLH

State Tr Num: 36931

State Status: Approved-Closed

Reviewer(s): Marie Bennett, Harris
Shearer

Disposition Date: 06/16/2008

Disposition Status: Approved-
Closed

Implementation Date Requested: 10/01/2007

Implementation Date:

State Filing Description:

General Information

Project Name: Group LTC Ancillary Forms

Project Number: 37616 8/17/07

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/16/2008

State Status Changed: 06/16/2008

Corresponding Filing Tracking Number:

Filing Description:

Ancillary Forms For Use With GROUP LONG TERM CARE INSURANCE POLICY FORM 7046POL, et al previously approved on September 13, 2005:

Personal Worksheet (Suitability Form), Form Number 37616 08/17/07

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Forms were filed
9/5/2007.

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association,
Discretionary, Trust

Deemer Date:

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Replacement Form, Form Number 43472 08/03/07

Group Policy Amendatory Rider, Form Number 62109G

Purpose. On behalf of Genworth Life Insurance Company, we are submitting the referenced documents for the Department's approval. We have outlined the way these forms will be used below.

Personal Worksheet (Suitability Form): Form 37616 08/17/07 will be used for our group long term care insurance product. Because of an impending rate action for our individual policy forms, Genworth Life, in the interest of fair disclosure, is changing the rate history section of the Personal Worksheet, even though our group product is not the same type of coverage with respect to availability and rating. After approval, and beginning October 1, 2007, form 37616 08/17/07 will replace the currently approved form 37616.

Replacement Form: Form 43472 08/03/07 will be used for our group long term care insurance product whenever an agent could be involved in the solicitation process with an eligible individual. The currently approved form, 7046RPMT will continue to be used for our traditional employer/employee groups. Bracketed material is variable, and allows for changes based on contractual language.

Group Policy Amendatory Rider: Form 62109G will be used to change on a prospective basis, those terms of coverage that fall within permitted variables and are subject to agreement between Genworth Life Insurance Company and the Group Policyholder, after the Group Contract's effective date. For example, an addition or change in the eligible classes, the length of the rate guarantee, or for benefits as stated in the Master Benefit Schedule, would be indicated.

The enclosed forms are in final printed format other than for the variable information required within the group context, and minor modification in paper size and stock, ink, border, font type (but not size) and adaptation to electronic and computer printing. To the best of our knowledge and belief, this submission is in compliance with all relevant statutes and regulations of your State, including its readability standards, and does not contain any provisions previously disapproved by your Department.

We trust that you will find our filing to be in order and hope that you will grant your Department's approval to this submission. If you have any questions, or would like to discuss any of the materials included in this submission, please feel free to contact me, at 804 922.5085 or Marcia.Chalfant@GENWORTH.com. My fax number is 804 484.3999.

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Company and Contact

Filing Contact Information

Marcia Chalfant, Policy Contract Analyst marcia.chalfant@genworth.com
 6620 W Broad Street (804) 922-5085 [Phone]
 Richmond, VA 23230 (804) 281-6285[FAX]

Filing Company Information

Genworth Life Insurance Company CoCode: 70025 State of Domicile: Delaware
 6610 W Broad Street Group Code: 350 Company Type: LifeHealth &
 Annuity
 Richmond, VA 23230 Group Name: State ID Number:
 (804) 281-6600 ext. [Phone] FEIN Number: 91-6027719

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50 per (1) filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Genworth Life Insurance Company	\$50.00	09/19/2007	15697526

<i>SERFF Tracking Number:</i>	<i>GEFA-125277086</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Genworth Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>36931</i>
<i>Company Tracking Number:</i>	<i>ANCILLARY FORMS</i>		
<i>TOI:</i>	<i>LTC03G Group Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03G.001 Qualified</i>
<i>Product Name:</i>	<i>Group LTC Ancillary Forms</i>		
<i>Project Name/Number:</i>	<i>Group LTC Ancillary Forms/37616 8/17/07</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor (FM)	06/16/2008	06/16/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Status of Review	Note To Reviewer	Kathleen Hamby	04/02/2008	04/02/2008

SERFF Tracking Number: *GEFA-125277086* *State:* *Arkansas*
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Disposition

Disposition Date: 06/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Personal Worksheet	Approved-Closed	Yes
Form	Replacement Form	Approved-Closed	Yes
Form	Group Policy Amendment	Approved-Closed	Yes

SERFF Tracking Number: *GEFA-125277086* *State:* *Arkansas*
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Note To Reviewer

Created By:

Kathleen Hamby on 04/02/2008 12:02 PM

Subject:

Status of Review

Comments:

Please advise the status of the Department's review for this submission. We would like to have an idea of when the forms will be reviewed. Thanks.

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Form Schedule

Lead Form Number: 37616 8/17/07

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	37616 8/17/07	Other	Personal Worksheet	Initial		59	37616-081707 Personal Worksheet REVISED 09-11-07.pdf
Approved-Closed	43472 08/03/07	Other	Replacement Form	Initial		0	43472_080307_FILE VERS.pdf
Approved-Closed	62109G	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Group Policy	Initial		0	Group Contract Amendment 62109G.pdf

Genworth Life Insurance Company

[Administrative Office: P. O. Box 64010, St. Paul, MN Tel. 800-416-3624]

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 Medicaid. 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 coverage.

[If you are an employee {or spouse or domestic partner of an employee}, you may wish to review and complete this form for your own use. However, you DO NOT NEED to submit it with your application.]

[If you are eligible for coverage other than as the employee or his or her spouse or partner, you/You] MUST complete and submit this form with your application. We cannot process your application without it.

Premium Information

Policy Form Number 7046 Series

The premium for the coverage you are considering will be \$ _____ per month, or \$ _____ per year.

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums

The Company has the right to increase premiums on this policy form in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rate may be increased based on the experience of all persons with coverage similar to yours.

Rate Increase History

The Company has sold long term care insurance since 1974 and has sold group long term care insurance since 1999. It has sold this group policy form since 2005. The Company has never raised its rates for this group policy form or similar group policy forms in this state or any other state in the last 10 years. However, for certain of its individual policy forms that are not available for sale, the Company raised its premium rates in 2007.

Questions Related to Your Income

How will you pay each year's premium? (Check one)

From my Income From my Savings/Investments My Family will Pay

Have you considered whether you could afford to keep this coverage if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

Under \$10,000 \$10,000-\$20,000 \$20,000-\$30,000
 \$30,000-\$50,000 Over \$50,000

How do you expect your income to change over the next 10 years? (Check one)

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments My Family will Pay

The national average annual cost of nursing home care in [2006] was [\$74,800 (approximately \$200 a day for a private room)], but this figure varies across the country. In ten years, the national average annual cost would be about [\$121,800] if costs increase 5% annually.

What elimination period are you considering? Number of days _____

Approximate cost \$ _____ for that period of care.

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

Questions Related to Your Savings and Investments

Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

Under \$20,000 \$20,000-\$30,000 \$30,000-\$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 coverage 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.

Disclosure Statement

(Must Check One)

<input type="checkbox"/> The answers to the questions above describe my financial situation.	<input type="checkbox"/> I choose not to complete this information.
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(Check Below)

I acknowledge that I have reviewed this form 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 form series may increase in the future.**
(This box must be checked.)

Signed: _____ (Applicant) _____ (Date)

If an Agent/Producer assists with the Application, the following items must be completed as appropriate.

2 The Agent/Producer has advised me that this insurance does not seem to be suitable for me. However, I still want the company to consider my application

Applicant Signature	Printed Name	Date
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Agent/Producer Statement:

I explained to the Applicant(s) the importance of completing this information.

Agent/Producer Signature	Printed Name	Date
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1 **PLEASE NOTE:** [If you are eligible for the Group Long Term Care Insurance program as other than the employee or his/her spouse or partner, you/You] **MUST** complete and submit this form with your application. We cannot process your application without it.

1 Please return this signed statement along with your application to: Genworth Life Insurance Company, Administrative Office, [P. O. Box 64010, St. Paul, MN 55164-0010], along with your application.]

Genworth Life Insurance Company may contact you to verify your answers.

Genworth Life Insurance Company

Long Term Care Division

Home Office: Richmond, Virginia

Administrative Office Address:[3100 Albert Lankford Drive, Lynchburg, VA 24501-4948]

**Submit a completed copy with application.
Keep a copy for applicant's records.**

Applicant Copy

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

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with long term care coverage, issued by Genworth Life Insurance Company. Your new coverage provides [30/60] 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting 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 a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods,

elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy or certificate. 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.
4. If, after due consideration, you still wish to terminate your present coverage and replace it with the 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 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.

IF AN AGENT/PRODUCER ASSISTS WITH THE APPLICATION, HE OR SHE MUST COMPLETE THE FOLLOWING.

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved with this transaction materially improves your position. My conclusion has taken into account the above considerations, which I have reviewed with you.

Agent's Signature	Print Name	Date (mm/dd/yyyy)
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Applicant: The above "Notice to Applicant" was delivered to me on the date this form is signed.

Applicant A's Signature	Print Name	Date (mm/dd/yyyy)
Applicant B's Signature	Print Name	Date (mm/dd/yyyy)

Genworth Life Insurance Company

Long Term Care Division

Home Office: Richmond, Virginia

Administrative Office Address:[3100 Albert Lankford Drive, Lynchburg, VA 24501-4948]

**Submit a completed copy with application.
Keep a copy for applicant's records.**

Company Copy

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You should review this new coverage carefully, comparing it with all accident and sickness or long term care coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

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2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods,

elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy or certificate. 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.
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Agent's Signature	Print Name	Date (mm/dd/yyyy)
-------------------	------------	-------------------

Applicant: The above "Notice to Applicant" was delivered to me on the date this form is signed.

Applicant A's Signature	Print Name	Date (mm/dd/yyyy)
Applicant B's Signature	Print Name	Date (mm/dd/yyyy)

GENWORTH LIFE INSURANCE COMPANY

Administrative Office: [3100 Albert Lankford Drive, Lynchburg, VA 24501]

GROUP POLICY AMENDATORY RIDER

Group Policyholder:

Group Policy Number:

Amendment Number:

Effective Date of Change:

This Rider shall be attached to and form a part of the Group Policy named above. It takes effect on the Effective Date of Rider.

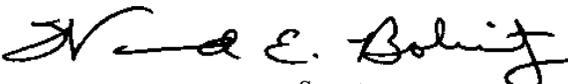
1. The Eligible Persons and Effective Date provisions are changed by the addition of the following classes.
Actively at work, part-time employees, working at least 20 hours per week.
2. The Address of the Group Policyholder is changed to:
99 Main Street, Anytown, US 99999
3. The Benefit Masters Schedule is changed by the addition of the following available benefit options:
 - a. Home and Community Care Maximum of 100%
 - b. A 60 Calendar Day Elimination Period.
4. The Benefit Masters Schedule is changed by the addition of the following optional riders:
 - a. Automatic Benefit Increases – 3% Compound for Life and
 - b. Optional Nonforfeiture Benefit.]

By the terms of this Rider, it is understood and agreed that the Group Policy is changed as stated herein.

- [• The address of the Group Policyholder is changed.
- The description of eligible classes has been modified to include part-time employees.
- The available plan options have been changed.]

All other terms and conditions of the Group Policy remain unchanged.

Signed for Genworth Life Insurance Company.

[
Secretary


President and CEO, Long Term Care Division]

Signed for the Group Policyholder on _____, by

Signature

Title

Signed original to be returned to the Company. First copy to be retained with the Group Policy.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	06/16/2008
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Comments:

Consumer Information Notice and Rule & Regulations 19 & 49 are N/A to this filing.

Attachment:

Readability Certification signed.pdf

Bypassed -Name:	Application	Review Status:	Approved-Closed	06/16/2008
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Bypass Reason: N/A

Comments:

Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	06/16/2008
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Bypass Reason: N/A

Comments:

Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	06/16/2008
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Bypass Reason: N/A

Comments:

GENWORTH LIFE INSURANCE COMPANY
Flesch Certification

This is to certify that the forms listed below, when scored under the Flesch Reading Ease Test meet your state's minimum Flesch Score as follows:

FORM	DESCRIPTION	SCORE
37616 08/17/07	Personal Worksheet	58.9
43472 08/03/07	Notice to Applicant Regarding Replacement of...LTC Insurance	Mandated content
62109G	Group Policy Amendatory Rider	Variable content



Paul Loveland
Vice President, Product Development

September 11, 2007