

SERFF Tracking Number: GEFA-125368281 State: Arkansas
Filing Company: Genworth Life Insurance Company State Tracking Number: 39746
Company Tracking Number: 43146 EXP VARS ANC SIMPLE
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
Product Name: GROUP LTC 7046 Expanded Vars & Application
Project Name/Number: Group COMBINATION Vars Expanded/43146 et al

Filing at a Glance

Company: Genworth Life Insurance Company
Product Name: GROUP LTC 7046 Expanded Vars & Application
TOI: LTC03G Group Long Term Care
Sub-TOI: LTC03G.001 Qualified
Filing Type: Form/Rate
Implementation Date Requested: On Approval
State Filing Description:

SERFF Tr Num: GEFA-125368281 State: ArkansasLH
SERFF Status: Closed State Tr Num: 39746
Co Tr Num: 43146 EXP VARS ANC SIMPLE
State Status: Approved-Closed
Co Status: Reviewer(s): Marie Bennett, Harris Shearer
Disposition Date: 09/17/2008
Authors: Marcia Chalfant, June Lipscomb, Jeanette Mai, Kathleen Hamby, Edwina Word
Date Submitted: 07/25/2008 Disposition Status: Approved
Implementation Date:

General Information

Project Name: Group COMBINATION Vars Expanded
Project Number: 43146 et al
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 09/17/2007
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Employer, Association, Discretionary, Trust

Filing Status Changed: 09/17/2008
State Status Changed: 09/17/2008
Corresponding Filing Tracking Number:
Filing Description:
GROUP LONG TERM CARE INSURANCE POLICY FORM 7046POL, et al
Previously Approved on September 13, 2005

Deemer Date:

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Purpose. On behalf of Genworth Life Insurance Company, we are submitting the following documents for the Department's approval:

1. Addendum to our Actuarial Memorandum for Group Policy Form Series 7046; and
2. Application for Insurance insurability form, form number 43146; and
3. An expanded Explanation of Variability for Policy Form 7046POL, et al.; and
4. Automatic Inflation Protection –5% Simple Annual Increase Rider, form number 7046INFSMPRDR 02/01/08.

This material broadens the parameters of our previously approved group long term care insurance product referenced above.

Addendum to our Actuarial Memorandum: We are submitting additional rating factors for our group product. Upon approval, these factors will permit a broader outreach for our product within the group marketplace. The ability to use two of these factors is predicated upon the use of the enclosed Application for Insurance insurability form, form number 43146. The additional rating factors are as follows:

1. Preferred and Standard Health Underwriting Factors: The use of this differentiation in rating will only be permitted, if case underwriting permits, and if the appropriate application is used to apply for coverage.
2. Couples Discount: The expanded Couples Discount factors will only be available, if case underwriting permits and the appropriate application is used to apply for coverage.
3. Rate Guarantee Period: The Addendum also expands our rate guarantee availability to permit additional guarantee periods at the group level, as well as a rate guarantee at the certificate level. Availability of the additional guarantee periods for a particular group is based on case underwriting.
4. Case Level Underwriting: The case factors have been adjusted to address a wider range of business risks.

Application of Insurance: We created form 43146 using the format and health questions in our individual application form, 36156FN, approved by your department on January 7, 2005. No changes were made to the health questions found on pages 1 through 5 of that form; and only minimal changes were made to the language found in other sections of the form, mostly those to denote "coverage" rather than "policy," and the addition of the group eligibility language on page 1. The declarations page also includes the required rejection of both the optional Nonforfeiture benefit rider as well as the 5% Compound for Life inflation protection. Variables are indicated by brackets and explained in our revised Explanation of Variability for the group product.

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The enclosed application is in final printed format other than for the variable information required within the group and minor modification in paper size and stock, ink, border, font type (but not size) and adaptation to electronic and computer printing.

This form does not replace any previously filed or approved form.

Explanation of Variability (Rev): As with any new endeavor, we found that our approved variables did not give us the full range of flexibility that is required in the group marketplace for long term care insurance. To that end, we have structured our Explanation of Variability more carefully, using a numbering system for the types of variables. The types of variables as stated in the Explanation of Variables are as follows:

Type 1. Variable information based on the dynamics of the specific group, such as the policyholder name, description of eligible persons, phone numbers, addresses, plans, premiums, etc.

Type 2. Inclusive information that may or may not appear for a particular client, such as a specific rider or component of the material, driven by the parameters for the specific group.

Type 3. Substitute language that will be used to replace the language shown driven by the dynamics of a particular group. The Explanation of Variables contains any necessary or additional language that would be appropriate as a Type 3 variable.

The Explanation of Variability (Rev) document includes copies of the previously approved forms with the variable types marked on each. Please note that changes to the previously filed variables include the following:

1. As a Type 3 variable, we are expanding the available options for the age on which rates are based in the Group Policy.
2. As a Type 3 variable, we are expanding available eligible classes to include siblings and adult children in the Certificate of Insurance.
3. As a Type 3 variable, we are expanding the definitions that may be used for spouse to include partners in a legally recognized relationship.
4. As a Type 3 variable, we are expanding the available parameters for the Deferred Effective Date, including the use of Active Service requirements in lieu of Actively at Work requirement, in the Certificate of Insurance and the Application forms.
5. As a Type 2 variable, we are expanding the variables surrounding timeframes to address longer timeframes than originally anticipated. Please note that these timeframes will never be less than that permitted by the laws and/or regulations of your state, in both the Group Policy and Certificate..

<i>SERFF Tracking Number:</i>	<i>GEFA-125368281</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Genworth Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39746</i>
<i>Company Tracking Number:</i>	<i>43146 EXP VARS ANC SIMPLE</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 7046 Expanded Vars & Application</i>		
<i>Project Name/Number:</i>	<i>Group COMBINATION Vars Expanded/43146 et al</i>		

- 6. As a Type 3 variable, we are expanding the use of our applications forms to a broader range of eligible persons.
- 7. The full range of variables that will be used for the enclosed application, form 43146.

In preparing this filing, we found that our 5% Simple Automatic Benefit Increase Rider, form 7046INFSMPDR might be misconstrued. To that end, and since this rider has not yet been issued for your state, we have revised the provision "How This Rider Works" to indicate how the lifetime maximum is affected by the rider. A similar correction was made to the outline of coverage.

The readability certification provided for the previously approved forms is still applicable when using these variables.

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.

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:	\$90.00
Retaliatory?	No
Fee Explanation:	\$20.00 per form x 2 forms

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\$50.00 per rate x 1 rate
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Genworth Life Insurance Company	\$90.00	07/25/2008	21604270

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	09/17/2008	09/17/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Marie Bennett	09/11/2008	09/11/2008	Marcia Chalfant	09/12/2008	09/12/2008
Industry Response						

SERFF Tracking Number: *GEFA-125368281* *State:* *Arkansas*
Filing Company: *Genworth Life Insurance Company* *State Tracking Number:* *39746*
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Product Name: *GROUP LTC 7046 Expanded Vars & Application*
Project Name/Number: *Group COMBINATION Vars Expanded/43146 et al*

Disposition

Disposition Date: 09/17/2008

Implementation Date:

Status: Approved

Comment: Approval subject to attachment of page 9-A (Form No. 43150) to the application.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Explanation of Variability		Yes
Form	Application for Insurance Insurability Form		Yes
Form	Automatic Inflation Protection-5% Simple Annual Increases Rider		Yes
Form	Agent Information/Report		Yes
Rate	Addendum to Actuarial Memorandum		No

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/11/2008
Submitted Date 09/11/2008
Respond By Date 10/13/2008

Dear Marcia Chalfant,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Insurance Insurability Form (Form)

Comment: The application does not have the Agents questions regarding policies sold to the applicant during the last 5 years (lapsed as well as inforce) as required by Rule 13, Sec. 14.B. Is this information obtained in a Supplementary Application? If so, please furnish certification of compliance and the previously approved form number.

Please feel free to contact me if you have questions.

Sincerely,

Marie Bennett

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/12/2008
Submitted Date 09/12/2008

Dear Harris Shearer,

Comments:

Response 1

Comments: Dear Ms. Bennett,

Thank you for your comment, yesterday. We obtain the required information via another page of the application: page A-9 is form number 43150 Agent Information/Report. With this response, I have attached the form 43150 to the Form Schedule for your review and approval.

Please let us know if you need anything further to complete your review our submission.

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Respectfully,
 Marcia Chalfant

Related Objection 1

Applies To:

- Application for Insurance Insurability Form (Form)

Comment:

The application does not have the Agents questions regarding policies sold to the applicant during the last 5 years (lapsed as well as inforce) as required by Rule 13, Sec. 14.B. Is this information obtained in a Supplementary Application? If so, please furnish certification of compliance and the previously approved form number.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Agent Information/Report	43150		Other	Initial			43150_06 1507_filing_preprint.pdf

No Rate/Rule Schedule items changed.

Sincerely,
 Edwina Word, Jeanette Mai, June Lipscomb, Kathleen Hamby, Marcia Chalfant

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Form Schedule

Lead Form Number: 43146

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	43146	Application/ Enrollment Form	Application for Insurance Insurability Form	Initial		53	43146_052008_brackets_preprint.pdf
	7046INFS MPRDR 02/01/08	Certificate	Automatic Inflation Protection-5% Simple Annual Increases Rider	Initial		59	7046ABI Simple2008 with Variables.pdf
	43150	Other	Agent Information/Report	Initial			43150_061507_filing_preprint.pdf

APPLICATION

* For Insurance *

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

1

A. INSURABILITY PROFILE

Applicant A			Applicant B	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	1. Are you covered by Medicaid (not the same as Medicare)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2A. Do you use a Walker, Wheelchair or Quad Cane; Hospital Bed; Oxygen, Respirator or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair, Bathing, Dressing, Eating, Toileting, Bowel/Bladder control, or Walking?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	B. Have you been advised to: receive home care, use an adult day care facility, enter a nursing home, enter an assisted care facility, or enter any other long term care facility?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following: <ul style="list-style-type: none"> •ALS (Lou Gehrig's disease) •Alzheimer's Disease •Congestive Heart Failure (CHF) in combination with any of the following: Heart Attack or Angina; Emphysema/Chronic Obstructive Pulmonary Disease (COPD); Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis •Cirrhosis of the Liver •Cystic Fibrosis •Dementia •Diabetes under treatment with Insulin or 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) •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 	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, or Stomach?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection, or other sickness or condition derived from such infection, or tested positive for HIV or exposure to the HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>

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.

B. PERSONAL PROFILE

Print clearly - Use black ink

[APPLICANT A]

Mr. Mrs. Miss Ms. Other Title: _____

Name _____
(As it should appear on your Coverage documents)

Married/Legal Couple Single Widowed

Social Security Number _____

1 [Employee/Member ID] Number _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ a.m. p.m.

E-mail address _____

[APPLICANT B]

Mr. Mrs. Miss Ms. Other Title: _____

Name _____
(As it should appear on your Coverage documents)

Married/Legal Couple Single Widowed

Social Security Number _____

1 [Employee/Member ID] Number _____

Birthdate _____ Age _____ Birthplace (state) _____

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

Daytime Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ a.m. p.m.

E-mail address _____

1 I am eligible as: [Employee/Member] [Spouse/Partner] [Other _____]

1 I am eligible as: [Employee/Member] [Spouse/Partner] [Other _____]

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

City _____ State _____ Zip _____

Mailing Address (if different) _____

City _____ State _____ Zip _____

C. MEDICAL PROFILE

[Applicant A] **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?
 [YES NO] **2** If 'YES,' please check appropriate boxes for *each applicant (A and B)* and explain under the DETAILS section.

[Applicant B] **2**
 [YES NO]

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

<input type="checkbox"/> Epilepsy, Seizures, or Convulsions	<input type="checkbox"/>
<input type="checkbox"/> Fainting Spells or Blacking Out	<input type="checkbox"/>
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/>
<input type="checkbox"/> Heart Attack, Angina or Atrial Fibrillation	<input type="checkbox"/>
<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/>
<input type="checkbox"/> Immune System Disorders	<input type="checkbox"/>
<input type="checkbox"/> Injury due to Falls or Imbalance	<input type="checkbox"/>
<input type="checkbox"/> Joint Replacement Surgery	<input type="checkbox"/>
<input type="checkbox"/> Kidney Failure	<input type="checkbox"/>
<input type="checkbox"/> Leukemia	<input type="checkbox"/>
<input type="checkbox"/> Lupus	<input type="checkbox"/>
<input type="checkbox"/> Mental Illness	<input type="checkbox"/>
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/>
<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/>

<input type="checkbox"/> Myasthenia Gravis	<input type="checkbox"/>
<input type="checkbox"/> Organ Transplant	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>
<input type="checkbox"/> Post-Polio Syndrome	<input type="checkbox"/>
<input type="checkbox"/> Paralysis	<input type="checkbox"/>
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>
<input type="checkbox"/> Scleroderma	<input type="checkbox"/>
<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/>
<input type="checkbox"/> Tremor	<input type="checkbox"/>
<input type="checkbox"/> Other Conditions Causing Crippling or Limited Motion, or Requiring Adaptive Devices	<input type="checkbox"/>

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

[Applicant A] **7.** Within the past 5 years, have you:

[Applicant B] **2**
 YES NO

A. Smoked or used other tobacco products?

B. Required assistance with managing medications, shopping, using transportation, or housekeeping/cooking?
 If YES to any, please explain.

[Applicant A]	[Applicant B]	Type of assistance	Reason
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

C. Received home health care; used an adult day care facility; been confined to a nursing home, assisted care facility, or other long term care facility? If YES to any, please explain.

[Applicant A]	[Applicant B]	Date	Reason
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

D. Been medically advised to have surgery which has not been performed?
 If YES, please explain (including dates of scheduled surgeries).

[Applicant A]	[Applicant B]	Date	Surgery Type	Reason
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

E. Received Social Security Disability Insurance benefits?

F. Taken any prescription medications for High Blood Pressure and/or any form of Arthritis?
 If YES, list each medication and why it's needed.

[Applicant A]	[Applicant B]	Medication	Why needed?
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

[Applicant A] **2** YES NO **2** 8. Within the past 2 years, have you: [Applicant B] **2** YES NO **2**

- A. Received Disability Income, Worker's Compensation, or any state disability benefit?
- B. Had another Long Term Care insurance application denied by us or any other company? *If YES, by what company?*
- [Applicant A] Company: _____ [Applicant B] Company: _____

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 why it's needed.

[Applicant A]	[Applicant B]	Medication	Why needed?
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

B. Been medically advised to enter or been confined to a hospital or other health care facility?

If YES, please explain (including dates and reasons).

[Applicant A]	[Applicant B]	Date	Facility	Reason
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

10A. Who is your primary care physician with most of your medical records? [Applicant A] **2** [Applicant B] **2**

Doctor's Name _____	Doctor's Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone No. _____ Date last seen (Mo/Day/Yr) _____	Phone No. _____ Date last seen (Mo/Day/Yr) _____
Reason Last Seen _____	Reason Last Seen _____

2 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? **2**

If YES, please complete the following.

[Applicant A]	[Applicant B]	Physician's Name	City, State	Specialty	Reasons Consulted/Treated	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____

E. FAMILY HISTORY PROFILE

[Applicant A] 2			[Applicant B] 2		
YES	NO	UNKNOWN	YES	NO	UNKNOWN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11A. 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?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Diabetes					
• Coronary Artery Disease or any other form of Vascular Disease					
• Alzheimer's or any other form of Dementia					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12A. 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?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Diabetes					
• Coronary Artery Disease or any other form of Vascular Disease					
• Alzheimer's or any other form of Dementia					

F. APPLICANT PROFILE

[Applicant A] 2		[Applicant B] 2	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13A. Do you work 20 or more hours a week outside your home? <i>If YES, list occupation.</i>			
[Applicant A] 2 Occupation: _____		[Applicant B] 2 Occupation: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Do you perform volunteer work? <i>If YES, list type of work and list hours worked per week.</i>			
[Applicant A] 2 Type of work: _____ hrs/week		[Applicant B] 2 Type of work: _____ hrs/week	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? <i>If YES, please describe.</i>			
[Applicant A] 2 Activities: _____		[Applicant B] 2 Activities: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you drive an automobile? <i>If YES, provide approximate annual mileage:</i>			
[Applicant A] 2 Mileage: _____		[Applicant B] 2 Mileage: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you live in some form of a residential retirement community?			
<i>If YES, list the specific services that are received (e.g., housekeeping, laundry, meals):</i>			
[Applicant A] 2 Services: _____		[Applicant B] 2 Services: _____	

G. OTHER COVERAGE AND REPLACEMENT

[Applicant A] YES NO	2	<input type="checkbox"/> <input type="checkbox"/> 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? <i>If YES, provide DETAILS below.</i> [Applicant A] Company: <u>2</u> [Applicant B] Company: _____ Long Term Care? <input type="checkbox"/> No <input type="checkbox"/> Yes Daily Benefit: \$ _____ Long Term Care? <input type="checkbox"/> No <input type="checkbox"/> Yes Daily Benefit: \$ _____	[Applicant B] YES NO	2
<input type="checkbox"/> <input type="checkbox"/>		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): _____	<input type="checkbox"/> <input type="checkbox"/>	2
<input type="checkbox"/> <input type="checkbox"/>		C. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy/certificate in force during the last 12 months? <i>If YES, with which company?</i> [Applicant A] Company: <u>2</u> [Applicant B] Company: _____ <i>If that insurance lapsed, when did it lapse?</i> [Applicant A] Lapse Date: _____ [Applicant B] Lapse Date: _____	<input type="checkbox"/> <input type="checkbox"/>	2
<input type="checkbox"/> <input type="checkbox"/>		D. Do you intend to replace <i>any</i> of your long term care, medical, or health insurance with this Coverage? <i>If YES, name company being replaced:</i> [Applicant A] Company: <u>2</u> [Applicant B] Company: _____ AGENT: <i>If YES, the Replacement Notice must be completed, dated and signed by both you and the Applicant. Leave a copy with the Applicant and send a copy with the application.</i> APPLICANT with no AGENT: <i>If YES, please complete, date and sign the Replacement Notice. Send a copy with your application and keep a copy for your records.</i>	<input type="checkbox"/> <input type="checkbox"/>	2

H. PROTECTION AGAINST UNINTENTIONAL LAPSE

One of the boxes 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 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)] 1 **2**

- I elect NOT to designate any person to receive such notice.
- I designate the following person to receive notice prior to cancellation of my Coverage 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 _____

[Applicant B (Complete whenever there is a second applicant)] 2

- 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 Coverage for nonpayment of premium:

Mr. Mrs. Miss Ms. Other Title: _____

Full Name _____

Home Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Relationship _____

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.

REJECTION OF 5% COMPOUND FOR LIFE INFLATION PROTECTION:

Check box **only** if you have selected a benefit increase option other than 5% Compound for Life.

[Applicant A] 2

I have reviewed the outline of coverage (or disclosure form) and the graphs that compare the benefits and premiums of this Coverage with and without inflation protection. Specifically, I have reviewed plans with and without inflation protection, and I reject inflation protection 5% Compound for Life.

[Applicant B]

I have reviewed the outline of coverage (or disclosure form) and the graphs that compare the benefits and premiums of this Coverage with and without inflation protection. Specifically, I have reviewed plans with and without inflation protection, and I reject inflation protection 5% Compound for Life.]

1 REJECTION OF OPTIONAL NONFORFEITURE BENEFIT RIDER:

[Applicant A] 2

Yes No I have reviewed the Outline of Coverage and compared the benefits and premiums of this Coverage with and without the Nonforfeiture Benefit Rider, and I reject this Rider.]

[Applicant B]

Yes No I have reviewed the Outline of Coverage and compared the benefits and premiums of this Coverage with and without the Nonforfeiture Benefit Rider, and I reject this Rider.]

AUTHORIZATION: I authorize Genworth Life Insurance Company, its insurance support organizations, 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, consumer reporting agency or insurance support organization or other person or 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.

RECEIPT: I have received and read the Privacy Notice. When I applied for this Coverage to be issued by Genworth Life Insurance Company, I also received the Outline of Coverage (called Disclosure Form in some states), the applicable Shopper's or Buyer's Guide, the Potential Rate Increase Disclosure, the Suitability Disclosure, and the Personal Worksheet.

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 Coverage for which I am applying; and
3. if I qualify, the Group Policy is in effect and there has been no change in my health that would change the answers to any of the questions in this application, my Coverage will take effect according to the terms of the Group Policy.]

2 [REQUEST FOR A LATER EFFECTIVE DATE:

If the Initial Premium is paid, check this box **only** to request that your Coverage become effective at a date later than the date you sign this application.

1 [INDIVIDUAL PLANS:] * Applicant A * Applicant B] 2

[SHARED PLANS:] *

* By checking this box 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 this application is signed in their underwriting decision, and that the Initial Premium will begin as of the Effective Date set by the Company.]

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act, which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial penalties may be imposed.

CAUTION: If your answers on this application are incorrect or untrue, Genworth Life Insurance Company may have the right to deny benefits or rescind your Coverage, subject to the Misstatement/Incontestability provisions of the Group Policy.

X
Signature of Applicant [A]

X
Signature of Applicant B

X
Signature of Licensed and Appointed Insurance Producer/Agent/Representative, if applicable

Date Signed
43146

Date Signed

Date Signed

GENWORTH LIFE INSURANCE COMPANY

AUTOMATIC INFLATION PROTECTION – 5% SIMPLE ANNUAL INCREASES RIDER

This rider is attached to and made part of Your Certificate as of Your Coverage Effective Date. It is issued in consideration of Your Application and premium submitted for this rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How This Rider Works

Every year on the anniversary of Your Coverage Effective Date We will increase by 5% of the amounts in effect on Your Coverage Effective Date:

- Your Facility Care Maximum;
- All other maximums that are based on the Facility Care Maximum; and
- Your Policy Lifetime Maximum; however, increases to Your Policy Lifetime Maximum will be reduced to the lesser of 5% of the amount in effect on Your Coverage Effective Date, or 5% of Policy Lifetime Maximum reduced by benefits paid.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

Increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

Termination

If You request that We remove this rider from Your Coverage:

- The change will be effective as of the first day of the calendar month following Our receipt of Your request;
- Your benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. Premiums will be calculated based on Your original issue age.

2

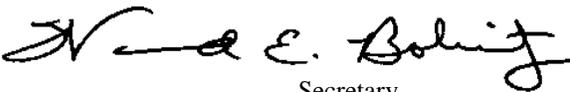
Annual inflation protection increases will terminate when requested by You or if Your Coverage is continuing in effect under:

- The Extension of Benefits provision;[or]
- The Contingent Nonforfeiture Benefit; or
- The Nonforfeiture Benefit Rider.]

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1

[
Secretary


President and CEO, Long Term Care Division]

M. AGENT INFORMATION

Name of Licensed and Appointed Agent (Please print)

Street Address

Producer Code # or Soc. Sec. #/Tax ID

E-mail Address

City, State, Zip

X
Signature of Soliciting Agent

Phone No.

Fax No.

Name of Licensed and Appointed Brokerage General Agency (if applicable)

Producer Code # of Brokerage General Agency

If more than one agent worked on this sale, please provide the following:

Name of Licensed and Appointed Agent

Percentage

Name of Licensed and Appointed Agent

Percentage

Producer Code # or Soc. Sec. #/Tax ID

E-mail Address

Producer Code # or Soc. Sec. #/Tax ID

E-mail Address

[N.] AGENT'S REPORT

To ensure against delays in processing please provide complete details.

[Applicant A]
YES NO

2

[Applicant B]
YES NO

2

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]

SERFF Tracking Number: *GEFA-125368281* *State:* *Arkansas*
Filing Company: *Genworth Life Insurance Company* *State Tracking Number:* *39746*
Company Tracking Number: *43146 EXP VARS ANC SIMPLE*
TOI: *LTC03G Group Long Term Care* *Sub-TOI:* *LTC03G.001 Qualified*
Product Name: *GROUP LTC 7046 Expanded Vars & Application*
Project Name/Number: *Group COMBINATION Vars Expanded/43146 et al*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: GEFA-125368281 State: Arkansas
 Filing Company: Genworth Life Insurance Company State Tracking Number: 39746
 Company Tracking Number: 43146 EXP VARS ANC SIMPLE
 TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
 Product Name: GROUP LTC 7046 Expanded Vars & Application
 Project Name/Number: Group COMBINATION Vars Expanded/43146 et al

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 11/26/2007
Comments:
Attachment:
 Readability Certification 43146 signed.pdf

Review Status:

Satisfied -Name: Application 11/26/2007
Comments:
 The application form 43146 is provided under the Forms Tab.

Review Status:

Bypassed -Name: Outline of Coverage 11/26/2007
Bypass Reason: N/A
Comments:

Review Status:

Satisfied -Name: Explanation of Variability 07/23/2008
Comments:
 These additional forms support the Explanation of Variability.
Attachments:
 AR 07-2008 AR VARIABILITY - 7046 series.pdf
 AR 7046CERT-AR with Variables.pdf
 AR 7046CERT-AR SCH Monthly with Variables.pdf
 AR 7046CERT-AR SCH Daily with Variables.pdf
 7046POL with Variables.pdf
 7046GMA-W VARIABLES 050107.pdf
 37606 OOC with Chart Variables 06 2008.pdf
 37607 -GI with Variables.pdf
 37608- MGI with Variables.pdf
 37609-MGI (Comp) with Variables.pdf
 37610-Short APP with Variables.pdf
 37611-Long Form App with Variables.pdf

SERFF Tracking Number: GEFA-125368281 State: Arkansas
Filing Company: Genworth Life Insurance Company State Tracking Number: 39746
Company Tracking Number: 43146 EXP VARS ANC SIMPLE
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
Product Name: GROUP LTC 7046 Expanded Vars & Application
Project Name/Number: Group COMBINATION Vars Expanded/43146 et al

37612-APP Long Form (Spouses) with Variables.pdf

37613-APP Long Form (Others) with Variables.pdf

37614-Short Form _Spouses_ with Variables.pdf

37615-CORE-BUYUP APP with Variables.pdf

7046 - ABI70 with Variables.pdf

7046 ABI61_76 with Variables.pdf

7046 ABI Life with Variables.pdf

7046 ABIC61_76 with Variables.pdf

7046 ABIC65 with Variables.pdf

7046ABI Simple2008 with Variables.pdf

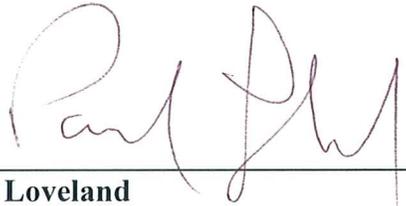
7046ABIC to 76 with Variables.pdf

7046-Nonforfeiture Rider with Variables.pdf

GENWORTH LIFE INSURANCE COMPANY
Certification

This is to certify that the forms listed below, when scored under the Flesch Reading Ease Test meet your state's minimum requirements with a Flesch score of 53.306.

Forms	Description
43146	Application for Insurance Insurability Questionnaire



Paul Loveland
Vice President Product Compliance

7/13/2007

Date

**GENWORTH LIFE INSURANCE COMPANY
EXPLANATION OF VARIABILITY (REV)
GROUP LONG TERM CARE INSURANCE POLICY
FORM SERIES 7046POL, et al**

This Explanation of Variability applies to our approved Group Long Term Care Insurance product forms under policy form series 7046POL et al. Variable material is bracketed. It includes three types of variability:

- Type 1. Variable information under the group policy, such as the policyholder name, description of eligible persons, phone numbers, addresses, plans, etc., which will be completed with information driven by the dynamics of the coverage for a specific group.
- Type 2. Inclusive information that may or may not appear for a particular client, such as a specific rider or component of the material, driven by the dynamics of a specific group.
- Type 3. Substitute language that will be used to replace a specific sentence or paragraph driven by the dynamics of a particular group.

Forms under policy form series 7046POL for the purpose of this Explanation of Variability are listed below. Variables for the specific form can be found in this document on the page shown.

FORM		PAGE
7046GMA	Group Master Application	2
7046POL	Group Master Policy	2
7046POL	Group Policy Benefits Master Schedule	3
7046CERT-AR	Group Certificate	4
7046CERT-AR	Certificate Schedule (Daily)	6
7046CERT-AR	Certificate Schedule (Monthly)	6
	Optional Benefit Riders:	7
7046CPDINFRDR	Automatic Inflation Protection – 5% Compound Annual Increases	
7046INFSMPRDR 02/01/08	Automatic Inflation Protection – 5% Simple Annual Increases	
7046CPDINF70RDR	Automatic Inflation Protection – 5% Compound Annual Increases to Age 70	
7046NFRRDR	Nonforfeiture Benefit Rider	
7046ABI-C76	Automatic Benefit Increases – X% Compound Annual Increases to Age 76	
7046ABI-C65	Automatic Benefit Increases – Age Adjusted Protection: Compound Through Age 65, Simple Thereafter	
7046ABI-61/76	Automatic Benefit Increases – Age Adjusted Protection: Ages 61 and 76	
7046ABI-C61/76	Automatic Benefit Increases – Age Adjusted Compound Protection: Ages 61 and 76	
37606-AR	Outline of Coverage	10
	Application Forms for Eligible Classes	12
37607	Simplified Guaranteed Issue Application	
37608	Modified Guaranteed Issue Application	
37609	Modified Guaranteed Issue Application	
37610	Short Form Application	
37611	Long Form Application	
37612	Long Form Application	
37613	Long Form Application	
37614	Short Form Application	
37615	Buy-Up Application	
43146	Application for Insurance insurability form	

GROUP MASTER APPLICATION

Type 1 Variables

- Specific Group information will appear for all illustrative information.
- Successive Part numbers will be revised if the ERISA section (Part 4) is not included for the Specific Group.

Type 2 Variables

- Reference to “Professional” will be deleted if not appropriate to an association group
- The section on ERISA will not be included if not appropriate to the group.
- Reference in Part 7 of the Application to the Deferred Effective Date may be deleted in its entirety if not appropriate to the group.

Type 3 Variables

- Reference in Part 7 of the Application to the Deferred Effective Date may be replaced with the following language.
 - A Deferred Effective Date may apply to an eligible person’s coverage under the Group Policy. Coverage will be in accordance with the Deferred Effective Date provision found in the Insured’s Certificate.

GROUP MASTER POLICY

Type 1 Variables: All Noted Provisions

- Variable information, such as the policyholder name, addresses, eligible classes, plans, signatures, timeframes, etc., will be completed with information appropriate to the specific group.

Type 2 Variables

- Face Page: The Rate Guarantee Period may be omitted if not applicable to the group.
- Information to Be Furnished: The paragraph concerning IRS reports may be deleted based on the type of group.
- Premium Provisions: The Premium Rate Guarantee provision may be omitted if not applicable to the group.
- Premium Provisions: Right to Change Premiums: Item (a) may be deleted in its entirety. Subsequent itemization will then be revised.
- Termination and Cancellation Provisions: Discontinuance of the Offer of Coverage under the Group Policy by the Company: The third bullet may be deleted in its entirety

Type 3 Variables

- Face Page: The Group Policy may include one of three types of rate guarantees. The following substitute language may be used:
 - “**Rate Guarantee Period:** ### (XX) years from the Group Policy Effective Date”
 - “**Rate Guarantee Period:** ### (XX) years from the Group Policy Effective Date, but not less than ##### (XX) years from the Effective Date of the Insured’s Coverage.”
 - “**Rate Guarantee Period:** ### (XX) years from the Insured’s Original Certificate Effective Date.”
- Premium Provisions:
 - Premium Rates: The following language may be used for the age on which premiums are based:
 - Premium rates will be based upon the age of the Insured on *his or her Coverage Effective Date*.
 - Premium rates will be based upon the age of the Insured on *the date his or her application is signed*.
 - Premium Rate Guarantee: The following language may be substituted for the second paragraph:

“This guarantee does not apply to a rate change due to a change in the terms of coverage, in benefits, in eligible classes, or a change in the terms of the Group Policy required by any law, regulation, or judicial or administrative order or decision.”

- Payment of Premiums and Grace Period: The time frames in which the group policyholder’s payment of premiums is required may vary based on the administrative parameters of the specific group from 31, 45 or 60 days.
- Policyholder Rating: The appropriate terminology for the class/classes on which rating is based will be used.
- Right to Change Premiums:
 - The following language may be substituted for item (b):
“(b) On or after the date there is a change in the terms of coverage, in benefits, in eligible classes, or a change in the terms of the Group Policy required by any law, regulation, or judicial or administrative order or decision.
 - The timeframes for written notice of change in Premium Rates may vary from 60, 90, 120, or 180 days.
- Termination and Cancellation Provisions:
 - Discontinuance of the Offer of Coverage Under the Group Policy by the Company: The timeframes for written notice of discontinuance of the offer of coverage may vary from 31, 60, 90, or 180 days.
 - Cancellation of the Group Policy by the Policyholder: The timeframes for written notice of cancellation by the Policyholder may vary from 31, 60, 90, or 120 days.
 - Cancellation of the Group Policy by the Company: The timeframes for written notice of cancellation by the Company may vary from 60, 90 or 120 days.

GROUP POLICY BENEFITS MASTER SCHEDULE

Type 1 Variables: All Noted Provisions

Illustrative information is shown. Variable information, such as the policyholder name, policy number, eligible classes, plans, benefit structure, and timeframes, etc., will be stated with information appropriate to the specific group.

GROUP LONG TERM CARE INSURANCE CERTIFICATE

Type 1 Variables: All Noted Provisions

Variable information, such as the policyholder name, policy number, description of eligible classes, plans, benefits, table of contents and page numbers, signatures, and timeframes, etc., will be included as appropriate to the specific group.

Type 3 Variables - Face Page:

- The timeframe in the Free Look provision may vary from 30, 45, 60 or 90 days.

Type 2 Variables: Eligible Persons and Effective Dates:

- Eligible Persons: Only the appropriate definitions for eligible classes as defined by the group policyholder will be included. If appropriate, the eligible classes may also include the following definitions:
 - “Adult Child” means Your child, stepchild, or adopted child who has reached full legal age, with attendant rights and responsibilities.
 - “Sibling” means Your brother, sister, brother-in-law or sister-in-law, including step-brothers and step-sisters.
- Coverage Eligibility: The second paragraph will be included only if family members are an eligible class.

- Deferred Effective Date:
- This provision may be deleted in its entirety if full underwriting is provided for each eligible person.
- The applicability statement may be deleted.
- The timeframes for Actively at Work status may vary from 10 / 30 / 45. and from workdays to calendar days.
- Multiple Coverage Prohibited: This provision may be not appear in the group policy if coverage is not provided for family members or persons otherwise associated with the primary eligible person.

Type 3 Variables – Eligible Persons and Effective Dates:

- Deferred Effective Date: The following language may appear in the event less restrictive underwriting parameters are provided for a given class of eligible persons other than employees:
-
- For Your Coverage to become effective, You must be in “Active Service” on the Coverage Effective Date and for the prior [10/30/45] [workdays] [calendar day period]. If You do not meet this requirement, Your Coverage Effective Date will be deferred until the [first/fifteenth] day of the month after] [first payroll period after] [date] You return to Active Service. “Active Service” means You are able to engage in substantially all of the usual activities of a person in good health of like age and sex, and are not: (1) confined in a hospital or nursing, assisted living, or custodial care facility; or (2) receiving home health care services.

Type 2 Variables: Definitions of Important Terms

- Actively At Work: This definition will appear if employees are covered under the Group Policy
- Elimination Period: Only the appropriate definition (calendar day or service day) for the Elimination Period will be included.
- The following definition will be included if the rate guarantee of the Group Policy applies at the certificate level:
“Original Certificate Effective Date means the original date Coverage was effective for You under the Group Policy, as shown on the Schedule of Benefits for this Certificate of Insurance.”

Type 3 Variables: Definitions of Important Terms

- Actively At Work: The criteria for employment can vary by group. It may include part-time, full-time or another basis that the group policyholder may use. The definition of that criteria may also vary by group.
- The definition of Coverage Effective Date may appear in the following manner:
 - “Coverage Effective Date means the date your Coverage under the Group Policy begins, as shown on the Schedule of Benefits.”
 - “Coverage Effective Date means the date Your Coverage, or any changes to Your Coverage, under the Group Policy, became effective as shown on the Schedule of Benefits.”

Type 2 Variables: Future Purchase Options Benefit

- The Future Purchase Options Benefit will not appear if it is not part of the group program design offering.
- The following language will appear only if automatic inflation protection riders are a part of the group program design offering:
If Your Coverage includes an Automatic Benefit Increase Option, these Benefit Provisions do not apply.

Type 3 Variables: Future Purchase Options Benefit

- The timeframes for the offer of additional coverage may vary from second, third or fifth anniversary.
- The timeframes for the response to the offer may vary from 31, 45 or 60 days.
- The number of declines permitted under the Benefit may change from “two consecutive offers;” however, the number will never be less than two.

Type 2 Variables: Informal Care Benefit

- The Informal Care Benefit will not appear if it is not part of the group program design offering.

Type 3 Variables: Informal Care Benefit

- The timeframes for the offer of additional coverage may vary from second, third or fifth anniversary.
- Reference to the Elimination Period in the Payment Limitation provision may be removed. The following language may appear:
- Payment of this Informal Care Benefit is not subject to the Elimination Period; and days of Covered Care under it cannot be used to satisfy the Elimination Period.

Type 2 Variables: Waiver of Premium Benefit

- The reference to the mode of premium payment may or may not appear.

Type 2 Variables: Return of Premium On Death Benefit

- The Return of Premium On Death Benefit will not appear if it is not part of the group program design.

Type 3 Variables: Contingent Nonforfeiture Benefit

- The schedule may be revised to conform to new state requirements.

Type 2 Variables: Exclusions and Limitations

- Exclusions: Any of the listed exclusions may or may not be included in the group policy, based on the group program design.
- Coordination with Other Coverage: The provision may or may not be included in the group policy, based on the group program design.

Type 3 Variables: Exclusions and Limitations

- Coordination with Other Coverage: The provision may be restricted to other group long term care insurance only. If so, the language will read
We consider **Long Term Care Coverage** to be *group coverage* that provides nursing facility, assisted living facility or home health care benefits.

Type 2 Variables: Coverage Changes

- Continuing Coverage Paid For By The Policyholder: The provision may or may not be included in the group policy, based on the group program design.

Type 2 Variables: Premiums and Renewals

- Your Premium Rate Guarantee: The following provision will be included if the rate guarantee of the Group Policy applies at the certificate level.
“Your Premium Rate Guarantee
The rates that determine the Premium for Your Coverage are guaranteed under the Group Policy for [three/five years/Rate Guarantee Period shown in Your Schedule of Benefits] from Your Original Certificate Effective Date, while Your Coverage remains in effect under the Group Policy.”
- Refund of Premiums Paid Beyond Death: Reference to the payment of premium by the Policyholder may be deleted if the group policyholder does not provide premium for the group program. The last sentence will read: The refund will be paid to Your estate.
- Protection Against Unintentional Lapse: Reference to payroll or pension deductions may be deleted if not part of the group policy.

Type 3 Variables: Premiums and Renewals

- Your Premium Rate Guarantee: The rate guarantee period can vary by case within the parameters currently approved for this policy form.
- Our Right To Change Premium Rates: The following language may be substituted for the last sentence of the first paragraph:
 - “Your Premium rates will not change:
 - Due to a change in Your age or health; or
 - Due to Your use of benefits; or
 - During the Premium Rate Guarantee period stated above. Your Premium Rate Guarantee does not apply to a change in Your Premium due to a change in benefits or a change in the terms of the Group Policy required by any law, regulation, judicial or administrative order or decision.”
- Our Right To Change Premium Rates: The timeframe for notice to the Group Policyholder may vary from 60, 90, 120 or 180 days.
- Your Options If Premium Rates Change:
 - The coverage amount for a decrease in coverage may be limited to the amounts available under the group program.
 - The timeframe for notice to the company for a plan change, may vary from 30/45/60/120 days
- Protection Against Unintentional Lapse: The timeframe for reminders concerning the designation may vary from one to two years.

Type 2 Variables: Termination and Coverage Continuation

- Your Right to Cancel Coverage At Anytime: Reference to the payment of premium by the Policyholder may be deleted if the group policyholder does not provide premium for the group program.

Type 3 Variables: Termination and Coverage Continuation

- Your Right to Cancel Coverage At Anytime: The effective date of cancellation may be changed to be consistent with the premium due dates under the group program.

Type 2 Variables: Replacement Provisions

- The Replacement Provisions will not appear unless the Group Policy is replacing another group policy issued to the same Group Policyholder.
- The bulleted item concerning the Return of Premium On Death Benefit will appear only if the benefit is in force under this replacing policy

CERTIFICATE SCHEDULE OF BENEFITS (DAILY) 7046CERT

Type 1 Variables: All Noted Provisions

- Variable information, such as the policyholder name, addresses, eligible classes, plans, premiums, discounts, signatures, timeframes, etc., will be completed with information appropriate to the specific group.

Type 2 Variables: Coverage Features and Limits

- The Schedule may include additional fields for the Original Certificate Effective Date, and for the Premium Rate Guarantee period, as appropriate to the specific group.
- The Schedule includes all benefit limits currently available under our group product for a group program that includes a daily cap on the Facility Care Maximum. Only those appropriate to the Insured will appear as a dollar amount based on the calculation shown.
 - Future Purchase Options will always appear in the issued certificate. If the Insured has elected an optional Automatic Benefit Increase Rider, the Coverage Features and Limits schedule will state Not Applicable.

- Certain Benefits will only be listed if part of the Group Program, and when appropriate, if elected by the insured: Informal Care Benefit, Return of Premium on Death Benefit, and any of the optional riders.
- Premium Contributions: References to Group Policyholder contributions and spousal or couples discount will only appear when included for the group program.
- Schedule of Benefits Print Date will reflect the date the form is created.
- Only the appropriate discounts will be stated, based on those provided for the insured.

CERTIFICATE SCHEDULE OF BENEFITS (MONTHLY)

Type 1 Variables: All Noted Provisions

- Variable information, such as the policyholder name, addresses, eligible classes, plans, premiums, discounts, signatures, timeframes, etc., will be completed with information appropriate to the specific group.

Type 2 Variables: Coverage Features and Limits

- The Schedule may include additional fields for the Original Certificate Effective Date, and for the Premium Rate Guarantee period, as appropriate to the specific group.
- The Schedule includes all benefit limits currently available under our group product for a group program that includes a daily cap on the Facility Care Maximum. Only those appropriate to the Insured will appear as a dollar amount based on the calculation shown.
 - Future Purchase Options will always appear in the issued certificate. If the Insured has elected an optional Automatic Benefit Increase Rider, the Coverage Features and Limits schedule will state Not Applicable.
 - Certain Benefits will only be listed if part of the Group Program, and when appropriate, if elected by the insured: Informal Care Benefit, Return of Premium on Death Benefit, and any of the optional riders.
 - Premium Contributions: References to Group Policyholder contributions and spousal or couples discount will only appear when included for the group program.
 - Schedule of Benefits Print Date will reflect the date the form is created.
 - Only the appropriate discounts will be stated, based on those provided for the insured.

OPTIONAL BENEFIT RIDERS

Only those riders available under the Group Program will be included in the group policy. Any rider may be included as part of the base coverage at the option of the Group Policyholder.

Type 1 Variables: All Riders

- Variable information, such as the policyholder name, addresses, signatures, etc., will be completed with information appropriate to the specific group.

AUTOMATIC INFLATION PROTECTION BENEFIT RIDER – 5% COMPOUND ANNUAL INCREASES FOR LIFE

Type 2 Variables:

- Termination:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be corrected if the reference does not appear.

AUTOMATIC BENEFIT INCREASE RIDER – 5% COMPOUND ANNUAL INCREASES TO AGE 70

Type 2 Variables:

- Termination:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be corrected if the reference does not appear.

AUTOMATIC INFLATION PROTECTION – SIMPLE ANNUAL INCREASES BENEFIT RIDER

Type 2 Variables:

- Termination:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be corrected if the reference does not appear.

AUTOMATIC BENEFIT INCREASES – AGE ADJUSTED PROTECTION: AGES 61 AND 76

Type 2 Variables:

- Effective Date: Only the appropriate language will appear depending on whether the rider is elected at the time the Certificate takes effect or subsequently.
- How This Rider Works After You Are Age 61 but Younger than Age 76: If the increase percentage does not change at age 76, the bracketed references to age 76 will not appear.
- How This Rider Works After You Are Age 76: If the increase percentage does not change at age 76, this paragraph will not appear.
- How Increases Are Determined: Only the appropriate definition of "Simple" will appear, based on the group program requirements.
- When Increases Stop:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be correct if the reference does not appear.
- Rider Termination:
 - The Rider will show the appropriate termination date based the Group Policy requirements.

Type 3 Variables:

- Increase Percentages: The amount of the increase will be based on that selected by the Group Policyholder, from 2%, 3%, or 5%.

AUTOMATIC BENEFIT INCREASE RIDER – AGE ADJUSTED COMPOUND PROTECTION: AGES 61 AND 76

Type 2 Variables:

- Effective Date: Only the appropriate language will appear depending on whether the rider is elected at the time the Certificate takes effect or subsequently.
 - How This Rider Works After You Are Age 61 but Younger than Age 76:
 - The rider will reflect the age at which the change in the percentage of the increase occurs: either 61 or 76, based on case specific requirements. If it is the later age, the reference will be to the later age only.
- How This Rider Works After You Are Age 76: If the increase percentage does not change at age 76, this paragraph will not appear.
- When Increases Stop:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be correct if the reference does not appear.
- Rider Termination:
 - The Rider will show the appropriate termination date based case specific requirements.

Type 3 Variables:

- How This Rider Works While You Are Younger Than Age 61:
 - The date the specific increase ends (either the anniversary date or the exact date) will be based on case specific requirements.
 - The age at which the percentage of the increase changes can vary between age 61 or 76, based on case specific requirements.
 - The specific percentage increase can vary from 3% to 5%, based on case specific requirements.
- How This Rider Works After You Are Age 61 but Younger than Age 76:
 - The rider will reflect the age at which the change in the percentage of the increase occurs: either 61 or 76. If it is the later age, the reference will be to the later age only, based on case specific requirements.
- How This Rider Works After You Are Age 76: The specific percentage increase can vary from 2%, 3% or 5%, based on case specific requirements.

AUTOMATIC BENEFIT INCREASE RIDER – X% COMPOUND ANNUAL INCREASES TO AGE 76

Type 2 Variables:

- Effective Date: Only the appropriate language will appear depending on whether the rider is elected at the time the Certificate takes effect or subsequently.
- When Increases Stop:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be correct if the reference does not appear.
- Termination:
 - The Rider will show the appropriate termination date based case specific requirements.
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be correct if the reference does not appear.

Type 3 Variables:

- Title: The correct percentage of the increase will be shown, based on case specific requirements, from 3%, 4% or 5%.
- How This Rider Works: The specific percentage increase can vary from 3%, 4% or 5%, based on case specific requirements.

AUTOMATIC BENEFIT INCREASE RIDER – AGE ADJUSTED PROTECTION: COMPOUND THROUGH AGE 65, SIMPLE THEREAFTER

Type 2 Variables:

- Effective Date: Only the appropriate language will appear depending on whether the rider is elected at the time the Certificate takes effect or subsequently.
- How Increases Are Determined: Only the appropriate language will appear for the date on which the value is determined in calculating the lifetime maximum, based on case specific requirements.
- When Increases Stop:
 - The reference to the Nonforfeiture Benefit Rider will not appear if it is not available under the Group Policy or part of the insured's coverage.
 - Grammatical sequencing will be correct if the reference does not appear.
- Rider Termination:
 - The Rider will show the appropriate termination date based case specific requirements.

NONFORFEITURE BENEFIT RIDER

Type 2 Variables:

- Inflation Protection Stops: Only the appropriate inflation option descriptions under the Group Policy will be included.

OUTLINE OF COVERAGE

Only the case specific options available under the Group Program will be included in the outline of coverage. Any rider may be included as part of the base coverage at the option of the Group Policyholder.

Type 1 Variables – All Provisions:

- Variable information, such as the policyholder name, policy number, pagination, addresses, signatures, etc., will be completed with information appropriate to the specific group.

Type 2 Variables -- Item 6:

- The reference to the Return of Premium Benefit will appear only if it is included in the Group Policy.
- If the Return of Premium Benefit is not part of the Group Policy, the second sentence will appear. In that event the word “However, “ will not appear in the last sentence.
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Type 3 Variables -- Item 6:

- The timeframes in the Free Look provision may vary from 30 to 60 days.

Type 2 Variables -- Item 9:

- Only the appropriate definition of the Elimination Period will be included.
- Only the appropriate reference for the Facility Care Maximum, daily or monthly, will be included.
- Only the appropriate reference to the benefit cap for the Home Assistance Benefit will be included, either 50 when there is a daily cap; 2 when there is a monthly cap.
- The Informal Care Benefit will be included only if part of the case specific plan design. If it is part of a specific plan design under the Group Policy, the outline will reference that in the title, e.g., Informal Care Benefit (Included under the Preferred and Premium Plan options).
- Only the appropriate reference to the benefit cap for the Respite Care Benefit will be included, either 21 or 30 times the Facility Care Maximum when there is a daily cap; the bracketed text will not appear if there is a monthly cap.
- Only the appropriate reference to the benefit cap for the Informal Care Benefit will be included, either 25% when there is a daily cap; 1% when there is a monthly cap.
- Only the appropriate reference to the Facility Care Maximum in the International Benefit, either day or month, will be included.
- The Optional Nonforfeiture Benefit Rider will be included only if part of the case specific plan design. Reference to “optional” will be removed if the rider is part of the coverage provided.

Type 2 Variables -- Item 10:

- Exclusions: Any of the listed exclusions may or may not be included in the group policy, based on the group program design.
- Coordination with Other Coverage: The provision may or may not be included in the group policy, based on the group program design.

Type 3 Variables -- Item 10:

- Coordination with Other Coverage: The provision may be restricted to other group long term care insurance only. If so, the language will read
We consider **Long Term Care Coverage** to be *group coverage* that provides nursing facility, assisted living facility or home health care benefits.

Type 2 Variables – Item 11:

- Relationship of Cost of Care and Benefits: The right to elect optional coverage may or may not appear in the event no optional riders are available under the Group Policy.
- Optional Benefit Increase Riders: Only those riders available under the group policy will be included in the Outline of Coverage.
- The Future Purchase Options Benefit will not appear if it is not part of the group program design offering.
- The following language will appear only if automatic inflation protection riders are a part of the group program design offering:
If You elect an Automatic Benefit Increase Option, the Future Purchase Options Benefit will not apply for your coverage.

Type 2 Variables - Automatic Benefit Increases – Age Adjusted Protection: Ages 61 And 76 :

- How This Rider Works After You Are Age 61 but Younger than Age 76: If the increase percentage does not change at age 76, the bracketed references to age 76 will not appear.
- How This Rider Works After You Are Age 76: If the increase percentage does not change at age 76, this paragraph will not appear.
- How Increases Are Determined: Only the appropriate definition of “Simple” will appear, based on the group program requirements.

Type 3 Variables -- Automatic Benefit Increases – Age Adjusted Protection: Ages 61 And 76 :

- Increase Percentages: The amount of the increase will be based on that selected by the Group Policyholder, from 2%, 3%, or 5%.

Type 2 Variables -- Automatic Benefit Increase Rider – Age Adjusted Compound Protection: Ages 61 And 76

- How This Rider Works After You Are Age 61 but Younger than Age 76:
 - The rider will reflect the age at which the change in the percentage of the increase occurs: either 61 or 76, based on case specific requirements. If it is the later age, the reference will be to the later age only.
- How This Rider Works After You Are Age 76: If the increase percentage does not change at age 76, this paragraph will not appear.

Type 3 Variables -- Automatic Benefit Increase Rider – Age Adjusted Compound Protection: Ages 61 And 76

- How This Rider Works While You Are Younger Than Age 61:
 - The date the specific increase ends (either the anniversary date or the exact date) will be based on case specific requirements.
 - The age at which the percentage of the increase changes can vary between age 61 or 76, based on case specific requirements.
 - The specific percentage increase can vary from 3% to 5%, based on case specific requirements.
- How This Rider Works After You Are Age 61 but Younger than Age 76:
 - The rider will reflect the age at which the change in the percentage of the increase occurs: either 61 or 76. If it is the later age, the reference will be to the later age only, based on case specific requirements.
- How This Rider Works After You Are Age 76: The specific percentage increase can vary from 2%, 3% or 5%, based on case specific requirements.

Type 3 Variables -- Automatic Benefit Increase Rider – X% Compound Annual Increases To Age 76:

- Title: The correct percentage of the increase will be shown, based on case specific requirements, from 3%, 4% or 5%.
- How This Rider Works: The specific percentage increase can vary from 3%, 4% or 5%, based on case specific requirements.

Type 3 Variables – Future Purchase Options Benefit:

- The timeframes for the offer of additional coverage may vary from second, third or fifth anniversary.
- The timeframes for the response to the offer may vary from 31, 45 or 60 days.
- The number of declines permitted under the Benefit may change from “two consecutive offers;” however, the number will never be less than two.

Type 3 Variables: Inflation Protection – Graphic Comparisons

- The example under the Inflation Protection – Graphic Comparisons language and the accompanying graphs are bracketed so that they may be adjusted to reflect the specific inflation protection features offered under the Group Policy. The specific numbers are bracketed so that only one set will appear, depending on whether the Group Policy pays benefits on a daily basis or a monthly basis.

INDIVIDUAL APPLICATIONS

Guaranteed Issue Application (37607)

Type 1 Variables:

- Title Section and Sections A, D and F: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections B and G: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Section F: Only the amounts and benefit options available under the Group Policy will be included.
- Section G: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Sections A and E:
 - The Actively at Work/Active Service definition will be based on case specific requirements.
- Section D:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The second paragraph may be replaced in its entirety to read: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that [any/voluntary] insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and the Group Policy is in effect.”

Simplified Guaranteed Issue Form Application (37608)

Type 1 Variables:

- Title Section and Sections A, F, and G: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Section B and H: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Section E: The last sentence in the first paragraph may or may not be included.
- Section G: Only the amounts and benefit options available under the Group Policy will be included.
- Section H: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Section A: The Actively at Work/Active Service definition will be based on case specific requirements.
- Section E:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The phrase “is in effect” may be used in lieu of the phrase “and Certificate have been delivered and accepted”.
- The second paragraph may be replaced in its entirety to read: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”

Comprehensive Modified Guaranteed Issue Application (37609)

Type 1 Variables:

- Title Section and Sections A, F, and G: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections B and H: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Section G: Only the amounts and benefit options available under the Group Policy will be included.
- Section H: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Section A: The Actively at Work/Active Service definition will be based on case specific requirements.
- Section D:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The second paragraph may be replaced in its entirety to read: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”

Short Form Application (37610)

Type 1 Variables:

- Title Section and Sections A, H, and I: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections B, I, and J: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Sections F and K:

- Reference to the Medical Information Bureau will be used only if the underwriting process includes review of the records in the Medical Information Bureau.
- Section J: Only those premium payment options available under the Group Policy will be included.
- Section K: The application may contain our most current notice of our Insurance Information Practices.

Type 3 Variables:

- Section A: The Actively at Work/Active Service definition will be based on case specific requirements.
- Section F:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The agreement statement may be replaced in its entirety with: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”

Long Form Application (37611)

Type 1 Variables:

- Title Section and Sections A, J, K, and M: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections B and L: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Section G, Item 2: If the application is to be submitted electronically, the phrase “in your own handwriting” will not appear.
- Sections I and M: Reference to the Medical Information Bureau will be used only if the underwriting process includes review of the records in the Medical Information Bureau.
- Section L: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Section A: The Actively at Work/Active Service definition will be based on case specific requirements.
- Section I:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The agreement statement may be replaced in its entirety with: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”
- Section M: The application may contain our most current notice of our Insurance Information Practices.

Long Form Application (37612)

Type 1 Variables:

- Title Section and Sections A, B, J, K, and M: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections A, B and L: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Section G, Item 3: If the application is to be submitted electronically, the phrase “in your own handwriting” will not appear.
- Sections I and M: Reference to the Medical Information Bureau will be used only if the underwriting process includes review of the records in the Medical Information Bureau.
- Section L: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Section I:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The agreement statement may be replaced in its entirety with: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”
-
- Section M: The application may contain our most current notice of our Insurance Information Practices.

Long Form Application (37613)

Type 1 Variables:

- Title Section and Sections A, B, J, K, L, and M: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Section G, Item 3: If the application is to be submitted electronically, the phrase “in your own handwriting” will not appear.
- Sections I and M: Reference to the Medical Information Bureau will be used only if the underwriting process includes review of the records in the Medical Information Bureau.
- Section K: Only the amounts and benefit options available under the Group Policy will be included.
- Section L:
 - Only those premium payment options available under the Group Policy will be included
 - References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.

Type 3 Variables:

- Section I:
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The agreement statement may be replaced in its entirety with: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted

in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”

- Section M: The application may contain our most current notice of our Insurance Information Practices.

Short Form Application (37614)

Type 1 Variables:

- Title Section and Sections A, B, H, I, and K: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections A, F and J: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Sections F and K: Reference to the Medical Information Bureau will be used only if the underwriting process includes review of the records in the Medical Information Bureau.
- Section I: Only the amounts and benefit options available under the Group Policy will be included.
- Section J: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Section F:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The agreement statement may be replaced in its entirety with: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”
- Section K: The application may contain our most current notice of our Insurance Information Practices.

Buy-Up GI Application (37615)

Type 1 Variables:

- Title Section and Sections A, B, H, I, and K: Variable information, such as the policyholder name, policy number, description of eligible classes and actively at work definitions, plans, benefits selections, etc., will be included as appropriate based on case specific requirements. The specific class may or may not appear in the title line.

Type 2 Variables:

- Sections A, F and J: References to Domestic Partners will only be included if they are eligible under the Group Policy. The reference may be changed as required by state law.
- Sections F and K: Reference to the Medical Information Bureau will be used only if the underwriting process includes review of the records in the Medical Information Bureau.
- Section I: Only the amounts and benefit options available under the Group Policy will be included.
- Section J: Only those premium payment options available under the Group Policy will be included.

Type 3 Variables:

- Section F:
 - Reference to the type of coverage may vary from “any” or “voluntary.”
 - The use of Actively at Work or Active Service will be based on case specific requirements.
 - The agreement statement may be replaced in its entirety with: “I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take

effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.”

- Section K: The application may contain our most current notice of our Insurance Information Practices.

Application for Insurance Insurability Questionnaire (43146)

Type 1 Variables:

- Section B: The description of eligibility will be included as appropriate based on case specific requirements. A specific class description may or may not appear.
- Section I: Rejection of Optional Nonforfeiture Benefit Rider: This text will only appear if the option is available under the Group Policy.

Type 2 Variables:

- All Sections: The form may be revised to contain answers for only one applicant. In that event, the form will not include title lines for Applicant A and Applicant B. Reference will be solely to the Applicant where appropriate and the check box columns and additional text, and spacing for the second applicant will be deleted. The dual check boxes and references would not then appear in any section of the form.
- Section I:
 - Request for a Later Effective Date: This section will only appear if acceptable for administration of a specific Group Policy.
 - Reference to Individual and Shared Plans in the Request for a Later Effective Date will only appear if the administration of the group allows for a shared application process, and the Group Policy offers a Shared Plan.
 - Signature Box: The Signature Box for an agent will not appear in the event there is not an agent involved in the sales process.
- Section J: This section may only appear if there is an agent involved in the application process.
- Section K: This section may only appear if case specific administrative requirements permit and premium is accepted with the application.
- Section M and N: This section will only be included if an agent is involved in the sale.

Type 3 Variables:

- Section B: The appropriate class description will be used based on the eligible classes under the Group Policy.
- Section I, Agreement, Item 3: Depending on case specific administrative requirements, the following variations may occur with respect to the effective date language shown under AGREEMENT Item 3.
 - *When premium is not included with the submitted application:* “3) if I qualify, the Group Policy is in effect and there has been no change in my health that would change the answers to any of the questions in this application, my Coverage will take effect according to the terms of the Group Policy.”
 - *When premium is included with the submitted application:* “3) if I qualify, the Group Policy is in effect, and the Initial Premium is paid, my Coverage will take effect on the later of the Group Policy Effective Date or the date the application is signed.”
 - *When premium is included with the submitted application and the applicant requests a later effective date:* “3) if I qualify, the Group Policy is in effect, and the Initial Premium is paid, my Coverage will take effect on the date set by the Company if I request a Later Effective Date.”
- Section J, K, and L: Successive titles of the application will be adjusted if a section does not appear in a case specific application.

GENWORTH LIFE INSURANCE COMPANY

A Stock Life Insurance Company (herein called We, Us and Our)

[Administrative Office: P. O. Box 947500, Maitland, FL 32794-7500 Phone Number 800-416-3624]

LONG TERM CARE CERTIFICATE OF INSURANCE

Policyholder: [ABC Company]

Group Policy Number: [XXXXXX-X]

This Certificate was issued in Arkansas and is governed by the laws of the State of Arkansas.

We have issued a Group Policy to the Policyholder shown above. The provisions of the Group Policy that are important to You are set forth in this Certificate. These provisions are effective only while Your Coverage is in force. This Certificate consists of this form, the Schedules of Benefits (including the Schedule of Benefits with the most recent Print Date), Your Application and any additional forms and riders that have been made a part of this Certificate. This Certificate replaces all Certificates that may have been given to You earlier in connection with Your Coverage.

CAUTION: The issuance of this Certificate is based upon Your answers to the questions on Your Application. A copy of Your Application is enclosed or provided separately. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Coverage. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of Your answers are incorrect, contact Us at the address and telephone number shown above.

NOTICE TO BUYER: The Group Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all coverage limitations.

THE GROUP POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare which is available from Us.

IMPORTANT NOTICE: The Group Policy is intended to be a federally tax qualified long term care insurance contract under 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).

GUARANTEED RENEWABLE. Your Coverage is guaranteed renewable. This means that You have the right to continue Your Coverage in force by paying the required premium when due. If the Group Policy terminates, You may continue Your Coverage under a replacement policy or under continued coverage as provided herein. Premiums may increase on a group or premium class basis as stated in the Premiums And Renewals section herein.

FREE LOOK – [30/45/60/90] DAY RIGHT TO EXAMINE YOUR CERTIFICATE: You may return this Certificate to the address shown above within [30/45/60/90] days after You received it if You are not satisfied with it for any reason. Upon surrender of this Certificate within the [30/45/60/90]-day period, Your Coverage under the Group Policy will be void from the beginning and We will refund any premium paid within 30 days of such surrender.

Signed for Genworth Life Insurance Company.

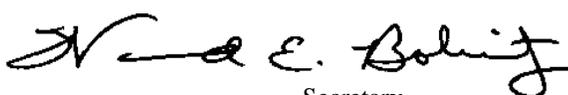
[ Secretary  President and CEO, Long Term Care Division]

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Refer to Your Schedule of Benefits to determine the benefits, options and applicable coverage details.

ELIGIBLE PERSONS AND EFFECTIVE DATE

1 Eligible Classes

[All Eligible Persons and their Eligible Family Members as defined below who are at least 18 years of age but less than age 80. A person may not be insured as both an Eligible Person and an Eligible Family Member.]

Eligible Persons: All individuals associated with the Policyholder in the manner described below.

[Employees: Regular full-time employees of the Policyholder who are Actively at Work.]

[Retirees: Former employees of the Policyholder who have retired under the Policyholder's retirement plan, and who satisfy the age and service requirements determined by the Policyholder.]

2

[Members: All members in good standing with the Policyholder.]

[Eligible Family Member: The members of an Eligible Person's family listed and described below.]

[Spouse: A person to whom an Eligible Person is legally married [or the Domestic Partner of an Eligible Person]. Spouse does not include a person from whom the Eligible Person is divorced or legally separated. / **Spouse** means the person to whom You are joined by: (a) marriage; or (b) a relationship legally recognized under state law.]

[Domestic Partner: A person who lives with the Eligible Person in a domestic partner relationship; provided that the Eligible Person has completed and returned a declaration of domestic partnership in a form and manner required by the Policyholder, and acceptable to Us.]

[Surviving Spouse: A person who is participating in a health benefits program or a retirement plan sponsored by the Policyholder and was a Spouse at the time of the Eligible Person's death.]

[Parents: The natural Parents, adoptive Parents or step Parents of an Eligible Person or Spouse.]

[Grandparents: The natural Grandparents, adoptive Grandparents or step Grandparents of an Eligible Person or Spouse.]

Coverage Eligibility

If You are an Eligible Person on the Group Policy Effective Date, You are eligible to apply for coverage on that date. Otherwise, You are eligible to apply for coverage on the date You enter an Eligible Class.

2

[If You are an Eligible Family Member, You are eligible to apply for coverage on the later of: (a) the date the Eligible Person is eligible for coverage; or (b) the date You enter an Eligible Class.]

Coverage Taking Effect

Coverage will become effective as described below.

A person must be in an eligible class, must apply for coverage, agree to pay the required premium, and be approved by Us based on Our requirement that You provide proof of insurability in a form and manner specified by Us.

Except as provided below, Your Coverage will become effective on the Coverage Effective Date shown in Your Schedule of Benefits, subject to payment of the required premium.

2 {Deferred Coverage Effective Date [(applicable only to employees)]:

3

If You are an Employee You must be Actively at Work on the Coverage Effective Date and for the prior [10/30/45] [workdays] [calendar day period]. If You cannot satisfy this requirement, Your Coverage Effective Date will be deferred until the first day of Your employer's regularly scheduled payroll billing period on which You are Actively at Work, and have been Actively at Work for the prior [10/30/45] [workdays] [calendar day period]. }

2 [Multiple Coverage Prohibited

No person may be covered under multiple classes or as a relative of more than one person.]

DEFINITIONS OF IMPORTANT TERMS

*This section provides the definitions of words used in this Certificate that have a special meaning when applied to Your Coverage. Additional definitions appear where they can assist You in understanding related text. For example, most Benefits have definitions for covered services and/or providers. To help You recognize defined terms, they are printed in **bold** where they are defined and the first letter of each word is capitalized wherever it appears.*

2

3

[Actively at Work] means You are an employee who is performing the usual duties of Your job at the usual place of work as required by Your employer on a [full-time basis at least 30 hours each week]. You will be considered Actively at Work while on employer approved vacations, holidays and regularly scheduled days off, or during temporary business closures. You will not be considered to be Actively at Work if You are unable to perform Your usual duties due to a sickness, accident or injury or if You are on a leave of absence, a sabbatical or retired from the same employer.]

Activities Of Daily Living (ADLs) means the following self-care functions:

- **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring:** Moving into or out of a bed, chair or wheelchair.
- **Continence:** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table).

Application means the written or electronic forms provided by Us and completed by You when You apply for coverage.

Confinement or Confined means You are a resident in a facility during a period for which room and board charges are Covered Expenses under Your Coverage.

Coverage Effective Date means the date Your Coverage under the Group Policy begins, as shown on the Schedule of Benefits.

Covered Care means only those Qualified Long Term Care Services for which Your Coverage pays benefits or would pay benefits in the absence of an Elimination Period.

Covered Expenses means costs You incur for which a benefit may be payable under Your Coverage. Each benefit section defines the Covered Expenses under that benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

2

[Elimination Period] means the total number of days that You remain a Chronically Ill Individual (as defined later in this Certificate) and incur Covered Expenses before benefits are payable. The Elimination Period begins on the first day that You are both a Chronically Ill Individual and incur Covered Expenses. Each day on which You remain a Chronically Ill Individual and incur Covered Expenses that are subject to the Elimination Period will count toward the

Elimination Period. Each Benefit states how its payment is affected by the Elimination Period.

Elimination Period days do not have to be consecutive. They may be accumulated before the filing of a claim if We can establish that You met these Elimination Period requirements before the filing of a claim.

The Elimination Period is shown on Your Schedule of Benefits. It needs to be met only once during Your lifetime. We will count towards satisfying the Elimination Period, days on which You receive Covered Care that is excluded from payment because it is covered by Medicare or other coverages identified in the Non-Duplication provision of the Exclusions and Limitations.]

2

[Elimination Period means the total number of days that You remain a Chronically Ill Individual (as defined later in this Certificate) before benefits are payable. Each Benefit states how its payment is affected by the Elimination Period. The Elimination Period begins on the first day that You are both a Chronically Ill Individual and incur Covered Expenses. However, You are not required to continue to incur Covered Expenses to satisfy the Elimination Period. You must remain a Chronically Ill Individual for each consecutive day following the first day of the Elimination Period in order to satisfy the Elimination Period.

Elimination Period days may be accumulated before the filing of a claim if We can establish that You met these Elimination Period requirements before the filing of a claim.

The Elimination Period is shown on Your Schedule of Benefits. It needs to be met only once during Your lifetime. We will count towards satisfying the Elimination Period, days on which You receive Covered Care that is excluded from payment because it is covered by Medicare or other coverage identified in the Non-Duplication provision of the Exclusions and Limitations.]

Facility Care Maximum means the maximum amount We will pay when You are Confined in a Nursing Facility, Assisted Living Facility or Hospice Care Facility as stated in the Schedule of Benefits. This amount is also used to determine other benefit maximums.

Home means the place where You maintain independent residence. This could be a house, condominium, apartment, unit in a congregate care community or similar residential environment. Home does not mean:

- A hospital;
- A Nursing Facility;
- An Assisted Living Facility; or
- A Hospice Care Facility.

Immediate Family means Your Spouse or anyone who is related to You or Your Spouse as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece. This includes adopted, in-law and step-relatives.

Licensed Health Care Practitioner means any of the following who is not a member of Your Immediate Family:

- A Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);
- A registered professional nurse;
- A licensed social worker; or
- Any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which You are a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicaid means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is practicing within the scope of that license.

Physician has the same meaning as that set forth in Sec. 1861(r)(1) of the Social Security Act and means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Policy Lifetime Maximum means the maximum amount of benefits payable to You. The Policy Lifetime Maximum will be reduced by the amount of claims paid, except that Covered Expenses We incur for Care Coordination Services do not count against Your Policy Lifetime Maximum. The Policy Lifetime Maximum will increase in accordance with the terms of any inflation protection in force. The Policy Lifetime Maximum will increase or decrease in accordance with any increase or decrease You elect under Coverage Changes. The Policy Lifetime Maximum is shown on Your Schedule of Benefits and is current as of the Schedule of Benefits Print Date.

Premium Due Date means the date on which premium payments are due to be paid to Us.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which:

- Are required by a Chronically Ill Individual; and
- Are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Important Note: To be eligible for benefit payments it is not sufficient for services only to be Qualified Long Term Care Services. Such services must also:

- Be care or support services for which Your Coverage pays benefits; and
- Satisfy all other requirements for benefit eligibility and payment.

Representative means a person or entity legally empowered to represent You.

We, Us or Our means Genworth Life Insurance Company.

You, Your or Yourself means the person named as the Insured in Your Schedule of Benefits who is covered under the Group Policy.

Your Coverage means the benefits You have under the Group Policy or Continuation Coverage.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Conditions For Receiving Benefits

For You to be eligible for the Benefits provided by Your Coverage We must have both:

- A Current Eligibility Certification; and
- Ongoing proof which demonstrates that the Covered Care You receive is needed due to Your continually being a Chronically Ill Individual. The proof can be based on information from care providers, personal physicians and other Licensed Health Care Practitioners.

Benefits will be paid as reimbursement for Covered Expenses incurred for Covered Care services that meet all of the following additional conditions:

- Your Coverage provides benefits for Covered Care services, as described in this Certificate;
- The Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- Except as stated in the Extension of Benefits provision, Your Coverage is in force on the date(s) the Covered Care is received;
- You have not exhausted any daily, monthly, annual or lifetime limits on the specific benefits claimed;
- You meet all additional requirements for the specific benefits You claim;
- The service, cost or item for which benefits are payable constitutes Qualified Long Term Care Services; and
- You satisfy the Elimination Period.

Once We determine that You are eligible for benefits, Your eligibility for benefits will continue for as long as You continue to be a Chronically Ill Individual, and have not exhausted the Policy Lifetime Maximum. We reserve the right to perform periodic reassessments of Your eligibility.

Definitions

An **Activity of Daily Living** is one of the following: Bathing; Dressing; Eating; Contenance; Toileting; and Transferring. These terms are defined in the Definitions of Important Terms.

A **Chronically Ill Individual** is a person who has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- Requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

A **Current Eligibility Certification** is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that You meet the above requirements for being a Chronically Ill Individual.

Substantial Assistance is either:

- **Hands-on Assistance** which is the physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living; or

- **Standby Assistance** which is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to Yourself while You are performing the Activity of Daily Living.

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that:

- Is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- Is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:
 - Short-term or long term memory;
 - Orientation as to people, places, or time;
 - Deductive or abstract reasoning; and
 - Judgment as it relates to safety awareness.

Substantial Supervision is continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another nearby person that is necessary to protect the severely cognitively impaired person from threats to his or her health or safety (such as may result from wandering).

A **Plan of Care** is a written, individualized plan for care and support services for You that:

- Has been developed as a result of an assessment and incorporates any information provided by Your personal Physician; and
- Has been prescribed by a Licensed Health Care Practitioner; and
- Fairly, accurately and appropriately addresses Your long term care and support service needs; and
- Specifies:
 - the type, frequency and duration of all services required to meet those needs;
 - the kinds of providers appropriate to furnish those services; and
 - an estimate of the appropriate cost of such services.

We retain the right to discuss the Plan of Care with the Licensed Health Care Practitioner. We may also verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual. The Plan of Care must be updated as Your needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 30 days. We will make a copy of the current Plan of Care available to Your personal Physician, when requested. No more than one Plan of Care may be in effect at a time.

2

[FUTURE PURCHASE OPTIONS BENEFIT

*[IF YOUR COVERAGE INCLUDES AN AUTOMATIC BENEFIT INCREASE OPTION,
THESE BENEFIT PROVISIONS DO NOT APPLY.]*

The Benefit

2

On every [second/third/fifth] anniversary of the Group Policy Effective Date, while Your Coverage is in force, You will be offered the opportunity to increase by 5% compounded annually:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum.

The offer will be made as long as:

- Your Coverage remains in force;
- You are not currently receiving benefits;
- You have not filed a claim which is pending;
- You have not been determined to be currently eligible for benefits; and
- You are not currently satisfying the Elimination Period.

Proof of Insurability Requirements

2

You may elect to increase Your Coverage by the amount offered under this benefit, without submitting proof of insurability, as long as You have not previously declined [two consecutive] offers.

Additional Premium For The Increased Coverage

The premium for the amount of increased coverage will be based on Your age as of the date the benefit increase offer is made to You.

How Do You Put The Increase Into Effect?

2

You must send Us a written request on the form We supply indicating that You have accepted the option to increase coverage. This must be received by Us within [31/45/60] days after We send You notification of the offer.

You May Decline The Offer

2

You may decline the offer to increase coverage any time it is made. Once You have refused [two consecutive] offers, this benefit will no longer be offered by Us. If, after that, You want to increase Your Coverage, You may apply to do so. You must submit proof of insurability acceptable to Us. The process for requesting an increase in coverage is described in the Coverage Changes provision of the Certificate.

Not Available If Your Coverage Has Lapsed Or If You Are In Nonforfeiture Status

If Your Coverage has lapsed or You are in Nonforfeiture status (this includes the Contingent Nonforfeiture Benefit), You are no longer eligible for coverage increase offers under this Benefit.]

CARE COORDINATION SERVICES

Care Coordination Services

These services are intended to help identify care needs and community resources available to deliver care when You are a Chronically Ill Individual. These services are furnished by a team of Covered Care Coordinators provided by Us at no cost to You. We will pay for these services when You receive them while Your Coverage is in effect. These payments will be at Our expense; and will NOT count against any payment maximum.

About The Care Coordination Services

Care Coordination Services will provide You with a team of Covered Care Coordinators who will review Your specific situation and develop Plans of Care to meet Your needs. Covered Care Coordinators will:

- Assess Your functional, cognitive and personal needs for care and services on an ongoing basis;
- Work with You to identify the specific services and care providers You require;
- Develop and suggest initial and subsequent Plans of Care to assist You in meeting Your needs;
- Provide the initial and ongoing Current Eligibility Certifications; and
- Monitor Your care needs on an ongoing basis to help You receive appropriate care.

You or Your family should contact Us immediately when You choose to use the services of a Covered Care Coordinator. We will then make arrangements for a Covered Care Coordinator to contact You and begin providing You with this assistance.

Definition

A **Covered Care Coordinator** is a Nurse or licensed social worker who is:

- Qualified by training and experience to assess and coordinate the overall care needs of a Chronically Ill Individual; and
- Meets standards satisfactory to Us that pertain to quality assurance, reporting and record maintenance requirements.

Care Coordination Services Are Voluntary

You are not required to use these Care Coordination Services. However, You may, at Your own expense, use a Licensed Health Care Practitioner who is not a Covered Care Coordinator to provide a Plan of Care, Current Eligibility Certification, or assist in coordinating services.

Benefits Paid Will Not Reduce Any Payment Maximums

Expenses paid for Care Coordination Services will not reduce the amount available under any daily, monthly, annual or lifetime benefit maximums.

Payment Limitations

Care Coordination Services will not be provided in connection with the International Coverage Benefit.

Payment for these services is NOT subject to: the Elimination Period; the Policy Lifetime Maximum; or any other payment limits. It cannot be used to satisfy the Elimination Period; and does not qualify You for the Waiver of Premium Benefit.

NURSING FACILITY BENEFIT

The Benefit

You are eligible to receive benefits during Your Confinement in a Nursing Facility.

Covered Expenses

Covered Expenses for Nursing Facility care means expenses You incur for care and support services (including room and board) provided by the Nursing Facility.

The expenses must be consistent with the level of charges normally made for other persons receiving similar Confinement care. Covered Expenses do not include expenses You incur for prescription medications or for any charges for Your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment.

How Much We Will Pay

We will pay up to the Facility Care Maximum for Covered Expenses You incur during Your Confinement. The Facility Care Maximum is shown on Your Schedule of Benefits.

Definition

A **Nursing Facility** is a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse; the facility must employ at least one full-time (at least 30 hours per week) Nurse; and a Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Facility does NOT include any of the following:

- A hospital or clinic.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- An Assisted Living Facility.
- Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- A substantially similar adult residence establishment or environment.

Payment Limitations

Payment of this Benefit is subject to: the Elimination Period; the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit except when we pay for: Care Coordination Services; or Caregiver Training covered under the Home Assistance Benefit.

ASSISTED LIVING FACILITY BENEFIT

The Benefit

You are eligible to receive benefits during Your Confinement in an Assisted Living Facility.

Covered Expenses

Covered Expenses for care in an Assisted Living Facility means expenses You incur for care and support services (including room and board) provided by the Assisted Living Facility.

The expenses must be consistent with the level of charges normally made for other persons receiving similar Confinement care. Covered Expenses do not include expenses You incur for prescription medications or any charges for Your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment.

How Much We Will Pay

We will pay up to the Facility Care Maximum for Covered Expenses You incur during Your Confinement. The Facility Care Maximum is shown on Your Schedule of Benefits.

Definition

An **Assisted Living Facility** is a facility (including one for people with Alzheimer's) that is not excluded below and is engaged primarily in providing Maintenance or Personal Care Services to its residents. It must provide those services 24 hours a day, every day:

- Under a license, certificate, or substantially similar permit and oversight from the federal government or the State in which it is located; OR
- To at least 10 residents, in accordance with all applicable laws, and continuously meet all of the following requirements:
 - It maintains records for all care and services provided to each resident;
 - It has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment;
 - It has an awake employee who is aware of the whereabouts of the resident inpatients;
 - It provides, at a minimum, assistance with Bathing and Dressing;
 - It provides three (3) meals a day and accommodates special dietary needs;
 - It has written formal procedures, including an agreement with a Physician or Nurse, for the furnishing of medical care and services in case of an emergency; and
 - It has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Living Facility is NOT any of the following:

- A hospital or clinic.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- A Nursing Facility.
- Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or a substantially similar adult residence establishment or environment.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Living Facility only if it is engaged primarily in providing care that satisfies the above definition.

Payment Limitations

Payment of this Benefit is subject to: the Elimination Period; the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit except when we pay for: Care Coordination Services; or Caregiver Training covered under the Home Assistance Benefit.

BED RESERVATION BENEFIT

The Benefit

You are eligible to receive benefits to reserve Your accommodations in a Nursing Facility or Assisted Living Facility during Your temporary absence from that facility.

Covered Expenses

Covered Expenses for Bed Reservation Benefits means the same as Covered Expenses for reserving Your room and board accommodations in the Nursing Facility or Assisted Living Facility.

How Much We Will Pay

We will pay up to the Facility Care Maximum for Covered Expenses You incur while You are temporarily absent from the Nursing Facility or Assisted Living Facility. This Benefit is payable for up to the maximum Days Per Calendar Year shown for this Benefit in the Schedule of Benefits.

The temporary absence can be for any reason, including, but not limited to, hospital stays as well as spending holidays or other time with Your family.

Payment Limitations

Payment under the terms of this Benefit is subject to: the Elimination Period; the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit except when we pay for: Care Coordination Services; or Caregiver Training covered under the Home Assistance Benefit.

HOME AND COMMUNITY CARE BENEFIT

The Benefit

You are eligible to receive benefits for Covered Expenses You incur for Home and Community Care.

Covered Expenses

Covered Expenses for Home and Community Care means expenses You incur for the following services:

- Adult Day Care;
- Nurse and Therapist Services;
- Home Health or Personal Care Services; and
- Incidental Homemaker and Chore Care.

How Much We Will Pay

We will pay up to the Home and Community Care Maximum for Covered Expenses You incur. The Home and Community Care Maximum is shown on Your Schedule of Benefits.

Definitions

Adult Day Care means a program for six (6) or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Nurse and Therapist Services means health care services provided in Your Home by a Nurse, or a licensed physical, occupational, respiratory, or speech therapist.

Home Health or Personal Care Services means assistance You receive in Your Home from a Home Health Agency or Independent Provider with: simple health care tasks; personal hygiene; managing medications; performing Activities of Daily Living; and supervision needed when You have Severe Cognitive Impairment.

Incidental Homemaker and Chore Care means assistance provided in Your Home:

- By the same person providing Home Health or Personal Care Services; and
- During the same visit in which You receive Home Health or Personal Care Services.

This assistance consists of: meal planning and preparation; doing laundry; light house cleaning (such as: vacuuming, dry mopping, dishwashing, cleaning the kitchen or bath, and changing bedding); minor household repairs related to Your safety at Home (such as to handrails and safety rails, stairs, or floors); taking out the garbage; and simple cleaning tasks to remove unsafe debris or dirt from Your Home. This does not mean any type of: residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; transportation or vehicle or equipment maintenance; or similar tasks.

Home Health Agency means an entity that is regularly engaged in providing Home Health or Personal Care Services for compensation and employs staff who are qualified by education, training, or experience to provide such care. The entity must:

- Be supervised by a qualified professional such as a Nurse, a licensed social worker, or a Physician;

- Keep clinical records or careplans on all patients;
- Provide ongoing supervision and training to its staff appropriate to the services to be provided; and
- Have the appropriate state licensure or certification, where required.

An **Independent Provider** means a person who is not affiliated with a Home Health Agency and is licensed or certified in the state where the care will be provided, to provide assistance in performing Activities of Daily Living or supervision for someone who has Severe Cognitive Impairment. If the state in which You live does not require licensure or certification for Independent Providers, We may approve benefits for an Independent Provider if We can determine, using Our sole discretion, that the individual is qualified by education, training and experience to provide Home Health or Personal Care Services. The education must include training in safely assisting Chronically Ill Individuals. We will require written proof of licensure or certification, and will accept inclusion in a state sponsored nurse aide registry, if the state in which You live maintains such a registry.

Payment Limitations

Payment under the terms of this Benefit is subject to: the Elimination Period; the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit except when we pay for: Care Coordination Services; or the Home Assistance Benefit.

HOME ASSISTANCE BENEFIT

The Benefit

You are eligible to receive benefits for Covered Expenses You incur for Home Assistance.

Covered Expenses

Covered Expenses for Home Assistance means expenses You incur (including tax, installation and labor costs) for the following services or items:

- Home Modifications, Assistive Devices and Supportive Equipment;
- Emergency Medical Response Systems; and
- Caregiver Training.

Covered Expenses must be:

- Intended to enable You to remain in Your Home; and
- Stated in, and furnished in accordance with, Your Plan of Care.

How Much We Will Pay

We will pay up to the Home Assistance Lifetime Maximum shown on Your Schedule of Benefits for Covered Expenses You incur for Home Assistance.

Definitions

Home Modifications, Assistive Devices and Supportive Equipment means items such as the following that are intended to relieve Your need for direct physical assistance; and (as stated in Your Plan of Care) are expected to enable You to remain in Your Home for at least 90 days after the date of purchase or first rental:

- Ramps to permit movement from one level of Your Home to another;
- Grab bars to assist in toileting, bathing or showering;
- Hospital-style beds, wheelchairs or crutches;
- Adaptive equipment to enable independent feeding and dressing (specialized utensils and fasteners); and
- Pumps and other devices for intravenous injection.

This does NOT include:

- Home repair, remodeling, or installation of an elevator, escalator, hot tub, swimming pool, or Jacuzzi or other similar items or services;
- Items that will, other than incidentally, increase the value of Your Home; and
- Artificial limbs, teeth, corrective lenses, hearing aids, or equipment placed in Your body, temporarily or permanently.

Emergency Medical Response Systems means the installation and any ongoing fees for any type of medical alert system.

Caregiver Training means the training of a family member, friend, or other person to provide care for You in Your Home. Caregiver Training must be included in Your Plan of Care. Covered Expenses for Caregiver Training means expenses incurred for training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for You. The training cannot be received when You are Confined in a hospital, Nursing Facility or Assisted Living Facility, unless it is reasonably expected that the training will make it possible for You to return to Your Home, where You can be cared for by the person receiving the training.

Payment Limitations

Payment under the terms of this Benefit is subject to: the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit except when we pay for: Care Coordination Services; or the Home and Community Care Benefit. Also, Caregiver Training covered under this Benefit may be paid at the same time as the Nursing Facility Benefit or Assisted Living Facility Benefit, as noted in the Caregiver Training definition above.

Payment under the terms of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

Payment under the terms of this Benefit does not qualify You for the Waiver of Premium Benefit.

[INFORMAL CARE BENEFIT]

The Benefit

You are eligible to receive benefits for Covered Expenses You incur for Informal Care.

Covered Expenses

Covered Expenses means expenses You incur for Informal Care that is:

- Intended to enable You to remain in Your Home; and
- Stated in, and furnished in accordance with, Your Plan of Care.

How Much We Will Pay

We will pay up to the Informal Care Limits shown on Your Schedule of Benefits for Covered Expenses You incur for Informal Care.

Definition

Informal Care means Maintenance or Personal Care Services another person (which may include a member of Your Immediate Family) provides to You, in Your Home, because You are a Chronically Ill Individual. In all instances the person providing the assistance or supervision must be someone who did not normally reside with You in Your Home at the time You became eligible for benefits and is neither from a Home Health Agency nor an Independent Provider. The assistance may be in the form of help with: simple health care tasks; personal hygiene; managing medications; or performing Activities of Daily Living. Supervision is applicable when You have Severe Cognitive Impairment. Your Plan of Care must specify the type, frequency and duration of Informal Care required.

Payment Limitations

2

Payment under the terms of this Benefit is subject to: [the Elimination Period;] the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit, except Care Coordination Services.

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[Days on which You receive Informal Care cannot be used to satisfy the Elimination Period.]

Payment under the terms of this Benefit does not qualify You for the Waiver of Premium Benefit.]

HOSPICE CARE BENEFIT

The Benefit

You are eligible to receive benefits for Covered Expenses You incur for Hospice Care when We determine that You are a Chronically Ill Individual, You are Terminally Ill, and You are not receiving preventive or curative treatment for that illness.

Covered Expenses

Covered Expenses for Hospice Care means expenses You incur for care and support services (including room and board) provided by a Hospice Care Facility, Nursing Facility or an Assisted Living Facility.

Covered Expenses for Hospice Care also means Covered Expenses for Home Health or Personal Care Services, and Incidental Homemaker and Chore Care. Covered Expenses for Hospice Care do not include the cost of medications, supplies, equipment or Physician visits. We will not pay for any charges for Your convenience such as transportation, televisions, telephones, beauty care, guest meals or entertainment.

How Much We Will Pay

We will pay up to the Facility Care Maximum, as set forth in the Schedule of Benefits, for Covered Expenses You incur for Hospice Care received while You are Confined in a: Hospice Care Facility; Nursing Facility; or Assisted Living Facility.

We will pay up to the Home and Community Care Maximum shown in the Schedule of Benefits for all other Covered Expenses You incur for Hospice Care.

Definitions

Hospice Care means services designed to provide palliative care and alleviate Your physical, emotional and social discomforts if You are Terminally Ill.

Hospice Care Facility means a facility which provides a formal Hospice Care program directed by a Physician on an inpatient basis. A Hospice Care Facility must be licensed or certified by the state in which it is located, if such license or certification is required. A Hospice Care Facility may be licensed or certified as a Nursing Facility, Assisted Living Facility, or other type of health care facility. A Hospice Care Facility does not mean a hospital, clinic, a community living center, or a place that provides residential or retirement care only.

Terminally Ill means having six (6) months or less to live, as determined by a Physician.

Payment Limitations

Payment under the terms of this Benefit is subject to: the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit; except when we pay for Care Coordination Services.

Payment of this Hospice Care Benefit is not subject to the Elimination Period; and days of Covered Care under it cannot be used to satisfy the Elimination Period.

RESPITE CARE BENEFIT

The Benefit

You are eligible to receive benefits for Covered Expenses You incur for Respite Care, when it provides temporary, short-term relief for those persons who normally and primarily care for You in Your Home on a regular, unpaid basis.

Covered Expenses

Covered Expenses for Respite Care means Covered Expenses for:

- Care in a Nursing Facility;
- Care in an Assisted Living Facility; and
- Home and Community Care.

How Much We Will Pay

We will pay up to the Facility Care Maximum for Covered Expenses You incur for Respite Care. This maximum applies to all such expenses You incur. We will pay this benefit until the Respite Care Benefit Annual Maximum shown on Your Schedule of Benefits is reached. Days on which You receive Respite Care do not need to be consecutive days.

Definition

Respite Care means temporary care You receive in order to relieve the unpaid person who normally and primarily provides You with care in Your Home. Your Plan of Care must state: the name of the unpaid caregiver for whom the respite is being provided; the period of respite; and the Covered Care You will require to replace that normally provided by that unpaid caregiver.

Payment Limitations

Payment of this Respite Care Benefit is not subject to the Elimination Period; and days of Covered Care under it cannot be used to satisfy the Elimination Period.

Payment under the terms of this Benefit is subject to: the Policy Lifetime Maximum; and the applicable payment limits determined from the Schedule of Benefits. This Benefit will not be payable at the same time as any other Benefit except when we pay for Care Coordination Services.

Payment for Respite Care does not qualify You for the Waiver of Premium Benefit.

ALTERNATE CARE BENEFIT

For expenses not otherwise covered. Prior approval by Us is required.

The Benefit

Subject to Our prior approval, You will be eligible to receive payment for Covered Expenses You incur for care, services, devices or treatments not otherwise payable under Your Coverage, or benefits otherwise covered may be paid in a different manner than specified.

Covered Expenses

Covered Expenses for this Alternate Care Benefit means fees charged for care, services, devices or treatments approved by Us after We determine that they:

- Are cost-effective;
- Are appropriate to Your needs;
- Are consistent with general standards of care;
- Provide You with an equal or greater quality of care than otherwise provided by Your Coverage;
- Are Qualified Long Term Care Services; and
- Are clearly specified in Your Plan of Care and in a separate written mutual agreement between Us, You (or Your Representative) and, if appropriate, Your Physician.

We reserve the right to decline to authorize payment for alternate care, services, devices or treatments.

How Much We Will Pay

We will pay up to the mutually agreed amounts for Covered Expenses You incur for services, devices or treatments You receive in accordance with this Alternate Care Benefit.

Payment Limitations

The written mutual agreement will state how the Elimination Period affects payment. It will also state any time and payment maximums.

Payment of this Benefit is also subject to: the Policy Lifetime Maximum; and all other provisions and conditions of Your Coverage.

Payment of this Benefit does not qualify You for the Waiver of Premium Benefit.

INTERNATIONAL COVERAGE BENEFIT

The Benefit

You are eligible to receive benefits during Your Confinement in an Out-of-Country Nursing Facility.

Covered Expenses

Covered Expenses for International Coverage means expenses You incur for care and support services (including room and board) provided by the Out-of-Country Nursing Facility.

The expenses must be consistent with the level of charges normally made for other persons receiving similar Confinement care in that facility. Covered Expenses do not include expenses You incur for prescription medications or any charges for Your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment.

How Much We Will Pay

We will pay up to International Coverage Limits shown on Your Schedule of Benefits for Covered Expenses during Your Confinement.

Conditions

Payment of this benefit is subject to the following conditions:

- Payment will be in lieu of all other benefits and reimbursement otherwise provided by Your Coverage for expenses incurred during the period for which benefits are being received under this Benefit;
- We will not provide Care Coordination Services in connection with this benefit;
- The Waiver of Premium Benefit will not apply to any period for which payment is made under this benefit;
- We must receive proof, satisfactory to Us, that You are eligible for benefit payments. At Your own expense, You must obtain and furnish Us with complete documentation in English. Such documentation shall include, but is not limited to:
 - A Current Eligibility Certification from a Licensed Health Care Practitioner that You are a Chronically Ill Individual.
 - A satisfactory Plan of Care prescribing the need for Confinement care due to Your being a Chronically Ill Individual.
 - Properly completed claims forms, billing statements, and supporting medical and care documentation.
 - A copy of Your passport, airline ticket or other proof acceptable to Us that You are outside the United States of America, its territories and possessions.
- We may require that You provide Us with all of the above information at reasonable intervals. We will not require this more frequently than monthly.

Payment will only be made to You, in the lawful money of the United States of America. Any foreign exchange rate will be as determined by Us at the time of payment and will reflect the exchange rate for the date on which the service was provided as reported by a licensed bank or other financial institution designated by Us. This benefit will not be payable if it is prohibited by the United States Government sanctions as specified by the United States Department of the Treasury's Office of Foreign Assets Control (or its successor organization).

Definition

An **Out-of-Country Nursing Facility** is an institution, not excluded below, that:

- Is located outside the United States, its territories and possessions; and
- Is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients; and
- Satisfies all of the following Conditions.

Conditions: To satisfy this Out-of-Country Nursing Facility definition, such facility, or a separate portion, ward, wing or unit thereof, must at all times:

- Provide such nursing care in accordance with the authority granted by a license or similar accreditation acceptable to Us that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which benefits would be payable under the Nursing Facility Benefit;
- Employ at least one full-time (at least 30 hours per week) Graduate Nurse;
- Have a Graduate Nurse on duty or on call in the facility at all times;
- Have an awake employee on duty in the facility who is:
 - Trained and ready to provide its residents with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
 - Aware of the whereabouts of the residents;
- Provide three (3) meals a day and accommodate special dietary needs;
- Have arrangements with a Physician or Graduate Nurse to furnish medical care and services in case of an emergency;
- Have the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications; and
- Have accommodations for at least 10 resident inpatients in that location.

For the purposes of this definition, a **Graduate Nurse** is a person who has:

- Completed an extensive post-secondary nursing care training program; and
- A current license to provide skilled nursing care to sick or infirm individuals under the direction of a Physician.

Excluded Places: The definition of an Out-of-Country Nursing Facility does NOT include any of the following:

- A hospital or clinic.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or a substantially similar adult residence establishment or environment.

Payment Limitations

Payment of this Benefit is subject to: the Elimination Period; the Policy Lifetime Maximum; and the payment limits determined from the Schedule of Benefits.

This Benefit will not be payable at the same time as any other Benefit; nor will it qualify You for the Waiver of Premium Benefit.

WAIVER OF PREMIUM BENEFIT

The Benefit

We will waive Your premium payments that become due when benefits are payable under:

- The Nursing Facility Benefit;
- The Assisted Living Facility Benefit;
- The Home and Community Care Benefit;
- The Bed Reservation Benefit; or
- The Hospice Care Benefit.

This waiver will begin on the first Premium Due Date following the date benefits become payable and will continue as long as the benefits listed above are payable.

2

When this waiver stops You will be required to resume and continue paying premiums as they become due [in accordance with this Certificate's current premium payment mode.]

This waiver applies to the entire premium for this Certificate and all attachments.

The Benefit

This Benefit provides a full or partial return of premium that We will pay in the event You die before age 75 and while Your Coverage is in force.

How Much We Will Pay

We will pay as a return of premium an amount equal to:

- The Covered Percent of the total amount of earned premiums actually paid for Your Coverage.

REDUCED BY

- The amount of any benefits paid or payable for Your Coverage.

The Covered Percent used to determine the return amount depends on Your age at death as determined from the table below.

<u>Age at Death</u>	<u>Covered Percent</u>
65 or less	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or later	0%

Payment Limitations

We must receive written proof of Your death within one (1) year of Your death. This Benefit will not be paid if Your Coverage was being continued in force under a Nonforfeiture Benefit.

The payment for any claim We receive after this Benefit has been paid will be reduced by the amount paid under this Benefit.

Important Notice Regarding Tax Law - Please note that payment of this Return of Premium On Death Benefit may have tax implications for Your estate. You are advised to review this benefit with a qualified tax professional to determine any such tax impact.]

CONTINGENT NONFORFEITURE BENEFIT

The Benefit

This benefit allows You to convert to a shortened benefit period if there is a substantial increase in the premium rates for Your Coverage.

How This Benefit Works

If there is a substantial increase in premium rates, as determined by the schedule below, We will do all of the following:

- Offer to reduce Your current level of coverage without proof of insurability so that the required premium rates for Your Coverage are not increased;
- Offer to convert coverage to a paid-up status with a shortened benefit period as described below. This option may be elected at any time during the 120-day period following the date of the premium rate increase;
- Notify You that a default or lapse at any time during the 120-day period following the date of the premium increase will be deemed to be the election of the preceding offer to convert. A default or lapse is Your failure to pay the required premiums within the Grace Period.

Shortened Benefit Period

If You convert Your Coverage in accordance with the provisions above, We will continue to pay benefits, subject to all of the terms and conditions of the Group Policy in effect at the time of lapse. Benefits for Covered Expenses You incur will be subject to the applicable daily, monthly, annual, and lifetime benefit maximums in effect at the time Your Coverage terminated due to non-payment of premium, until the Shortened Benefit Period Allowance has been exhausted.

The Shortened Benefit Period Allowance

Under the Shortened Benefit Period Allowance We will pay is the greater of: (a) 100% of all premiums paid for Your Coverage, excluding any waived premiums; or (b) the maximum amount in effect at the time of lapse applicable to one month (30 days) of Nursing Facility Confinement. The Shortened Benefit Period Allowance is not reduced by any benefits previously paid to You.

Payment Limitations

The Shortened Benefit Period Allowance is the maximum amount We will pay under this Benefit. In no event will the amount payable under this Benefit exceed the Policy Lifetime Maximum applicable at the time of conversion.

After the date Your Coverage is converted in accordance with the provisions above, the benefit amount in effect will not increase.

This Benefit will not apply if Your Coverage is continued in accordance with any other Nonforfeiture Benefit. If You have a Nonforfeiture Benefit, that Benefit will apply whenever Your Coverage lapses after having been in force for at least three (3) years (even if there have been no premium increases).

The following schedule determines what constitutes a substantial increase in premium rates.

Cumulative premium increase over original premium that will allow Contingent Nonforfeiture to be initiated. (Percentage increase is cumulative from date of original issue. It does NOT include any increases attributed to new policy provisions or Your voluntary election of additional or increased benefit levels.)

Schedule of Triggers Indicating a Substantial Premium Increase

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

EXCLUSIONS AND LIMITATIONS

This section states the conditions under which benefit payment will be limited, or not made at all, even if You otherwise qualify for benefits.

Exclusions

We will not pay benefits for any expenses incurred for any room and board, care, treatment, services, equipment, or other items:

- [For which no charge is normally made in the absence of insurance;]
- [Provided outside the United States of America, its territories and possessions; except as described in the International Coverage Benefit;]
- [Provided by Your Immediate Family, unless a Benefit specifically states that a member of Your Immediate Family can provide Covered Care. We will not consider care to have been provided by a member of Your Immediate Family when:
 - He or she is a regular employee of the organization that is providing the services; and
 - Such organization receives payment for the services; and
 - He or she receives no compensation other than the normal compensation for employees in her or his job category;]
- 2 • [Provided by or in a Veteran’s Administration or Federal government facility, unless a valid charge is made to You or Your estate;]
- [Resulting from war or any act of war, whether declared or not;]
- [Resulting from attempted suicide or an intentionally self-inflicted injury;]
- [Resulting from participation in a felony, riot, or insurrection;]
- [Resulting from Your alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);]
- [For which You receive, or are eligible to receive, workers’ compensation benefits, occupational disease act benefits, or similar benefits.]

Note: We will pay benefits for Alzheimer’s disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

Non-Duplication

Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medicaid.

However, this Non-Duplication provision will not disqualify a Covered Care expense from being used to satisfy the Elimination Period.

2 [Coordination with Other Coverage

We will reduce the amount We will pay for Covered Care when the total amount payable under this and all other Long Term Care Coverage is greater than the actual expense You incur for that Covered Care.

- 3 We consider **Long Term Care Coverage** to be [group] coverage[, whether group or individual,] that provides nursing facility, assisted living facility or home health care benefits. This applies whether those benefits are payable on an expense reimbursement, indemnity, cash payment or other basis.

When benefits are reduced, the amount We will pay will be the lesser of:

- The amount We would pay in the absence of this provision; or

- The difference between the actual expense incurred and the amount payable under all other Long Term Care Coverages whose benefits are payable before those of Your Coverage. In making this determination We will use the order of benefit payments stated below.

Any Long Term Care Coverage without a coordination of coverage provision will pay first without any reduction in its benefits. For this and all other Long Term Care Coverage, the coverage with the earliest effective date will be deemed to be first to pay, and the later coverage(s) secondary, in order of effective date, from the earliest to the latest.]

COVERAGE CHANGES

You May Request An Increase In Your Coverage

You have the right to request to increase Your Coverage at any time. The increase must be to an amount or plan then being offered under the Group Policy. We reserve the right to determine what represents an increase in coverage. You will be required to provide an Application and proof of insurability in a form and manner acceptable to Us. The premium for the amount of increased coverage will be based on Your age as of the date the increase in coverage becomes effective. Premium for any previously purchased coverage will not be affected. However, You cannot apply to increase Your Coverage if You: are currently receiving benefits; or have filed a claim; or have been determined to be eligible for benefits; or are continuing coverage under a Nonforfeiture Benefit, or the Coverage Continuation provision.

If You make written Application to increase coverage and the increase is approved by Us, the change is effective as of the date Your next premium is due.

You May Elect To Decrease Coverage

You have the right to reduce Your future premiums at any time by changing to a decreased coverage amount offered under the Group Policy. We reserve the right to determine what represents a decrease in coverage. The premium for the reduced coverage will be based on Your original issue age. The reduced coverage is effective as of the date Your next premium is due.

If You request a decrease in coverage, You will not be required to provide proof of insurability.

2 [Continuing Coverage Paid For By The Policyholder

If the Policyholder stops paying premiums for all or a portion of Your Coverage, You have the right to continue that coverage by paying the premiums Yourself. If the Policyholder does this, We will send You a notice giving You the option to pay the difference in premium and maintain Your Coverage at its existing level.

If the Policyholder is paying premiums for all or a portion of Your Coverage and You cease to be an Eligible Person, You may continue Your Coverage through Continuing Coverage.]

PREMIUMS AND RENEWALS

Paying Premiums

Each premium paid continues Your Coverage in force until the date the next premium is due, except as stated in the Grace Period provision. Premiums are subject to change as described below.

Premiums are payable to Us. The first premium is due on Your Coverage Effective Date. Your Schedule of Benefits shows the initial premium payment mode that applies to Your Coverage. Premium payment modes available under the Group Policy are determined by mutual agreement between the Policyholder and Us.

You are responsible for notifying Us if Your method of premium payment changes. You must notify Us within 30 days of the effective date of the change.

If payments are being made through electronic funds transfer, payroll deduction or pension deduction, and the method of payment cannot be accomplished for any reason, We will bill You directly.

Our Right To Change Premium Rates

We reserve the right to change premiums in the future. Premiums will not change due to a change in Your age or health. Premiums may increase on a group or premium class basis. Premium changes will not be made any more frequently than once every 12 months.

If We set new premium rates:

3

- We will notify the Policyholder at least [60/90] days before the date the new rates become effective; and
- If You are paying premiums directly to Us, We will notify You at least 60 days before the date the new rates become effective.

If Your premiums are paid by payroll or pension deduction, either We, or the Policyholder will notify You directly.

Your Options If Premium Rates Change

3

If Your Premiums increase, You will have the option of: maintaining Your current benefits at the increased premium rate; or electing a decrease in coverage to a coverage amount [available under the Group Policy][We offer] that maintains or reduces Your current premium.

3

Unless You notify Us within [30/45/60/120] days after receiving Our notice, You will be considered to have elected to maintain Your current benefit amount at the increased premium rate.

Refund Of Premiums Paid Beyond Your Death

2

If You die while Your Coverage is in effect, We will refund the pro rata part of any unearned premium paid for the period after Your death. The refund will be made within 30 days of Our receipt of written notice and proof of Your death. [If the Policyholder pays any of the premium for Your Coverage, the refund will be made to the Policyholder. The Policyholder will be responsible for refunding to Your estate any premium for Your Coverage paid by You and returned to the Policyholder. If the Policyholder does not pay any of the premium for Your Coverage,] the refund will be paid to Your estate.

Protection Against Unintentional Lapse

2

[Unless Your premiums are paid using payroll or pension deduction,] You have the right to designate at least one person, in addition to Yourself, who is to receive notice of termination for non-payment of premium. You may change this designation at any time. To do so, You must notify Us in writing. We will remind You in writing every

3

[one (1)/two (2) years] of this opportunity.

Grace Period

An initial period of 31 days will be granted for each premium that is unpaid on the date due. If premium has not been paid by the end of that 31-day period, We will send a notice to the Policyholder or You (if You pay premiums to Us directly) explaining that a payment has been missed and that coverage is in danger of lapsing. The notice will provide an additional 35 days to pay the unpaid premium beginning on the date We mail the notice.

If You pay premiums to Us directly and You have designated an individual to be notified in case of lapse, We will also send notice to Your designee at the address You provided.

Payment will allow coverage to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of coverage as of the date the premium was initially due.

Reinstatement

Your Coverage will terminate if premium is not paid before the end of the applicable Grace Period. Your Coverage may be reinstated if it ends because premiums were not paid on time, and within 12 months of termination You:

- Request reinstatement;
- Provide proof of insurability satisfactory to Us at Your own expense;
- Pay all Your back premiums; and
- Received no care or services, during the period after Your Coverage had terminated, which would qualify as Covered Care had Your Coverage not terminated.

If the reinstatement Application is approved and payment received, Your Coverage will be reinstated as of the last Premium Due Date. A new Misstatements/Incontestability period will begin on that date for statements and omissions on the reinstatement Application.

Unpaid Premiums

When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

Continuation For Lapse Due To Cognitive Or Functional Impairment

If Your Coverage terminates due to non-payment of premiums, We will provide a retroactive continuation of coverage as specified below, if certain conditions are met. To be eligible for this reinstatement, You must provide Us with proof that You were a Chronically Ill Individual, beginning on or before the expiration date of the Grace Period.

The proof must be in the form of an assessment from a Licensed Health Care Practitioner (or other proof approved by Us) which demonstrates that You were a Chronically Ill Individual. In addition We require a Current Eligibility Certification. The proof must be provided to Us within seven (7) months of the termination date. All past due premiums for Your Coverage that was in force immediately prior to the date of lapse must be paid. In that event, any benefits for

which You qualified during the continuation period will be paid to the same extent they would have been paid if Your Coverage had remained in force from the date of termination.

TERMINATION AND COVERAGE CONTINUATION

Your Right To Cancel Coverage At Any Time

You may cancel Your Coverage at any time by sending Us written notice. The effective date of Your cancellation will be the later of:

- 3 • The cancellation date requested by You; or
- The [first day of the calendar month/premium due date following][the date of] Our receipt of Your request.

- 2 We will promptly return the unearned portion of any premium paid. [The refund of premiums paid by the Policyholder, if any, will be paid to the Policyholder.] The refund of premiums paid by You, if any, will be paid to You. The cancellation will not prejudice any claim for Covered Expenses incurred before the effective date of the cancellation.

Continuation Coverage

If the Policyholder terminates the Group Policy or You cease to be an Eligible Person, Your Coverage may be continued without change until it ends for a reason stated below.

You must pay Us all premiums required for the continuation of Your Coverage, subject to the terms of the Premiums and Renewal section of this Certificate. The rates for the continuation of Your Coverage may change in the future. Any such changes will be made on a class basis. This means You cannot be singled out for an increase because of any change in Your age or health.

When Your Coverage Ends

Your Coverage ends on the first to occur of:

- The date of Your death;
- The date coverage is cancelled pursuant to Your request;
- The date You exhaust the Policy Lifetime Maximum;
- The end of the Grace Period if the amount of any overdue premium is not received by Us by the end of the Grace Period; or
- The date the Policyholder discontinues the Group Policy or coverage of a group of Eligible Persons to which You belong, but only if, within 31 days thereafter Your Coverage is replaced by other group coverage that:
 - Is effective on the day following the date Your Coverage ends; and
 - Provides benefits that are substantially equivalent to or greater than those provided under the Group Policy; and
 - Provides immediate coverage to all persons insured under the Group Policy on the date their coverage under the Group Policy is discontinued; and
 - Calculates premium based on the basis of Your age on Your Coverage Effective Date.

Your Coverage will provide no benefits for any care received after Your insurance ends, except as provided in the Extension of Benefits provision below.

Extension Of Benefits

If Your Coverage terminates due to failure to pay premium while You are Confined in a Nursing Facility, an Assisted Living Facility, or a Hospice Care Facility, benefits will be paid in the same manner as if Your Coverage was in force. Extension of Benefits stops on the earliest of:

- The date when You no longer meet the requirements of the Conditions for Receiving Benefits provision;
- The date You are no longer Confined in a Nursing Facility, an Assisted Living Facility or a Hospice Care Facility; or
- The date You exhaust the Policy Lifetime Maximum.

CLAIM PAYMENTS

How Do You Start A Claim

To start a claim, You or Your Representative should call Us, notify Us in writing, or submit a completed claim form We provide.

Notice of Claim

We must be notified when You have a claim. The notice must be received by Us within 30 days of the date the covered loss starts, or as soon as reasonably possible. Include in the notice at least: Your name; Your Certificate Number as shown in the Schedule of Benefits; and an address to which the claim forms should be sent.

How We Evaluate Claims

We will obtain information about You by working with You and Your personal Physician. We will also consult with any Licensed Health Care Practitioners, agencies and other care providers You used. We will then review that information to determine Your eligibility for benefits. We reserve the right, as part of the review and at Our expense, to do an assessment or a physical examination of You. Similar reviews may be required, at reasonable intervals, to determine eligibility for continued benefits. We may use outside services to assist in evaluating Your condition.

On an ongoing basis, We must receive updates to Your Plan of Care and Current Eligibility Certifications. We will also need a copy of Your Medicare Explanation(s) of Benefits (or similar form for other plans and programs subject to the Non-Duplication provision) to determine which expenses (if any) are excluded from coverage.

Claim Forms

When We get notice of claim We will send out the forms needed to file proof of loss.

The forms will tell You how to complete them and where to send them. Read them carefully. Answer all questions and send all required information to the address on the forms. This proof You submit must be in the form of written documentation acceptable to Us that:

- Confirms that You are a Chronically Ill Individual due to Your inability to perform at least two (2) Activities of Daily Living or Your Severe Cognitive Impairment;
- Includes a Current Eligibility Certification from a Licensed Health Care Practitioner;
- Describes Your Plan of Care;
- Describes and confirms the Covered Care You are receiving; and
- Includes copies of itemized bills, paid invoices and, if necessary, cancelled checks for charges You incurred for Covered Care.

In addition, We may request copies of medical records or a care provider's daily notes of care. We may also choose to consult by telephone with the Licensed Health Care Practitioner who prescribed Your Plan of Care or any care provider You used.

This information will assist Us in the evaluation of Your claim so that We can determine the benefits, if any, for which You are eligible.

If You or Your Representative do not get the necessary claim forms from Us within 15 days, proof of loss can be filed without them, by sending Us a letter

which describes the nature and extent of Your loss and the Covered Expense for which Your claim is made. That letter must be sent to Us at Our Administrative Office within the time period stated in the next paragraph.

Proofs Of Loss

When You have a claim for continuing loss, written proof of loss must be given to Us within 90 days after the end of each monthly period for which benefits may be payable. For any other loss, written proof must be given to Us within 90 days after the date of such loss. If it is not possible to give Us written proof in the time required, We will not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless You are not legally capable, the required proof must always be given to Us no later than one (1) year from the time specified.

Written Notification

We will notify You in writing if Your request for benefits is approved or denied.

Time of Payment Of Claims

Once You have satisfied the Elimination Period, benefit payments will be made on a monthly basis after receipt of Your claim as long as You remain a Chronically Ill Individual, and Your covered loss and Our liability continue. When a claim is paid You will receive an Explanation of Benefits that will show the total amount of benefits You have been paid to date.

Payment of Claims

All benefits and premium refunds will be payable to You unless otherwise assigned. Any benefits or refunds unpaid at Your death will be payable to Your estate. If benefits or refunds are payable to an estate, We may pay a portion of those benefits or refunds, up to \$1,000, directly to someone related to You by blood or marriage who is deemed by Us to be justly entitled to the benefits. We will be discharged to the extent of any such payment in good faith.

Direct Payment Of Benefits To Facilities (Assignment Of Benefits)

You may instruct Us to pay benefits due You under this coverage directly to a Nursing Facility; Assisted Living Facility; or Hospice Care Facility providing the care for which We are reimbursing expenses. The care provider must also agree to the assignment of benefits. You must notify Us in writing. No assignment shall be binding upon Us unless a copy is on file with Us. We do not assume any responsibility for the validity or effect of an assignment of benefits.

Physical Examination

At Our expense, We have the right to require a medical examination when a claim is made, and at reasonable intervals while continued benefits are being claimed.

Appealing A Claim Decision

If You disagree with Our decision regarding Your claim, You may request in writing that We reconsider Your claim. You should submit Your request within 60 days after receiving Our decision and include any additional information that You feel We need to review. Also include the names, addresses, and phone numbers of any care providers You think We should contact to learn more about Your condition. We will reconsider Our decision and send You written notification of the results. If We deny Your appeal request and You want to receive written information related to such denial, that information will be sent to You within 60 days of receipt of Your written request.

Legal Actions

No action may be brought to recover under Your Coverage until 60 days after proof of loss has been given. No action can be brought more than three (3) years from the date written proof of loss was required to be given.

Right To Recover Overpayments

If We make payments which, at any time, are in excess of the amount of benefits payable under Your Coverage, We have the right to recover such excess from:

- Any person to whom, or for whom, or with respect to whom, such payments were made; and
- Any organization which should have made such payments.

Any overpayment that is not returned to Us within 60 days of Our request will be deducted from future claims payments.

GENERAL PROVISIONS

Entire Contract Changes

This Certificate reflects Your Coverage and is a part of the Group Policy. While the Group Policy is in force, it determines governing contractual provisions. If You continue Your Coverage after the Group Policy terminates, Your Coverage will be as described in this Certificate. No change in the Group Policy or this Certificate is valid unless approved in writing by one of Our officers. No change will affect any claim incurred prior to the date of the change.

Misstatements/ Incontestability

In issuing this Certificate, We have relied upon the information presented by You in Your Application. For any portion of Your Coverage that has been in effect for less than six (6) months, We may rescind it or deny an otherwise valid claim upon a showing of a misrepresentation in Your Application that is material to Our acceptance of Your Application. Failure to disclose material information is considered a misrepresentation.

For any portion of Your Coverage that has been in force for at least six (6) months but less than two (2) years, We may rescind it or deny an otherwise valid claim upon a showing of a misrepresentation that is both material to the acceptance of Your Coverage and pertains to the conditions for which benefits are sought.

Any portion of Your Coverage that has been in force for two (2) years will not be contestable upon the grounds of misrepresentation alone; and may be contested only upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

Any benefits We pay will not be recovered by Us in the event all or a portion of Your Coverage is rescinded.

No Pre-Existing Conditions Exclusion

Except as stated above, We will not reduce or deny any claim because of a sickness or physical or medical condition that existed prior to Your Coverage Effective Date.

Misstatement Of Age

If Your age was misstated in Your Application, We will adjust Your premium to the correct amount for Your insurance at Your correct age. The amount of the insurance shall not be affected, provided that any necessary adjustment in premium is made.

Clerical Error

Clerical error or delays in making entries on the records by Us or Our designees will not void Your Coverage if Your Coverage would otherwise have been in effect. Such clerical error will not cause You to become insured if You are otherwise not eligible. Such clerical error will also not extend Your Coverage if Your Coverage would otherwise have ended or been reduced. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of Your Coverage.

Time Periods

All time periods start and end at 12:01 a.m. in the time zone in which You reside.

Non-Participating; Dividends Not Payable

Your Coverage does not participate in Our profits or surplus earnings, has no cash values, and will not earn dividends at any time.

Conformity With Internal Revenue Code

If on its effective date, Your Coverage does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. We will inform You in writing of any required change in the provisions of Your Coverage.

2 [REPLACEMENT PROVISIONS]

If Your Coverage is replacing comparable coverage under another group long term care insurance policy that was issued to the Group Policyholder, the following terms and conditions will apply.

Definition

Replaced Coverage means the coverage You had under the long term care policy that was replaced by the Group Policy described in this Certificate.

Conditions

In order for Your Coverage to take effect:

- Your Replaced Coverage must have been in force on a premium paying basis on the day immediately prior to this Certificate's Coverage Effective Date;
- There is no interruption between Your Replaced Coverage and Your Coverage under the Group Policy;
- All premiums for the Replaced Coverage must be fully paid up through the date on which the Replaced Coverage ends; and
- We must receive Your first premium for Your Coverage when it is due.

Terms Applicable To Your Coverage

- The premium for Your Coverage will be based upon Your age on the original effective date of the Replaced Coverage;
- Any Actively at Work requirement (if applicable) will be waived for Your Coverage to the extent that the requirement is the same as the actively at work requirement under the Replaced Coverage;
- Your Policy Lifetime Maximum will be reduced to the extent that benefits similar to the Benefits under Your Coverage were paid to You under the Replaced Coverage;
- Any periodic maximum or lifetime limit that applies to a particular item of Covered Care will be reduced to the extent that benefits were paid for a similar service under the Replaced Coverage;
- If You had a periodic inflation increase feature under the Replaced Coverage, our initial increase offer to You will be timed based on the date of Your last such increase under the replaced coverage. Subsequent increase offers will be made to You in accordance with the terms of this Certificate;
- [The calculation of the amount returned under the Return of Premium on Death Benefit will reflect the length of time You were covered under the Replaced Coverage and the benefit amounts paid to You under the Replaced Coverage, to the extent that the Replaced Coverage had a similar return of premium provision;]
- If Your Coverage is converted to paid-up status under a Nonforfeiture Benefit, the calculation of Your Nonforfeiture Benefit Allowance will reflect the length of time You were covered and the benefit amounts paid to You under the Replaced Coverage, to the extent that the Replaced Coverage had a nonforfeiture protection provision other than a contingent nonforfeiture benefit; and
- Your Elimination Period will be reduced to the extent that a similar elimination period was completely or partially satisfied by You under the Replaced Coverage.]

2

GENWORTH LIFE INSURANCE COMPANY

CERTIFICATE OF INSURANCE SCHEDULE OF BENEFITS

Group Policyholder: [ABC Company]

Group Policy Number: [XXXXXXX]

Group Policy Effective Date: [01/01/2005]

Insured: [John Q. Doe]

Certificate Number: [XXXXXXXX]

Insured's Address: [1234 Main Street, Anytown, USA 99999]

Coverage Effective Date: [01/01/2007]

Age At Issue: [45]

COVERAGE FEATURES AND LIMITS

Elimination Period: [30, 60, 90 or 180] [Days of Covered Care]
[Calendar Days]

Policy Lifetime Maximum: [24, 36, 48, 60, 72, 99, 120 X Facility Care
Maximum OR Unlimited]

Facility Care Maximum: [\$1,500 - \$12,000 in \$750 increments] per
Calendar Month

Except for Covered Expenses under the Home Assistance Benefit and the Alternate Care Benefit, the maximum total amount payable for all Covered Expenses incurred during a Calendar Month is limited to the Facility Care Maximum.

Future Purchase Options Benefit: [Included/Not Applicable]

Care Coordination Services: Included

Nursing Facility Benefit: Pays Covered Expenses up to [\$___] per month

Assisted Living Facility Benefit: Pays Covered Expenses up to [\$___]per month

Bed Reservation Benefit: 60 Days per Calendar Year

Home and Community Care Maximum: [50%, 60%, 75% or 100% of the Facility Care
Maximum] per Calendar Month

Home Assistance Lifetime Maximum: [2 X Facility Care Maximum]

[Informal Care Limits: [1% of the Facility Care Maximum] per
Calendar Day for no more than 30 days per
Calendar Year]

Hospice Care Benefit:	Included
Respite Care Benefit Annual Maximum:	[Up to the Facility Care Maximum] per Calendar Year
Alternate Care Benefit:	Included
International Coverage Limits:	[75% of the Facility Care Maximum] per Calendar Month for not more than 1,460 days per Lifetime

If the Facility Care Maximum applies to a Calendar Month, payment under this Benefit for periods of less than a full month will be pro-rated based on a 30-day month and the number of days for which payment is being made.

Waiver of Premium Benefit:	Included
[Return of Premium on Death Benefit:	Included]
Contingent Nonforfeiture Benefit:	Included
[Optional Riders:]	[Nonforfeiture Benefit Rider] [Automatic Inflation Protection – 5% Compound Annual Increases Rider] [Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider] [Automatic Inflation Protection – 5% Simple Annual Increases Rider]

2 Annual Premium Contribution ^[1,2]		[\$XX.XX]
[Insured’s Annual Premium Contribution		[\$XX.XX]
[Insured’s] Modal Premium Contribution	[Monthly]	[\$XX.XX]
Group Policyholder’s Annual Premium Contribution:		[\$XX.XX]

Schedule of Benefits Print Date: [02/01/07]

3 ¹[The Annual Premium includes the premium paid by the Policyholder.]
² [Premiums reflect the Couples/Spousal Discount.]

GENWORTH LIFE INSURANCE COMPANY

CERTIFICATE OF INSURANCE SCHEDULE OF BENEFITS

1 Group Policyholder: [ABC Company] Group Policy Number: [XXXXXXX]

Group Policy Effective Date: [01/01/2005]

Insured: [John Q. Doe] Certificate Number: [XXXXXXXX]

Insured's Address: [1234 Main Street, Anytown, USA 99999]

Coverage Effective Date: [01/01/2007] Age At Issue: [45]

COVERAGE FEATURES AND LIMITS

2

Elimination Period:	[30, 60, 90, or 180] [Days of Covered Care] [Calendar Days]
Policy Lifetime Maximum:	[730, 1,000, 1,095, 1,460, 1,825, 2,000, 2,190, 3,000, 3,650 X Facility Care Maximum OR Unlimited]
Facility Care Maximum:	[\$50 - \$400 in \$25 increments] per Calendar Day
[Future Purchase Options Benefit:	Included/Not Applicable]
Care Coordination Services:	Included
Nursing Facility Benefit:	Pays Covered Expenses up to [\$___]per day
Assisted Living Facility Benefit:	Pays Covered Expenses up to [\$___]per day
Bed Reservation Benefit:	60 Days per Calendar Year
Home and Community Care Maximum:	[50%, 60%, 75% or 100% of the Facility Care Maximum] per Calendar Day
Home Assistance Lifetime Maximum:	[50 X Facility Care Maximum]
[Informal Care Limits:	[25% of the Facility Care Maximum] per Calendar Day for no more than 30 days per Calendar Year]
Hospice Care Benefit:	Included
Respite Care Benefit Annual Maximum:	[[30, 21] X Facility Care Maximum] per Calendar Year
Alternate Care Benefit:	Included

2	International Coverage Limits:	[75% of the Facility Care Maximum] per Calendar Day for not more than 1,460 days per Lifetime]
	Waiver of Premium Benefit:	Included
	[Return of Premium On Death Benefit:	Included]
	Contingent Nonforfeiture Benefit:	Included
	[Optional Riders:]	[Nonforfeiture Benefit Rider] [Automatic Inflation Protection – 5% Compound Annual Increases Rider] [Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider] [Automatic Inflation Protection – 5% Simple Annual Increases Rider]

2	Annual Premium Contribution ^[1,2]	[\$XX.XX]
	[Insured's Annual Premium Contribution	[\$XX.XX]
	[Insured's] Modal Premium Contribution [Monthly]	[\$XX.XX]
	Group Policyholder's Annual Premium Contribution:	[\$XX.XX]

1 Schedule of Benefits Print Date: [02/01/07]

3 ¹[The Annual Premium includes the premium paid by the Policyholder.]
² [Premiums reflect the Couples/Spousal Discount.]

GENWORTH LIFE INSURANCE COMPANY

A Stock Life Insurance Company (herein called We, Us and Our)

[Administrative Office: P. O. Box 947500, Maitland, FL 32794-7500 Phone Number 800-416-3624]
has issued this

GROUP LONG TERM CARE INSURANCE POLICY (herein called the Group Policy)

to

[XYZ Employer] (herein called the Policyholder)

The Company agrees with the Policyholder to pay the benefits and provide the other rights set forth herein. Such agreement is in consideration of payment of the premiums due and is subject to all the conditions and provisions of this contract.

Policy Number: [XXXXXXX]

Group Policy Effective Date: [January 1, 2007]

Policy Issued In: [State]

Policy Anniversary Dates: [January 1 of 2007] and each succeeding year

Premium Due Dates: [The Group Policy Effective Date and the first day of each succeeding month]

[Rate Guarantee Period: [xx] years from the Group Policy Effective Date]

The Group Policy is subject to the laws of the jurisdiction in which it is issued.

The Group Policy is non-participating.

For purposes of effective dates and ending dates under the Group Policy, all days begin at 12:01 AM and end at 12:00 midnight at the Policyholder's address as stated in the Group Master Application.

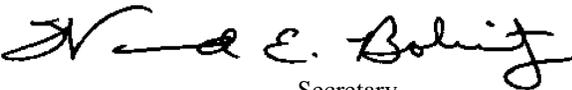
NOTICES: PLEASE READ CAREFULLY!

The Group Policy may not cover all of the costs associated with long term care incurred during the period of coverage. The buyer is advised to review carefully all policy limitations.

The Group Policy is not a Medicare Supplement Policy. If a person is eligible for Medicare, the Guide to Health Insurance for People with Medicare is available from Us for review.

TAX DISCLOSURE: The Group Policy is intended to be a federally tax-qualified long term care insurance contract under 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).

The Company has caused the Group Policy to be executed on the Group Policy Effective Date.

[
Secretary

[
President and CEO, Long Term Care Division]

NOTE: The Insurance Department, or similar regulating body, of the state in which this Group Policy is issued does not in any way warrant that this Group Policy meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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GENERAL PROVISIONS

CONTRACT

The Group Policy constitutes the entire contract between the Company and the Policyholder. The terms of the Group Policy govern while the Group Policy is in force. If the Group Policy terminates, each person's coverage shall continue in accordance with the terms of his/her Certificate.

The Group Policy consists of:

- The Face page;
- The Table of Contents page;
- The Benefits Master Schedule;
- The General Provisions, Premium Provisions, and Terminations and Cancellation Provisions sections;
- The Group Master Application;
- Any Group Policy Riders;
- The Schedule of Exhibits, which includes any Certificate form(s) and Certificate Riders, the Schedule of Benefits form(s) and the Premium Rate Schedule.

GOVERNING JURISDICTION

Coverage under the Group Policy will be governed by the laws of the jurisdiction in which it was issued, unless special provisions apply in the residence state of an Insured on the Insured's original Coverage Effective Date as evidenced by the Certificate issued to the Insured.

INCONTESTABILITY

The Company will not contest the validity of the Group Policy after it has been in force one (1) year, except for nonpayment of premium.

CERTIFICATES

The Company or the Policyholder will deliver an individual Certificate to each Insured. The Certificate will include a description of the benefits and coverage provided by the Group Policy and a statement of the exclusions, reductions and limitations of the Group Policy.

A "Certificate" consists of:

- A Certificate form;
- The Insured's Application;
- A Schedule of Benefits form; and
- Any Certificate Rider or other attachments that may be issued to support or amend the Certificate form.

NON-PARTICIPATING; DIVIDENDS NOT PAYABLE

The Group Policy and coverage under it does not participate in the Company's profits or surplus earnings; has no cash values; and will not pay dividends at any time.

POLICYHOLDER COVERAGE UNDER THE GROUP POLICY

The Group Policy is issued to the Policyholder, who must apply for coverage by submitting a completed Group Master Application and agreeing to pay premiums. No insurance under the Group Policy is effective until approved by the Company in writing.

INFORMATION TO BE FURNISHED

The Policyholder and each Insured will furnish Us with all information which We reasonably require regarding matters related to the insurance provided and any reporting requirements imposed under applicable law. This includes information that will enable us to determine a person's eligibility for coverage and premiums due.

The Policyholder will allow Us to inspect all documents, books and records which relate to premiums and the insurance provided.

2

[On or prior to January 31 of each year We will furnish copies of information We are required to report to the Internal Revenue Service. The information:

- Will be given to each Insured on whose account Benefits have been paid during the preceding year; and
- Will show the aggregate amount of long term care benefits paid to such Insured.]

GROUP POLICY CHANGES

The Group Policy may be changed at any time by written agreement between the Policyholder and the Company without the consent of any other person. All agreements made by the Company shall be signed by one of its officers. No other person may change or waive any of the Group Policy or coverage terms or make any agreement binding the Company. The Policyholder's written approval of a change in the Group Policy is not needed if:

- The Policyholder has made written request for the change and the Company has agreed to it.
- The change is needed so that the Group Policy will conform to any law, regulation or ruling of:
 - A jurisdiction that affects a person covered under the Group Policy; or
 - The federal government.
- The change is needed to reflect a premium rate change.

Except with respect to premium rate changes, no such change shall affect coverage in force prior to the date of change.

PREMIUM PROVISIONS

PREMIUM RATES

3 The initial premium rates for long term care coverage for each Insured appear in the Premium Rate Schedule, which is incorporated as part of the Group Policy as an exhibit. They can be changed as shown in these Provisions. Premium rates will be based upon the age of the Insured [on his or her Coverage Effective Date.]

[PREMIUM RATE GUARANTEE

2 Premium rates are guaranteed for the Rate Guarantee Period shown on page one. This guarantee does not apply to a rate change for reason of change in benefits or eligibility for benefits, or a change in the terms of the Group Policy required by any law, regulation, judicial or administrative order or decision.]

PAYMENT OF PREMIUMS AND GRACE PERIOD

3 The total premiums due on any Premium Due Date will be the sum of the individual premiums due for the coverage then provided for all Insureds. Premiums must be paid in advance. The Policyholder is responsible for submitting all premiums due except those for Insureds who are direct billed, who must pay their premiums directly to the Company or its insurance administrator. When the Policyholder is responsible for paying premiums, premiums must be paid within [31/45/60] days of the Premium Due Date. If premiums are not paid within the [31/45/60]-day period, the Grace Period provisions as stated in the Certificate will apply.

Premiums will be determined in accordance with the Premium Rate Schedule.

POLICYHOLDER RATING

The Company has issued the Group Policy based upon current information regarding the following, and reserves the right to change premium rates on or after the date there is a change in such factors:

- 3 (a) The industry of the Policyholder and the age, gender, occupation, earnings, location and size of the Policyholder's Employee/Retiree/Member] population; and
(b) Laws, regulations and judicial and administrative orders and decisions affecting benefits and the cost of administration.

RIGHT TO CHANGE PREMIUMS

In addition to the right to change premium rates in accordance with the preceding paragraphs, the Company may change premium rates:

- 2 [(a) Any time after the Rate Guarantee Period has expired;]
[(b) On or after the date there is a change in benefits or eligibility for benefits under the Group Policy;
3 [(c) Due to actual or expected experience, a change in the factors bearing on the risk assumed or the Company's estimates for future cost factors.

3 A change in premium rates due to experience may occur only once during any policy year. Any such change in rates will be made on a group or premium class basis. No person's rates will be changed solely due to his or her age or use of the long term care coverage. Each change shall be made by written notice to the Policyholder by Us, [60/90] days before the effective date of the proposed change.

TERMINATION AND CANCELLATION PROVISIONS

DISCONTINUANCE OF THE OFFER OF COVERAGE UNDER THE GROUP POLICY BY THE POLICYHOLDER

The Policyholder may discontinue the offer of coverage under the Group Policy for any or all eligible classes. The Company must be given 31 days advance written notice. The notice must state when discontinuance shall occur.

DISCONTINUANCE OF THE OFFER OF COVERAGE UNDER THE GROUP POLICY BY THE COMPANY

Following at least [31/60/90] days advance written notice to the Policyholder, the Company has the right to discontinue the offer of coverage under the Group Policy:

- To unenrolled Eligible Persons if the number of insured Eligible Persons is less than [20];
- To any unenrolled Eligible Family Member if the number of Eligible Persons insured is less than [20];
- To unenrolled Eligible Persons any time after the most recent Rate Guarantee Period, if any, has expired].

CANCELLATION OF THE GROUP POLICY BY THE POLICYHOLDER

The Group Policy shall be considered cancelled by the Policyholder on the earliest of:

- The Premium Due Date, if all premiums are not paid by the end of the Grace Period;
- The date chosen by the Policyholder, subject to the [31/60/90]-day advance written notice; or
- The date a premium increase that requires the Policyholder's written acceptance is effective but has not been accepted in writing by the Policyholder.

CANCELLATION OF THE GROUP POLICY BY THE COMPANY

We may terminate the Group Policy with [60/90/120] days advance written notice. Such termination will be effective on the first Premium Due Date following the [60/90/120]-day notice period.

GUARANTEED RENEWABILITY

Discontinuance of the Offer of Coverage or Cancellation of the Group Policy shall not affect an Insured's right to continue coverage then in force. An Insured's coverage is Guaranteed Renewable and may be continued in accordance with the Continuation Coverage provision in the Insured's Certificate.

SCHEDULE OF EXHIBITS
Certificate and Related Items

Identification

[Insert Benefits Master Schedule]

1 [Insert Premium Rate Schedules]

[Insert Cert Form #]

[Insert Schedule of Benefits Form #]

[Insert Automatic Inflation Riders]

[Insert Nonforfeiture Benefit Rider]

Applicable To

Eligible Persons [and Eligible Family Members]

GENWORTH LIFE INSURANCE COMPANY

BENEFITS MASTER SCHEDULE

1 Group Policyholder: [ABC Company]

Group Policy Effective Date: [01/01/2005]

Group Policy Number: [XXXXXXX]

1

COVERAGE FEATURES AND LIMITS

Elimination Period:	[30, 60, 90 or 180] [Days of Covered Care] [Calendar Days]
Policy Lifetime Maximum (Eligible Individual selects one):	[730, 1,000, 1,095, 1,460, 1,825, 2,000, 2,190, 3,000, 3,650 X Facility Care Maximum OR Unlimited] OR 24, 36, 48, 60, 72, 120 X Facility Care Maximum] OR Unlimited
Facility Care Maximum (Eligible Individual selects one):	[Choices may range from \$50 - \$400 in \$25 increments per calendar day] [Choices may range from \$1,500 - \$12,000 in \$750 increments per calendar month]
Home and Community Care Maximum:	[50%, 60%, 75% OR 100%] of Facility Care Maximum
[Future Purchase Options Benefit:	Automatically included if Eligible Individual does not select Inflation Protection Option below]
Inflation Protection Options (Eligible Individual selects one):	[Automatic Inflation Protection – 5% Compound Annual Increases Rider Automatic Inflation Protection – 5% Compound Annual Increases to Age 70 Rider Automatic Inflation Protection – 5% Simple Annual Increases Rider]
Respite Care Benefit Annual Maximum:	[30, 21 or 1] X Facility Care Maximum per Calendar Year
Home Assistance Lifetime Maximum:	[50] [2] X Facility Care Maximum
Hospice Care Benefit:	Included
Alternate Care Benefit:	Included
Bed Reservation Benefit:	60 Days per Calendar Year
International Coverage Limits:	[75% of the Facility Care Maximum per Calendar [Day/Month] for not more than 1,460 days per Lifetime]
Care Coordination Services:	Included

Waiver of Premium Benefit:	Included
Contingent Nonforfeiture Benefit:	Included
[Nonforfeiture Benefit Rider:	Included OR Available to Eligible Individual]
[Informal Care Limits:	[25%] [1%] of the Facility Care Maximum per Calendar Day for no more than 30 days per Calendar Year]]
[Return of Premium on Death Benefit:	Included]

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]
[Employer] No. [1234]

Group Master Application

PART 1. APPLICANT INFORMATION

ABC Company

Legal Name of Applicant

123 ANY STREET, ANYTOWN, USA 12345

Applicant's Address

Mailing Address (if different from above)

Corporate Systems Services

Nature of Business

(123) 456 – 7890

Business Telephone

12-34567890

Tax ID Number

12

Years in Business

Association

Partnership

Corporation

Other

PART 2. CONTACT INFORMATION

John Doe

Administrative Contact

Vice-President, Benefits

Title

(987) 654 – 3210

Business Phone

(987) 654 – 3211

Fax Number

John.Doe@abc.com

E-mail Address

Mary Smith

Executive Contact

Senior Vice President – Human Resources

Title

(987) 654 – 3212

Business Phone

(987) 654 – 3213

Fax Number

Mary.Smith@abc.com

E-mail Address

PART 3. COVERAGE REQUESTED

Benefits Requested:

Long Term Care Coverage

Type of Group:

Employer

[Professional] Association established for reason other than obtaining insurance

Other:

07/01/2007

Requested Effective Date

05/15 – 07/01/2007

Planned Initial Enrollment Period (MM/DD – MM/DD, YYYY)

[PART 4. ERISA

(Employee Retirement Security Act) Booklet Information

ERISA requires all plan sponsors to distribute a Summary Plan Description (SPD) to participants. If you provide your plan information, we will include it along with the ERISA language in your booklet-certificate.

Include plan specific information with Certificate? Yes No If "Yes," complete the following:

Plan Tax ID# (If different from Part 1)

1006

Plan #

12/31

Last Day of Plan Year (on 5500)

Mary Smith

If other than Applicant: Name, Address & Telephone Number of Plan Administrator

George Washington, Corporate Counsel, 123 Any Street, Anytown, USA 12345, 987-654-32145

If other than Applicant: Name, Address & Telephone Number of Agent for Service of Legal Process

Note: There may be ERISA disclosure required that your insurer cannot anticipate, such as a foreign language contact. We do provide a summary of benefits underwritten, including limitations and exclusions, along with generally applicable ERISA rights.]

PART [5]. MANDATED OFFERS

1 Regulation requires that the long term care Insurer offer you both a Nonforfeiture Benefit and an Inflation Protection benefit that meet certain standards. In many jurisdictions, rejection of either of these benefits requires policy applicant's signature.

Nonforfeiture Benefit: Include for all Insured's choice Declined

Benefits and costs of this benefit have been explained to me and I do not want it included.

Signature: X

5% Compound Inflation: Include for all Insured's choice Declined

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this coverage with and without inflation protection. Specifically, I have reviewed the 5% Compound Inflation benefit, and I reject that inflation protection.

Signature: X

PART [6]. SUBSIDIARIES / AFFILIATES TO BE COVERED

Name	City / State	Nature of Business	Relationship

PART [7]. NOTICE TO APPLICANT

The requested insurance coverage and effective date must be approved by Genworth Life Insurance Company under its current rules and practices. All coverage requests are subject to Home Office approval. No insurance agent or broker has the authority to guarantee the acceptability of the requested insurance coverage. In the event Genworth Life Insurance Company declines to issue this coverage, any premium deposit will be refunded promptly.

If coverage is provided, it will be in accordance with Genworth Life Insurance Company's current underwriting practices, including evidence of insurability requirements, as applicable.

The application will be attached to and made part of the policy. The policy will give a detailed description of the insurance coverage. The applicant agrees that acceptance of the policy will be an approval of the policy terms.

- The applicant represents that, to the best of his or her knowledge and belief, all information provided is true and complete and is bound by the terms and conditions of this coverage.
- 2/3 • [Employees will not become insured if not actively at work full-time on their coverage effective date, and for the prior 30 Calendar Days.]
- Coverage will terminate if premiums are not paid before the grace period ends. Payment of premium for coverage provided during the grace period is required.
- No one except an Officer of the Company can make, alter or discharge contracts or waive any of the Genworth Life Insurance Company's rights.

PART [8]. SIGNATURES

1 I, the Applicant's authorized representative, apply for the coverage(s) noted and certify that I have read and understood the Notice to Applicant.

X _____ Mary Smith, Senior VP, Human Resources 06/15/2007
Signature of Applicant Name and Title (Please Print) Date

X _____ 06/15/2007
Signature of Genworth Life Insurance Company Representative Date
Amy B. Insurer, Senior Account Manager Situs City, USA
Name and Title (Please Print) City / State

GENWORTH LIFE INSURANCE COMPANY

A Stock Life Insurance Company (herein called We, Us and Our)
[Administrative Office: P. O. Box 947500, Maitland, FL 32794-7500
Phone Number 800-416-3624]

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

Group Policy No.: Series 7046

Certificate Form No.: 7046CERT

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. You are advised to review carefully all limitations.

CAUTION: The issuance of this long term care insurance coverage is based upon the responses to questions on your application. A copy of your application will be provided to you. If your answers are incorrect or untrue, We have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Us at this address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland, FL 32794-7500].

1. POLICY DESIGNATION

The policy is a Group Policy issued in the [state of INSERT STATE].

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the Group Policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the group policy and certificate contain governing contractual provisions. This means that the group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CERTIFICATE CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

This insurance is intended to be federally tax-qualified long term care insurance under 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).

4. TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED

Renewability: THIS COVERAGE IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your Certificate, to continue your coverage as long as premiums for your coverage are paid on time. We cannot change any of the terms of the Group Policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Continuation Coverage: If the Group Policy is terminated, We will continue your coverage as stated in the Certificate you will receive if you become insured.

Waiver of Premium Benefit: We will waive your premium payments that become due when benefits are payable under: the Nursing Facility Benefit; the Assisted Living Facility Benefit; the Home and Community Care Benefit; the Bed Reservation Benefit; or the Hospice Care Benefit.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

We have a limited right to change the premium rates for your coverage. The premium rates for your coverage will not increase due to a change in your age or health. Premium rates may increase on a group or eligible class basis. We will give you and/or the policyholder at least 60 days notice before We change the premiums for your coverage.

6. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

You may return your Certificate for any reason within [30/45/60/90] days after you receive it. To do so, mail or deliver it to Our Administrative Office at the above address. We will refund the full amount of any premium paid within [30/60] days of such a return; and the Certificate will be considered never to have been issued.

[There is a Return of Premium on Death Benefit that provides for a refund of premiums paid for coverage upon your death. In order for it to be payable, you must die while insured before the age of 75. The amount returned is equal to a portion of the premiums paid less any claim payments made.] [The Group Policy does not include a benefit that returns premiums to you upon cancellation or to your heirs or estate upon your death.]

[However,] We will return unearned premium in the event your coverage terminates due to death, surrender or cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither We, nor our agents represent Medicare, the federal government, or any state government.

8. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the Home.

This coverage reimburses you for covered long term care expenses you incur. It is subject to limitations, Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE POLICY – BENEFIT ELIGIBILITY

BENEFITS

Benefits are available up to the daily, monthly, annual, and lifetime maximums until applicable maximum lifetime benefits you selected are exhausted. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

For you to be eligible for benefits provided by your coverage, We must have both:

- A Current Eligibility Certification; and
- Ongoing proof which demonstrates that the Covered Care you receive is needed due to your continually being a Chronically Ill Individual. The proof can be based on information from care providers, personal physicians and other Licensed Health Care Practitioners.

Activities of Daily Living means the following self-care functions: bathing (washing oneself); dressing (putting on and taking off clothes and assistive devices); toileting (including performing associated personal hygiene tasks); transferring (moving in and out of a bed, chair or wheelchair); continence (control of bowel and bladder functions); and eating (taking nourishment).

Chronically Ill Individual means a person who has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of

functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or

- Requiring Substantial Supervision to protect the person from threats to health and safety due to a Severe Cognitive Impairment.

Current Eligibility Certification means a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that you meet the requirements for being a Chronically Ill Individual.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in your: short-term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.

Hands-on Assistance is the physical assistance (minimal, moderate or maximal) of another person without which you would be unable to perform the Activity of Daily Living.

Standby Assistance means the presence of another person, within arm's reach of you, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired person from threats to his health or safety (such threats as may result from wandering.)

CONDITIONS

Benefits will be paid as reimbursement for Covered Expenses incurred for Covered Care services that meet all of the following additional conditions:

- Your coverage provides benefits for such Covered Care;
- The Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- Except as stated in the Extension of Benefits provision of the Certificate you will receive if you become insured, your coverage is in force on the date(s) the Covered Care is received;
- You have not exhausted any daily, monthly, annual or lifetime limits on the specific benefits claimed;
- You meet all additional requirements for the benefits you claim;
- The service, cost or item for which benefits are payable constitutes Qualified Long Term Care Services; and
- You satisfy the Elimination Period.

Benefit payments cease when your Policy Lifetime Maximum is exhausted and are subject to: the Elimination Period; the Facility Care Maximum; and all other limits determined from the specific benefits.

Those limits are based on your plan selection as shown on the enrollment material and stated in the Certificate you will receive if you become insured.

Covered Care means only those Qualified Long Term Care Services for which your coverage pays benefits or would pay benefits in the absence of an Elimination Period.

Covered Expenses means costs you incur for which a benefit may be payable under this coverage. Each benefit section defines the Covered Expenses under that benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

[Elimination Period] means the total number of days that you remain a Chronically Ill Individual and incur Covered Expenses before benefits are payable. The Elimination Period begins on the first day that you are both a Chronically Ill Individual and incur Covered Expenses. Each day on which you remain a Chronically Ill Individual and incur Covered Expenses that are subject to the Elimination Period will count toward the Elimination Period. The days do not have to be consecutive. Each benefit states how its payment is affected by the Elimination Period. The number of days may be accumulated before the filing of a claim if We can establish that you met these Elimination Period requirements before the filing of a claim. The Elimination Period need only be met once during your lifetime.]

2

[OR]

[Elimination Period] means the total number of days that you remain a Chronically Ill Individual before benefits are payable. Each benefit states how its payment is affected by the Elimination Period. The Elimination Period begins on the first day that you are both a Chronically Ill Individual and incur Covered Expenses. However, you are not required to continue to incur Covered Expenses to satisfy the Elimination Period. Elimination Period days may be accumulated before the filing of a claim if We can establish that you met these Elimination Period requirements before the filing of a claim. The Elimination Period need only be met once during your lifetime.]

2

Facility Care Maximum means the maximum amount We will pay [daily/monthly] when you are Confined in a Nursing Facility, Assisted Living Facility or Hospice Care Facility. This amount is also used to determine other benefit maximums.

Licensed Health Care Practitioner means any of the following who is not a family member: a Physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional Nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is practicing within the scope of that license.

Plan of Care means a written individualized plan for care and support services for you that: has been developed as a result of an assessment and incorporates any information provided by your personal physician; has been prescribed by a Licensed Health Care Practitioner; fairly, accurately and appropriately addresses your long term care and support service needs. It specifies: the type, frequency and duration of all services required to meet those needs; the kinds of providers appropriate to furnish those services; and an estimate of the appropriate cost of such services.

Policy Lifetime Maximum means the maximum amount of benefits payable to you. The Policy Lifetime Maximum will be reduced by the amount of claims paid, except that Covered Expenses We incur for Care Coordination Services do not count against your Policy Lifetime Maximum. The Policy Lifetime Maximum will increase in accordance with the terms of any inflation protection in force. The Policy Lifetime Maximum will increase or decrease in accordance with any increase or decrease you elect.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are: required by a Chronically Ill Individual; and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. **Maintenance or Personal Care Services** means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

CARE COORDINATION SERVICES

These services are intended to help identify care needs and community resources available to deliver care when you are a Chronically Ill Individual. These services are furnished by a team of Covered Care Coordinators provided by Us at no cost to you. We will pay for these services when you receive them while your coverage is in effect. These payments will be at our expense; and will NOT count against any payment maximum.

Care Coordination Services will provide you with a team of Covered Care Coordinators who will review your specific situation and develop Plans of Care to meet your needs. Covered Care Coordinators will: assess your functional, cognitive and personal needs for care and services on an ongoing basis; work with you to identify the specific services and care providers you require; develop and suggest initial and subsequent Plans of Care to assist you in meeting your needs; provide the initial and ongoing Current Eligibility Certifications; and monitor your care needs on an ongoing basis to help you receive appropriate care.

You or your family should contact Us immediately when you choose to use the services of a Covered Care Coordinator. We will then make arrangements for a Covered Care Coordinator to contact you and begin providing you with this assistance. You are not required to use these Care Coordination Services. However, you may, at your own expense, use a Licensed Health Care Practitioner who is not a Covered Care Coordinator to provide a Plan of Care, Current Eligibility Certification, or assist in coordinating services. Care Coordination Services will not be provided in connection with the International Coverage Benefit. Payment for these services is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period. Care Coordination Services are not subject to the Policy Lifetime Maximum.

NURSING FACILITY BENEFIT

You are eligible to receive benefits during your Confinement in a Nursing Facility. Covered Expenses for Nursing Facility care means expenses you incur for care and support services (including room and board) provided by the Nursing Facility. Covered Expenses do not include expenses you incur for prescription medications or any charges for your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment. We will pay up to the Facility Care Maximum for Covered Expenses you incur during your Confinement. The Nursing Facility Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

Confinement or Confined means you are a resident in a facility during a period for which room and board charges are Covered Expenses.

Nursing Facility means a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse; the facility must employ at least one full-time (at least 30 or more hours per week) Nurse; and a Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing, or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: A Nursing Facility does NOT include any of the following: a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; an Assisted Living Facility; your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); a substantially similar adult residence establishment or environment.

ASSISTED LIVING FACILITY BENEFIT

You are eligible to receive benefits during your Confinement in an Assisted Living Facility. Covered Expenses for care in an Assisted Living Facility means expenses you incur for care and support services (including room and board) provided by the Assisted Living Facility. Covered Expenses do not include expenses you incur for prescription medications or any charges for your comfort and convenience such as transportation, televisions, telephones, beauty care, guest meals and entertainment. We will pay up to the Facility Care Maximum for Covered Expenses you incur during your Confinement. The Assisted Living Facility Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

Assisted Living Facility means a facility (including one for people with Alzheimer's) that is engaged primarily in providing Maintenance or Personal Care Services to its residents. It must provide those services 24 hours a day, every day:

- Under a license, certificate or substantially similar permit and oversight from the federal government or the state in which it is located; OR
- To at least 10 residents, in accordance with all applicable laws, and continuously meet certain staffing and service level requirements.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Living Facility only if it is engaged primarily in providing care that satisfies the definition of an Assisted Living Facility.

Excluded Places: An Assisted Living Facility does NOT include any of the following: a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness; a Nursing Facility; your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities); or a substantially similar adult residence establishment or environment.

BED RESERVATION BENEFIT

You are eligible to receive benefits to reserve your accommodations in a Nursing Facility or Assisted Living Facility during your temporary absence (for any reason) from that facility. Covered Expenses for Bed Reservation Benefits means the same as Covered Expenses for reserving your room and board accommodations in the Nursing Facility or Assisted Living Facility. We will pay up to the Facility Care Maximum for Covered Expenses you incur while you are temporarily absent from the Nursing Facility or Assisted Living Facility. This benefit is payable for a maximum of 60 days per calendar year. The Bed Reservation Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

HOME AND COMMUNITY CARE BENEFIT

You are eligible to receive benefits for Covered Expenses you incur for Home and Community Care. Covered Expenses for Home and Community Care means expenses you incur for the following services: Adult Day Care; Nurse and Therapist Services; Home Health or Personal Care Services; and Incidental Homemaker and Chore Care. Based on your plan selection (choices shown in your enrollment materials), We will pay up to the Home and Community Care Maximum for Covered Expenses you incur. Your Home and Community Care Maximum is a percentage of your Facility Care Maximum. The Home and Community Care Benefit is also subject to the Elimination Period and the Policy Lifetime Maximum.

Home means the place where you maintain independent residence. This could be a house, condominium, apartment, unit in a congregate care community or similar residential environment. Home does not mean: a hospital; a Nursing Facility; an Assisted Living Facility; or a Hospice Care Facility.

Adult Day Care means a program for six (6) or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Nurse and Therapist Services means health care services provided in your Home by a Nurse, or a licensed physical, occupational, respiratory or speech therapist.

Home Health or Personal Care Services means assistance you receive in your Home from a Home Health Agency or Independent Provider with: simple health care tasks; personal hygiene; managing medications; performing Activities of Daily Living; and supervision needed when you have Severe Cognitive Impairment.

Incidental Homemaker and Chore Care means assistance provided in your Home: by the same person providing Home Health or Personal Care Services; and during the same visit in which you receive Home Health or Personal Care Services. This assistance consists of: meal planning and preparation; doing laundry; light house cleaning; minor household repairs related to your safety at Home; taking out the garbage; and simple cleaning tasks to remove unsafe debris or dirt from your Home. This does not include any type of: residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; transportation; vehicle or equipment maintenance; or similar tasks.

Home Health Agency means an entity that is regularly engaged in providing Home Health or Personal Care Services for compensation and employs staff who are qualified by education, training or experience to provide such care. The entity must: be supervised by a qualified professional such as a Nurse, a licensed social worker, or a Physician; keep clinical records or care plans on all patients; provide ongoing supervision and training to its staff appropriate to the services to be provided; and have the appropriate state licensure or certification, where required.

Independent Provider means a person who is not affiliated with a Home Health Agency and is licensed or certified in the state where the care will be provided, to provide assistance in performing Activities of Daily Living or supervision for someone who has Severe Cognitive Impairment. If the state in which you live does not require licensure or certification for Independent Providers, We may approve benefits for an Independent Provider if We can determine, using Our sole discretion, that the individual is qualified by education, training and experience to provide Home Health or Personal Care Services. The education must include training in safely assisting Chronically Ill Individuals. We will require written proof of licensure or certification, and will accept inclusion in a state sponsored nurse aide registry, if the state in which you live maintains such a registry.

HOME ASSISTANCE BENEFIT

You are eligible to receive benefits for Covered Expenses you incur for Home Assistance. Covered Expenses for Home Assistance means expenses you incur (including tax, installation and labor costs) for the following services or items: Home Modifications, Assistive Devices and Supportive Equipment; Emergency Medical Response Systems; and Caregiver Training. Covered Expenses must be: intended to enable you to remain independent in your Home; and stated in, and furnished in accordance with your Plan of Care. We will pay up to the Home Assistance Lifetime Maximum of [50] [2 (two)] times your Facility Care Maximum for Covered Expenses you incur for Home Assistance Services. Payment under the terms of this benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

Home Modifications, Assistive Devices and Supportive Equipment means items such as the following that are intended to relieve your need for direct physical assistance; and (as stated in your Plan of Care) are expected to enable you to remain at Home for at least 90 days after the date of purchase or first rental: ramps to permit movement from one level of your Home to another; grab bars to assist in toileting, bathing or showering; hospital-style beds, wheelchairs or crutches; adaptive equipment to enable independent feeding and dressing (specialized utensils and fasteners); and pumps and other devices for intravenous injection. This does NOT include: Home repair, remodeling, or installation of an elevator, escalator, hot tub, swimming pool, or Jacuzzi or other similar items or services; items that will, other than incidentally,

increase the value of your Home; and artificial limbs, teeth, corrective lenses, hearing aids, or equipment placed in your body, temporarily or permanently.

Emergency Medical Response Systems means the installation and any ongoing fees for any type of medical alert system.

Caregiver Training means the training of a family member, friend or other person to provide care for you in your Home. Caregiver Training must be included in your Plan of Care. Covered Expenses for Caregiver Training means expenses incurred for training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for you. The training cannot be received when you are Confined in a hospital, Assisted Living Facility or Nursing Facility, unless it is reasonably expected that the training will make it possible for you to return to your Home, where you can be cared for by the person receiving the training.

INFORMAL CARE BENEFIT

- 2 You are eligible to receive benefits for Covered Expenses you incur for Informal Care. Covered Expenses for Informal Care means expenses you incur for Informal Care that is: intended to enable you to remain independent in your Home; and stated in, and furnished in accordance with your Plan of Care. We will pay for Covered Expenses you incur for Informal Care up to [25%] [1%] of the Facility Care Maximum per calendar day for no more than 30 days per year. Payment under the terms of this benefit is subject to the Elimination Period. Days of Covered Care under this Benefit cannot be used to satisfy the Elimination Period. The Informal Care Benefit is also subject to the Policy Lifetime Maximum.

Informal Care means Maintenance or Personal Care Services another person (which may include a member of your Immediate Family) provides to you, in your Home, because you are a Chronically Ill Individual. In all instances the person providing the assistance and supervision must be someone who did not normally reside with you in your Home at the time you became eligible for benefits and is neither from a Home Health Agency nor an Independent Provider. The assistance may be in the form of help with: simple health care tasks; personal hygiene; managing medications; or performing Activities of Daily Living. Supervision is applicable when you have Severe Cognitive Impairment. Your Plan of Care must specify the type, frequency and duration of Informal Care required.]

HOSPICE CARE BENEFIT

You are eligible to receive Hospice Care Benefits when We determine that you are a Chronically Ill Individual, you are Terminally Ill, and you are not receiving preventive or curative treatment for that illness. Covered Expenses for Hospice Care means expenses you incur for care and support services (including room and board) in a Hospice Care Facility, Nursing Facility or Assisted Living Facility. Covered Expenses for Hospice Care also means Covered Expenses for Home Health or Personal Care Services, and Incidental Homemaker and Chore Care. Covered Expenses do not include expenses you incur for medications, supplies, equipment or Physician visits. We will not pay for any charges for your convenience such as transportation, televisions, telephones, beauty care, guest meals or entertainment. We will pay up to the Facility Care Maximum for Covered Expenses you incur during your Confinement in a Hospice Care Facility, Nursing Facility or Assisted Living Facility. We will pay up to the Home and Community Care Maximum for all other Covered Expenses you incur for Hospice Care. Payment under the terms of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period. The Hospice Care Benefit is also subject to the Policy Lifetime Maximum.

Hospice Care means services designed to provide palliative care and alleviate your physical, emotional and social discomforts if you are Terminally Ill.

Hospice Care Facility means a facility which provides a formal Hospice Care program directed by a Physician on an inpatient basis. A Hospice Care Facility must be licensed or certified by the state in which it

is located, if such license or certification is required. A Hospice Care Facility may be licensed or certified as a Nursing Facility, Assisted Living Facility, or other type of health care facility. Hospice Care Facility does not mean: a hospital, a clinic; a community living center; or a place that provides residential or retirement care only.

Terminally Ill means having six months or less to live, as determined by a physician.

RESPITE CARE BENEFIT

2 You are eligible to receive Respite Care Benefits, prior to your meeting the Elimination Period, when it provides temporary, short-term relief for those persons who normally and primarily care for you in your Home on a regular, unpaid basis. Covered Expenses for Respite Care means: care in a Nursing Facility; care in an Assisted Living Facility; and Home and Community Care. We will pay up to the Facility Care Maximum for Covered Expenses you incur for Respite Care. This maximum applies to all such expenses you incur. We will pay this Benefit until the Respite Care Benefit Annual Maximum of [one/21/30 time(s)] the Facility Care Maximum per calendar year is reached. Days on which you receive Respite Care do not need to be consecutive. Payment under the terms of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period. The Respite Care Benefit is also subject to the Policy Lifetime Maximum.

Respite Care means temporary care you receive in order to relieve the unpaid person who normally and primarily provides you with care in your Home. Your Plan of Care must state: the name of the unpaid caregiver for whom the respite is being provided; the period of respite; and the Covered Care you will require to replace that normally provided by that unpaid caregiver.

ALTERNATE CARE BENEFIT

Subject to our approval, you will be eligible to receive payment for Covered Expenses you incur for services, devices or treatments not otherwise payable under your coverage, or benefits payable in a different manner than specified. Covered Expenses for the Alternate Care Benefit means fees charged for care, services, devices or treatments approved by Us after We determine that they: are cost-effective; are appropriate to your needs; are consistent with general standards of care; provide you with an equal or greater quality of care than otherwise provided by your coverage; are Qualified Long Term Care Services; and are clearly specified in your Plan of Care and in a separate written mutual agreement between Us, you (or your representative) and, if appropriate, your Physician. The written mutual agreement will state how the Elimination Period affects payment. It will also state any time and payment maximums. The Alternate Care Benefit is also subject to the Policy Lifetime Maximum.

INTERNATIONAL COVERAGE BENEFIT

2 You are eligible to receive benefits during your Confinement in an Out-of-Country Nursing Facility. Covered Expenses for International Coverage means expenses you incur for care and support services (including room and board) provided by the Out-of-Country Nursing Facility (as defined in the Certificate you will receive if you become covered). We will pay up to 75% of the Facility Care Maximum per calendar [day/month] for not more than 1,460 days per lifetime. Payment under this benefit for less than a full month will be pre-rated based on a 30-day month and the number of days for which payment is being made. This Benefit will not qualify for waiver of premium; and is in lieu of all other Benefits and reimbursements otherwise provided by the policy for expenses incurred during the same period. The International Coverage Benefit is subject to the Elimination Period and the Policy Lifetime Maximum.

CONTINGENT NONFORFEITURE BENEFIT

You will receive coverage under this benefit if you are not covered by the Nonforfeiture Benefit. If there is a substantial increase in premium rates, you will be given the right to reduce coverage or convert to a paid-up status with a reduced Policy Lifetime Maximum equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) the maximum

amount in effect at the time of lapse applicable to one month (30 days) of Nursing Facility Confinement. In no event will this amount exceed the unused Policy Lifetime Maximum at the time of conversion.

[[OPTIONAL] NONFORFEITURE BENEFIT

2

If you are covered by the Nonforfeiture Benefit Rider, it will provide a continuation of your coverage up to a specified dollar amount, called the Nonforfeiture Benefit Allowance, if your coverage terminates due to non-payment of premium before your Policy Lifetime Maximum has been paid. If your coverage terminates due to non-payment of premium on or after it has been in force for three years, We will continue to pay benefits, subject to all of the terms and conditions of your coverage, until the Nonforfeiture Benefit Allowance has been reached or when you no longer meet the Eligibility for the Payment of Benefits requirements of the Group Policy, whichever occurs first. The Nonforfeiture Benefit Allowance We will pay will be the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) the maximum amount in effect at the time of lapse applicable to one month (30 days) of Nursing Facility Confinement. In no event will this amount exceed the unused Policy Lifetime Maximum at the time of lapse.]

10. EXCLUSIONS AND LIMITATIONS

There are no pre-existing conditions exclusions or limitations.

Non-eligible Facilities/Providers: A Nursing Facility, Assisted Living Facility or Hospice Care Facility is not covered unless it meets the applicable definition for such a facility. Your “**Home**” means the place where you maintain independent residence. This could be a house, condominium, apartment, unit in a congregate care community or similar residential environment. Your Home does not mean: a hospital; a Nursing Facility; an Assisted Living Facility; or a Hospice Care Facility.

Non-eligible Levels of Care: Coverage is not based on the specific level of care; but is for care furnished, for a specific covered reason, by or through the covered facilities and providers. Care from family members is covered only when specifically indicated.

Exclusions/Exceptions and Limitations: We will not pay benefits for any expenses incurred for any room and board, care, treatment, services, equipment, or other items:

2

- [For which no charge is normally made in the absence of insurance;]
- [Provided outside the United States of America, its territories and possessions, except as described in the International Coverage Benefit;]
- [Provided by a family member, unless a benefit specifically states that a family member can provide Covered Care. We will not consider care to have been provided by a family member when:
 - He or she is a regular employee of the organization that is providing the services; and
 - Such organization receives payment for the services; and
 - He or she receives no compensation other than the normal compensation for employees in his or her job category.]
- [Provided by or in a Veteran’s Administration or Federal government facility, unless a valid charge is made to you or your estate;]
- [Resulting from war or any act of war, whether declared or not;]
- [Resulting from attempted suicide or an intentionally self-inflicted injury;]
- [Resulting from participation in a felony, riot or, insurrection;]
- [Resulting from your alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);]
- [For which you receive, or are eligible to receive, workers’ compensation benefits, occupational disease act benefits, or similar benefits.]

Non-Duplication: Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medicaid.
- However, the Non-Duplication provision will not disqualify a Covered Care expense from being used to satisfy the Elimination Period.

2 *Coordination With Other Coverage:* We will reduce the amount We will pay for Covered Care when the total amount payable under this and all other Long Term Care Coverage is greater than the actual expense you incur for that Covered Care. We consider **Long Term Care Coverage** to be [group] coverage[, whether group or individual,] that provides nursing facility, assisted living facility or home health care benefits. This applies whether those benefits are payable on an expense reimbursement, indemnity, cash payment or other basis.

When benefits are reduced, the amount We will pay will be the lesser of:

- The amount We would pay in the absence of this provision; or
- The difference between the actual expense incurred and the amount payable under all other Long Term Care Coverages whose benefits are payable before those of your coverage. In making this determination We will use the order of benefit payments stated below.

Any Long Term Care Coverage without a coordination of coverage provision will pay first without any reduction in its benefits. For this and all other Long Term Care Coverage, the coverage with the earliest effective date will be deemed to be first to pay, and the later coverage(s) secondary, in order of effective date, from the earliest to the latest.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

2 Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [You may elect one of the inflation protection options to increase your coverage. Only increases taken in accordance with one of the inflation protection options do not require proof of insurability.]

[AUTOMATIC INFLATION PROTECTION – 5% COMPOUND ANNUAL INCREASES RIDER

2 If you have this option, We will increase by 5%: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage even if you are receiving benefits. The increased amounts will be rounded to the nearest whole dollar.]

[AUTOMATIC INFLATION PROTECTION – 5% COMPOUND ANNUAL INCREASES TO AGE 70 RIDER

2 If you have this option, We will increase by 5%: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage, even if you are receiving benefits. No increase will occur after you have reached 70 years of age. The increased amounts will be rounded to the nearest whole dollar.]

[AUTOMATIC INFLATION PROTECTION – 5% SIMPLE INCREASES RIDER

2 If you have this option, Your Facility Care Maximum and all other maximums that are based on the Facility Care Maximum, will increase each year by 5% of those amounts in effect on your original effective date. However, the increase to your Policy Lifetime Maximum will be the lesser of 5% of the Policy Lifetime Maximum in effect on your original effective date, or 5% of the Policy Lifetime Maximum less claims paid.

The increase will take effect on each anniversary of the effective date of your coverage even if you are receiving benefits. The increased amounts will be rounded to the nearest whole dollar.]

2 [AUTOMATIC BENEFIT INCREASE RIDER: AGE-ADJUSTED: COMPOUND TO 65, SIMPLE THEREAFTER.

If you have this option, We will increase: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage even if you are receiving benefits. The increase amounts will be: (a) prior to age 66 on a Compound Basis; (b) after age 66, on a Simple Basis; and (c) rounded to the nearest whole dollar.

“Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by 5% to determine the current benefit amounts. “Simple Basis” means, with respect to the Facility Care Maximum and benefit maximums other than the Policy Lifetime Maximum, that the amount of the increase will be determined by multiplying 5% times the Facility Care Maximum in effect on the anniversary date of your Coverage Effective Date next following your 66th birthday. This amount will be the amount of the increase that occurs on each anniversary thereafter while your coverage is in force. With respect to the Policy Lifetime Maximum, Simple Basis means that the amount of the increase will be determined by multiplying 5% times the lesser of: (a) the unused Policy Lifetime Maximum in effect on your Coverage Effective Date next following your 66th birthday; or (b) the unused Policy Lifetime Maximum in effect on the effective date of the increase. For additions to your benefit amounts that are not the result of this Rider, the amount of the increase will be determined separately.]

2 **3** [AUTOMATIC BENEFIT INCREASE RIDER: AGE ADJUSTED COMPOUND PROTECTION : AGES 61 [AND 76] – [5%, 3%] TO AGE 61 / 3% [TO AGE 76] [2%, 3%][THEREAFTER].

If you have this option, We will increase: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage, even if you are receiving benefits. The increase amounts will be on a Compound Basis and rounded to the nearest whole dollar.

3 “Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by the appropriate percentage based on Your age to determine the current benefit amounts: when younger than age 61, [3%, 5%]; after age 61, [but younger than age 76,] 3% [; and after age 76, [2%, 3%]].

2 [AUTOMATIC BENEFIT INCREASE RIDER –[3%, 4%, 5%] COMPOUND ANNUAL INCREASES TO AGE 76]

3 If you have this option, We will increase by [3%] [4%] [5%]: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the effective date of your coverage, even if you are receiving benefits. No increase will occur after you have reached 75 years of age. The increased amounts will be rounded to the nearest whole dollar.

“Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by the appropriate percentage to determine the current benefit amounts.”]

2 **3** [AUTOMATIC BENEFIT INCREASE RIDER: AGE ADJUSTED PROTECTION—AGE[S] 61 [AND 76] – 5% COMPOUND TO AGE 61 / 5% SIMPLE [TO AGE 76; [2%, 5%] SIMPLE] THEREAFTER].

3 If you have this option, We will increase: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. The increases will take effect on each anniversary of the Your Coverage Effective Date, even if you are receiving benefits. The increase amounts will be: (a) prior to age 61 on a Compound Basis; [(b)after age 61, on a Simple Basis;] [(b) from age 61 [to age 76,][and thereafter]on a Simple Basis;] [(c) from age 61 to age [76 and thereafter] on a Simple Basis;] and [(c)(d)] rounded to the nearest whole dollar.

3 “Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by [5%] to determine the current benefit amounts.

3 “Simple Basis” means, with respect to the Facility Care Maximum and benefit maximums other than the Policy Lifetime Maximum, that the amount of the increase will be determined by multiplying the appropriate percentage based on your age times the Facility Care Maximum in effect on the anniversary date of your Coverage Effective Date following your [61st and 76th] birthdays respectively. “Simple Basis” means that, with respect to an increase to your Policy Lifetime Maximum that occurs[: (a)]on the anniversary of Your Coverage Effective Date next following Your 61st birthday and [on each such anniversary until you are age 76/thereafter], the amount of the increase will be determined by multiplying 5% times the lesser of: (i) the unused Policy Lifetime Maximum in effect on the anniversary of Your Coverage Effective Date next following your 61st birthday; or (ii) the unused Policy Lifetime Maximum in effect on the effective date of the increase. [and (b) [On the anniversary of Your Coverage Effective Date next following Your 76th birthday and each such anniversary thereafter, the amount of the increase will be determined by multiplying [2%, 5%] times the lesser of: (i) the unused Policy Lifetime Maximum in effect on the Anniversary Date next following your 76th birthday; or (ii) the unused Policy Lifetime Maximum in effect on the effective date of the increase.]

With respect to an addition to your benefit amounts that is not the result of the Rider, the amount of the increase will be determined separately.

[FUTURE PURCHASE OPTIONS

2 3 If you have this option, you will be offered on every [third anniversary] of the Group Policy Effective Date, while your coverage is in force, the option to increase by 5% compounded annually: your Facility Care Maximum; the unused balance remaining in your Policy Lifetime Maximum; and all other maximums that are based on the Facility Care Maximum. You will receive these offers provided: your coverage remains in force; you are not currently receiving benefits; you have not filed a claim which is pending; you have not been determined to be currently eligible for benefits; and you are not currently satisfying the Elimination Period. The additional premium required for each increase will be based on your age and premium rate as of the effective date of the offer. Once you have refused [two consecutive] offers, future offers will cease; and you must submit proof of insurability satisfactory to Us if you want to increase coverage.]

3 INFLATION PROTECTION

[Benefit Increases: The charts below compare the benefit levels and costs of coverage over time (and at ages 75 and 85) with and without inflation protection. **CHART 1a** compares benefits with [three] different types of inflation coverage available under the Group Policy (5% Compound for Life, 3% Compound for Life, Future Purchase Options (with every other option taken), and the Age-Adjusted option); in **CHART 1b**, benefits are compared under the 5% Simple for Life option rather than the Age-Adjusted option. **CHART 2** compares the premiums for coverage with the same [inflation options/benefit increase riders]. These charts use the following plan design for a person aged 50 when coverage is issued: 3 Year Benefit Period, an initial \$6,000 Monthly Facility Care Maximum, a Home and Community Care Maximum of 75%, and without a Nonforfeiture Benefit. It is assumed that premiums did not change over the time span. *(This is not a rate guarantee. The company reserves the right to change premium rates as noted in the paragraph “TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.”)*

CHART 1a -

COVERAGE AVAILABLE TO THOSE LESS THAN AGE 61

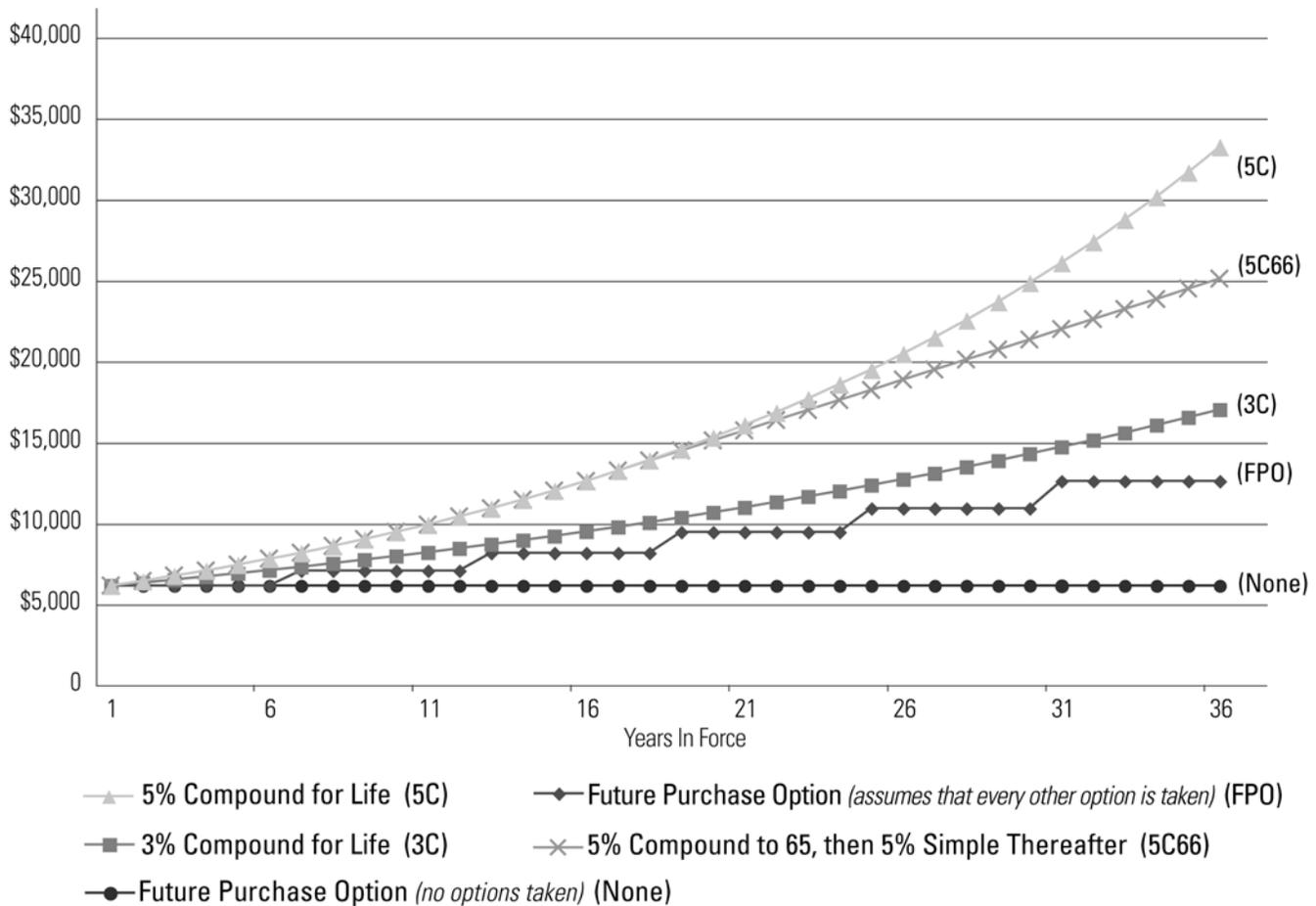


CHART 1b -

COVERAGE AVAILABLE TO THOSE 61 AND OVER

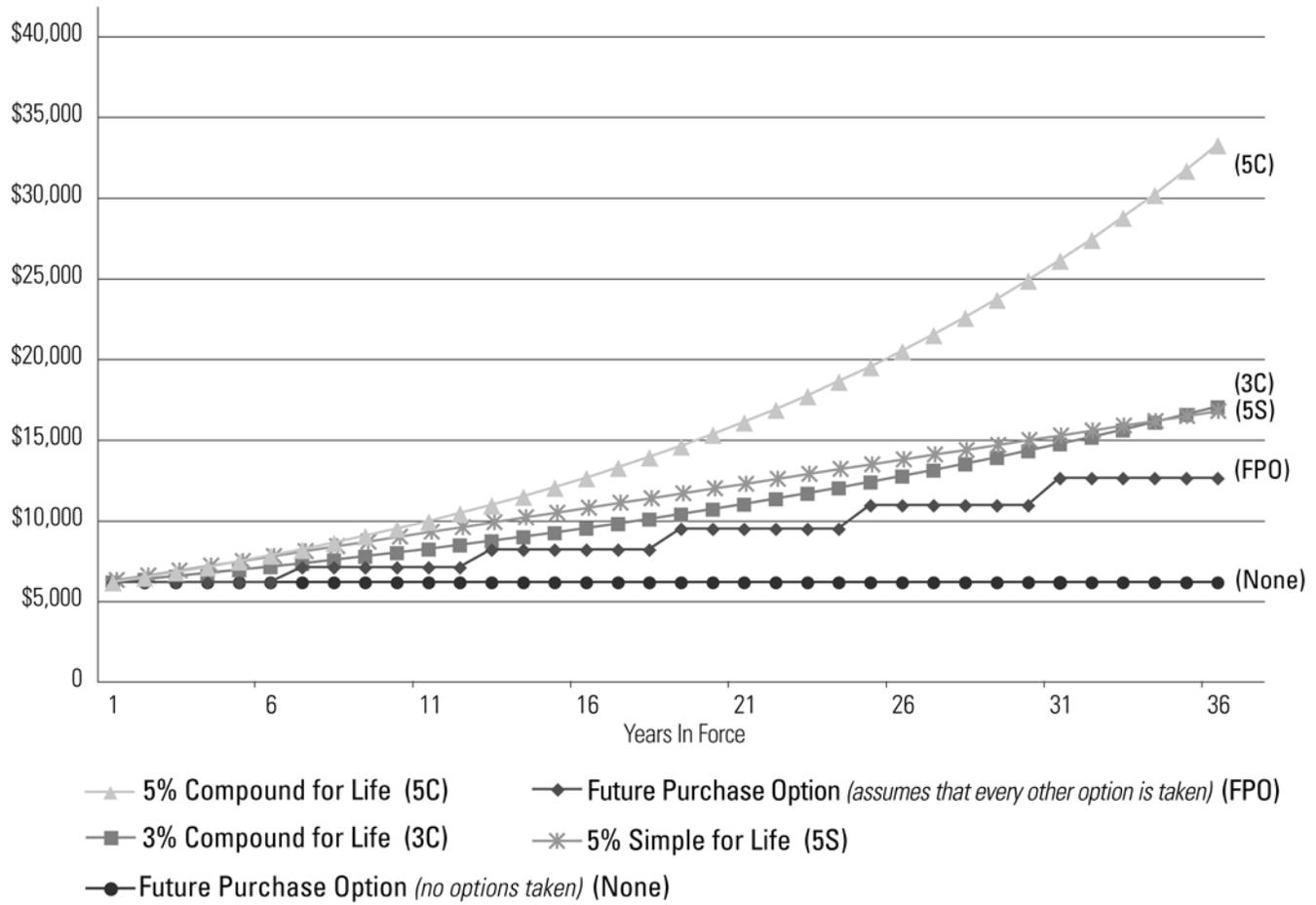
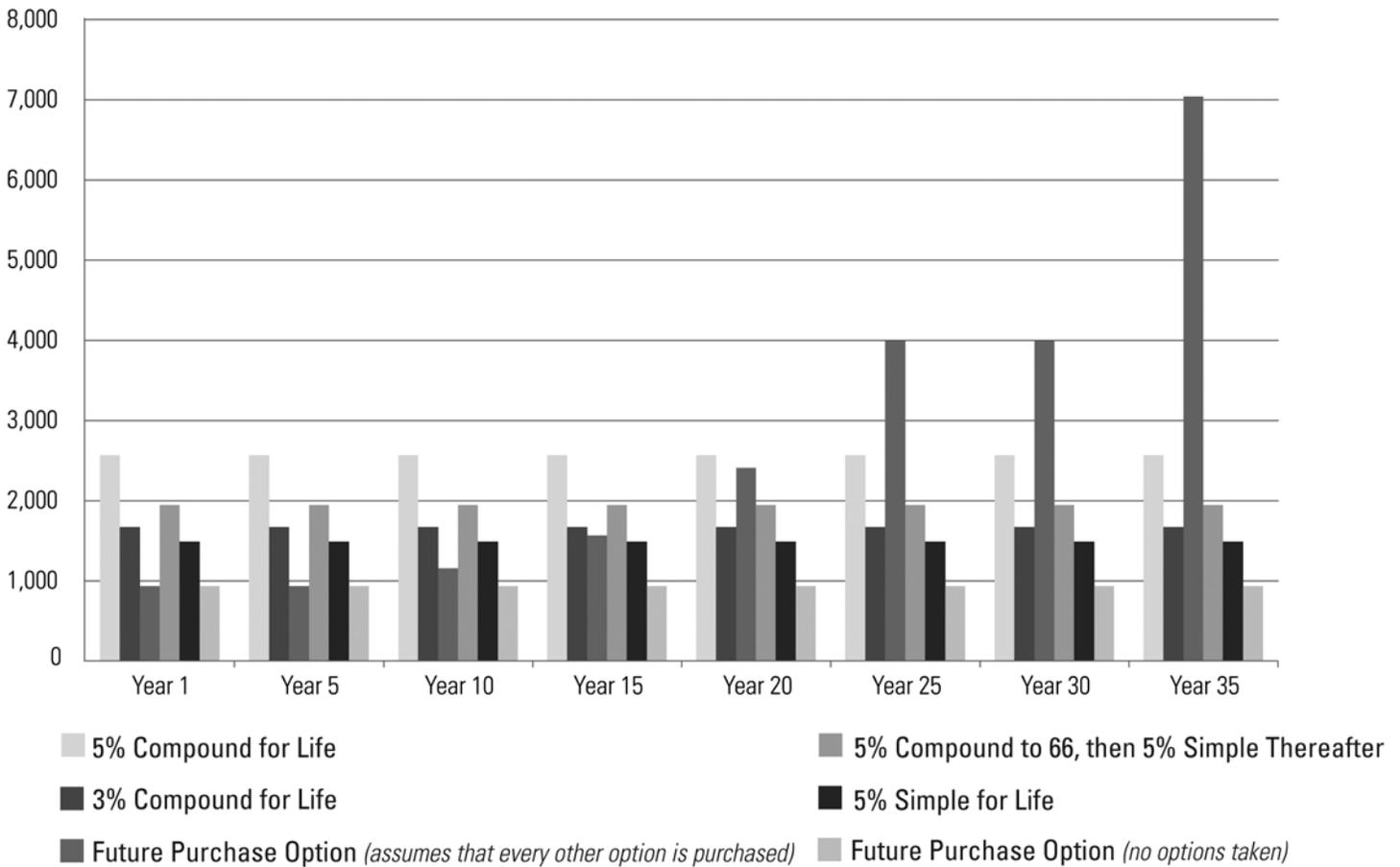


CHART 2 - Premium Costs: The following chart compares the annual premiums for coverage, with and without benefit increase options. The charts are based on a 50-year old and coverage with the following features: a 3-Year Benefit Period; an initial \$6,000 Monthly Facility Care Maximum; a Home and Community Care Maximum of 75%; and without a Nonforfeiture Benefit rider. It is assumed that the premiums did not change over the time span. *(This is not a rate guarantee. The Company reserves the right to change premium rates as noted in the paragraph "TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.")*

COST OF COVERAGE



]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your application for coverage under the Group Policy is approved, the Group Policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and all other forms of organic brain disease.

13. PREMIUM

The initial premium for your coverage will be determined from the premium rate schedule contained in your enrollment material based on the option selected and your issue age.

14. ADDITIONAL FEATURES

Underwriting

We will underwrite your application by reviewing one or more of the following: the information submitted on your application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Continuation for Lapse Due to Cognitive or Functional Impairment

If your coverage terminates due to non-payment of premiums, We will provide a retroactive continuation of coverage if within seven (7) months of the termination date you provide Us with proof that you were a Chronically Ill Individual, beginning on or before the expiration date of the grace period. All past due premiums for your coverage that was in force immediately prior to the date of lapse must be paid. In that event, any benefits for which you qualified during the continuation period will be paid to the same extent they would have been paid if your coverage had remained in force from the date of termination.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE COVERAGE.

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]

Guaranteed Issue Application [for Employees]

A. Eligible [Employee/Person] Information

Print clearly – Use black ink

1

Name (First) (MI) (Last)

Address

City State ZIP code Date of Birth / /

Social Security Number - - Sex Male Female Marital status Married Single Widowed

Work Phone Number Home Phone Number Height feet inches Weight lbs.

Best time to call a.m. p.m. Home Work Date of Hire / /

Name of Eligible [Employee's/Applicant's Employer]

3 **[[Actively At Work/Active Service] Certification:** I certify that I am [an actively at work employee][in Active Service]. I understand that coverage will not go into effect for me unless I am [Actively at Work/in Active Service] for the prior 30 calendar day period. [Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a [full-time basis at least 30 hours each week]. I will be considered Actively at Work while on employer approved vacations, holidays and regularly scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, a sabbatical or retired from the same employer.] ["Active Service" means I am able to engage in substantially all of the usual activities of a person in good health of like age and sex, and am not: (1) confined in a hospital or nursing, assisted living, or custodial care facility; or (2) receiving home health care services.]]

X

[Employee/Applicant] Signature

Date

B. Spouse [or Domestic Partner] Information

Please complete the information below if your spouse [or domestic partner] is also applying.

2

Name (First) (MI) (Last)

Social Security Number - -

C. Replacement

All questions must be answered.

- Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
- Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
- Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
- Are you covered by Medicaid? (not a reference to Medicare) Yes No

D. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice. I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First) (MI) (Last)

Street Address

City State ZIP code Phone Number

1 You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

E. Declarations

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of [any/voluntary] coverage under the Group Policy. [I understand that any misstatements or failure to report information that is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim.]

[I agree that if my application is approved by the Company, the effective date of [any/Voluntary] coverage will be determined in accordance with the terms of the Group Policy, including any applicable [Actively At Work/Active Service] requirements. I also understand and agree that no insurance will be in effect pursuant to this application, or under any group policy or certificate issued by the Company unless or until the Group Policy and Certificate have been delivered and accepted and there has been no change in the health of the applicant that would change the answer to any of the questions in the application./unless or until the Group Policy is in effect.] [I request to be insured under the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and the Group Policy is in effect.]

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

X Signature Applicant: _____ Date: _____
Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

F. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300] [per day]

Plan Package (Consult the enrollment materials for details of the coverage under each plan):

1 [Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following options:

2 [I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

[I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

[Automatic Inflation Protection – 5% Simple Annual Increases Rider]

[Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

[Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]

[Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]

[Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]

[Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]

[Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]

2 [Nonforfeiture Benefit:

Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature

Applicant: _____

Date: _____

2 [G. Premium Payment Authorization

Complete this section to authorize premium payment.

1. **AUTOMATIC PAYROLL DEDUCTION** (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event payroll deduction is not available.)

2 "I certify that I am an active employee. As such, I authorize my employer to deduct from my pay the required premium for my and/or my spouse's [or domestic partner's] long term care coverage."

Name (First) (MI) (Last) (provide name exactly as it appears on your payroll check)

X _____
Signature of Employee Date Social Security Number

Print Name of Employer Name of Department

OR

2. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

3. **MONTHLY ELECTRONIC FUNDS TRANSFER. How Monthly Electronic Funds Transfer Works:** Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement

I authorize the Company to electronically withdraw money from my account **Checking** **Savings** at:

name of bank _____

bank address _____

telephone _____

for the payment of premiums and other charges on this coverage.

I authorize the Company to continue to make these withdrawals if there is a renewal, or other change in my

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect.

This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

X _____
Signature of Accountholder

Print Name (First) (MI) (Last)

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

D. Declarations

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of [any/voluntary] coverage under the Group Policy. I understand that any misstatements or failure to report information that is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify the Company of any change in my medical condition while my enrollment application is pending.

[I agree that if my application is approved by the Company, the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any applicable [Actively At Work/Active Service] requirements. I also understand and agree that no insurance will be in effect pursuant to this application, or under any group policy or certificate issued by the Company unless or until the Group Policy [and Certificate have been delivered and accepted / is in effect] and there has been no change in the health of the applicant that would change the answer to any of the questions in the application.] [I request to be insured under the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and, there has been no change in my health that would change the answer to any of the questions in this application; and, the Group Policy is in effect.]

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

X Signature Applicant: _____ Date: _____
Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

E. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

F. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First)			(MI)	(Last)		
Street Address						
City		State	ZIP code	Phone Number		

1 You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

G. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

1 Plan Package (Consult the enrollment materials for details of the coverage under each plan):

[Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following options:

2 I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Simple Annual Increases Rider]

Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]

Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]

2 [Nonforfeiture Benefit:

Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature Applicant: _____

Date: _____

2 [H. Premium Payment Authorization

Complete this section to authorize premium payment.

- 1. [] AUTOMATIC PAYROLL DEDUCTION (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event payroll deduction is not available.)

2 "I certify that I am an active employee. As such, I authorize my employer to deduct from my pay the required premium for my and/or my spouse's [or domestic partner's] long term care coverage."

Name (First) (MI) (Last) (provide name exactly as it appears on your payroll check)

X Signature of [Employee/Applicant] Date Social Security Number

Print Name of Employer Name of Department

OR

- 2. [] BILL ME DIRECTLY. Select one billing frequency [] Annually [] Semi-Annually [] Quarterly

OR

- 3. [] MONTHLY ELECTRONIC FUNDS TRANSFER. How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement
I authorize the Company to electronically withdraw money from my account [] Checking [] Savings at:
name of bank
bank address
telephone
for the payment of premiums and other charges on this coverage.

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect.
This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

X Signature of Accountholder

Print Name (First) (MI) (Last)

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]

Comprehensive Modified Guaranteed Issue Application [for Employees]

A. Eligible [Employee/Person] Information

Print clearly – Use black ink

 Name (First) (MI) (Last)

 Address

_____ State _____ ZIP code _____ / / _____
 City Date of Birth

_____ - _____ - _____ Male Female Married Single Widowed
 Social Security Number Sex Marital status

_____ - _____ - _____ _____ feet _____ inches _____ lbs.
 Work Phone Number Home Phone Number Height Weight

_____ a.m. _____ p.m. Home Work _____ / / _____
 Best time to call Date of Hire

 Name of [Eligible Employee's/Applicant's] Employer

3 **[[Actively At Work/Active Service] Certification:** I certify that I am [an actively at work employee][in Active Service]. I understand that coverage will not go into effect for me unless I am [Actively at Work/in Active Service] for the prior 30 calendar day period. [Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a [full-time basis at least 30 hours each week]. I will be considered Actively at Work while on employer approved vacations, holidays and regularly scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, a sabbatical or retired from the same employer.] [“Active Service” means I am able to engage in substantially all of the usual activities of a person in good health of like age and sex, and am not: (1) confined in a hospital or nursing, assisted living, or custodial care facility; or (2) receiving home health care services.]]

X

[Employee/Applicant's] Signature

Date

B. Spouse [or Domestic Partner] Information

Please complete the information below if your spouse [or domestic partner] is also applying.

 Name (First) (MI) (Last)

_____ - _____ - _____
 Social Security Number

C. Insurability Profile

Please answer "Yes" or "No" by checking the box.

1. Within the past 12 months, have you used or been advised by a Healthcare Professional to use any of the following: Yes No
- Assistance or supervision with moving in or out of a bed or chair, bathing, dressing, eating, toileting, bowel or bladder control, walking or managing medications;
 - Home Health Care, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
 - A Walker, Wheelchair, Quad Cane, Motorized Scooter, Hospital Bed, Oxygen or Kidney Dialysis?
2. Do you have or have you ever been diagnosed by a Healthcare Professional as having any of the following: Yes No
- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or positive HIV test• Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease)• Alzheimer's Disease• Dementia• Frequent or persistent forgetfulness or memory loss• Organic Brain Syndrome• Senility | <ul style="list-style-type: none">• Cancer of the following within the past 4 years: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas or Stomach• Metastatic Cancer (cancer that has spread from its original site)• Congestive Heart Failure (CHF)• Cirrhosis of the Liver• Cystic Fibrosis• Diabetes under treatment with insulin or with a history of Transient Ischemic Attack (TIA), Heart Disease, or Circulatory/Vascular Disease | <ul style="list-style-type: none">• Huntington's Chorea• Multiple Sclerosis (MS)• Muscular Dystrophy• Organ Transplant, other than Kidney or Cornea• Parkinson's Disease• Schizophrenia or other forms of Psychosis• Stroke• Transient Ischemic Attack (TIA) within past 5 years or more than one TIA |
|--|---|--|

In most cases, answering "Yes" to questions 1 or 2 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Declarations

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of [any/voluntary] coverage ³ under the Group Policy. I understand that any misstatements or failure to report information that is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify the Company of any change in my medical condition while my enrollment application is pending.

[I agree that if my application is approved by the Company, the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any applicable [Actively At Work/Active Service] requirements. ³ I also understand and agree that no insurance will be in effect pursuant to this application, or under any group policy or certificate issued by the Company unless or until the Group Policy [and Certificate have been delivered and accepted / is in effect] and there has been no change in the health of the applicant that would change the answer to any of the questions in the application.] [I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service] ³ requirements noted in Section A]; and there has been no change in my health that would change the answer to any of the questions in this application; and the Group Policy is in effect.]

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

X Signature Applicant: _____ Date: _____
Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

E. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

F. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First)	(MI)	(Last)
Street Address		
City	State	ZIP code
Phone Number		

1 You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

G. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

Plan Package (Consult the enrollment materials for details of the coverage under each plan):

[Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following options:

[I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

2 [I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

[Automatic Inflation Protection – 5% Simple Annual Increases Rider]

[Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

[Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]

[Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]

[Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]

[Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]

[Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]

2 [Nonforfeiture Benefit:

Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X **Signature** Applicant: _____

Date: _____

E. Medical History

If you need more space to explain any answer below, please attach another sheet of paper.

1. In the past 3 years, have you:

a. Received advice, treatment, diagnosis or consultation from a Healthcare Professional for any of the following?

- Alcoholism Yes No
- Diabetes not treated with insulin..... Yes No
- Drug Addiction Yes No
- Kidney Transplant..... Yes No
- Mental Retardation Yes No
- Peripheral Vascular Disease (PVD) in combination with any form of tobacco use Yes No
- Rheumatoid Arthritis Yes No

b. Taken any prescription medications (If Yes, please list)? Yes No

Medication	Dosage	Reason

c. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No
If Yes, please explain and include dates and reasons. _____

d. Consulted with or been treated for any reason by a Healthcare Professional OTHER THAN your Primary Care Physician, eye doctor, podiatrist, dentist or allergist? Yes No
If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

e. Had any symptoms or knowledge of any other health condition that is not disclosed above?..... Yes No
If Yes, please describe. _____

f. Required assistance with shopping, using transportation, housekeeping, cooking or managing medications? Yes No
If Yes, please explain type of assistance required and include dates and reasons. _____

g. Been advised by a Healthcare Professional to have surgery that has not been performed? Yes No
If Yes, please explain type of surgery, reason for surgery and scheduled surgery date. _____

h. Used any form of tobacco or nicotine product? Yes No
Date last used: _____ List type of tobacco or nicotine products used: _____

i. Had any Nursing Home or Long Term Care Insurance Application denied?..... Yes No
If Yes, by which company? _____

2. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

F. Your Authorization and Signature

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, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, consumer reporting agency or insurance support organization or other person or organization which has such information. [The Company and its reinsurers may also obtain such information from and share with the MIB.] 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 request a photocopy of it.

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy.

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

x Signature Applicant: _____ Date: _____
Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

G. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If so, which company's coverage will you be replacing? _____

4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

H. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First)

(MI)

(Last)

Street Address

City

State

ZIP code

Phone Number

You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

I. Coverage Selections

Please select your coverage options.

Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

Plan Package (Consult the enrollment materials for details of the coverage under each plan):

[Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following option:

I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Simple Annual Increases Rider]

Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]

Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]

[Nonforfeiture Benefit:

Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature

Applicant: _____

Date: _____

K. Notice To The Applicant

2 [MEDICAL INFORMATION BUREAU]

The insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
(617) 426-3660

The insurer, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

2 [Insurance Information Practices]

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write to us at:

Genworth Life Insurance Company
[ADDRESS LINE 1
ADDRESS LINE 2]]

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]

Long Form Application [for Employees]

This application is for: New Applicant Reinstatement Coverage Increase

A. Eligible [Employee/Person] Information

Print clearly – Use black ink

Name (First) (MI) (Last)

Address

City State ZIP code Date of Birth

Social Security Number Male Female Married Single Widowed
Sex Marital status

Work Phone Number Home Phone Number ___ a.m. ___ p.m. Home Work
Best time to call

Name of [Eligible Employee/Applicant]'s Employer

{[Actively At Work/Active Service] Certification: I certify that I am [an actively at work employee][in Active Service]. I understand that coverage will not go into effect for me unless I am [Actively at Work/in Active Service] for the prior 30 calendar day period. [Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a [full-time basis at least 30 hours each week]. I will be considered Actively at Work while on employer approved vacations, holidays and regularly scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, a sabbatical or retired from the same employer.] ["Active Service" means I am able to engage in substantially all of the usual activities of a person in good health of like age and sex, and am not: (1) confined in a hospital or nursing, assisted living, or custodial care facility; or (2) receiving home health care services.]}

X

[Employee/Applicant] Signature

Date

B. Spouse [or Domestic Partner] Information

Please complete the information below if your spouse [or domestic partner] is also applying.

Name (First) (MI) (Last)

Social Security Number

C. Insurability Profile

Please answer "Yes" or "No" by checking the box.

1. Within the past 12 months, have you used or been advised by a Healthcare Professional to use any of the following: Yes No
- Assistance or supervision with moving in or out of a bed or chair, bathing, dressing, eating, toileting, bowel or bladder control or walking;
 - Home Health Care, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
 - A Walker, Wheelchair, Quad Cane, Motorized Scooter, Hospital Bed, Oxygen or Kidney Dialysis?
2. Do you have or have you ever been diagnosed by a Healthcare Professional as having any of the following: Yes No
- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or positive HIV test • Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) • Alzheimer's Disease • Dementia • Frequent or persistent forgetfulness or memory loss • Organic Brain Syndrome • Senility | <ul style="list-style-type: none"> • Cancer of the following within the past 4 years: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas or Stomach • Metastatic Cancer (cancer that has spread from its original site) • Congestive Heart Failure (CHF) • Cirrhosis of the Liver • Cystic Fibrosis • Diabetes under treatment with insulin or with a history of Transient Ischemic Attack (TIA), Heart Disease, or Circulatory/Vascular Disease | <ul style="list-style-type: none"> • Huntington's Chorea • Multiple Sclerosis (MS) • Muscular Dystrophy • Organ Transplant, other than Kidney or Cornea • Parkinson's Disease • Schizophrenia or other forms of Psychosis • Stroke • Transient Ischemic Attack (TIA) within past 5 years or more than one TIA |
|--|--|---|

In most cases, answering "Yes" to questions 1 or 2 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (the physician with most of your medical records).

Physician's Name (First) _____ (Last) _____

Street Address _____

City _____

State _____

ZIP code _____

Phone Number _____ - _____ - _____

Have you seen this physician in the last two years? Yes No

Date of last visit: ____ / ____ / ____

Reason: _____

E. Medical History

If you need more space to explain any answer below, please attach another sheet of paper.

1. In the past 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a Healthcare Professional for any of the following conditions (check all that apply or NONE OF THE ABOVE)

- | | |
|---|---|
| <input type="checkbox"/> 1. Alcoholism | <input type="checkbox"/> 21. Multiple Myeloma |
| <input type="checkbox"/> 2. Drug Addiction | <input type="checkbox"/> 22. CREST Syndrome |
| <input type="checkbox"/> 3. Amputation | <input type="checkbox"/> 23. Scleroderma |
| <input type="checkbox"/> 4. Angioplasty or Heart Surgery | <input type="checkbox"/> 24. Lupus |
| <input type="checkbox"/> 5. Carotid or other Arterial Surgery | <input type="checkbox"/> 25. Depression |
| <input type="checkbox"/> 6. Congestive Heart Failure | <input type="checkbox"/> 26. Mental Illness |
| <input type="checkbox"/> 7. Heart Attack, Angina, or Atrial Fibrillation | <input type="checkbox"/> 27. Mental Retardation |
| <input type="checkbox"/> 8. Peripheral Vascular Disease (PVD) in Combination with any form of Tobacco Use | <input type="checkbox"/> 28. Diabetes not treated with Insulin |
| <input type="checkbox"/> 9. Asthma or Chronic Bronchitis | <input type="checkbox"/> 29. Disabling Back or Spine Condition |
| <input type="checkbox"/> 10. Emphysema/Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> 30. Fibromyalgia |
| <input type="checkbox"/> 11. Brain Disorder | <input type="checkbox"/> 31. Injury due to Falls or Imbalance |
| <input type="checkbox"/> 12. Epilepsy, Seizures or Convulsions | <input type="checkbox"/> 32. Joint Replacement Surgery |
| <input type="checkbox"/> 13. Fainting Spells or Blacking Out | <input type="checkbox"/> 33. Osteoporosis |
| <input type="checkbox"/> 14. Tremor | <input type="checkbox"/> 34. Rheumatoid Arthritis |
| <input type="checkbox"/> 15. Myasthenia Gravis | <input type="checkbox"/> 35. Immune System Disorder |
| <input type="checkbox"/> 16. Post-Polio Syndrome | <input type="checkbox"/> 36. Kidney Failure |
| <input type="checkbox"/> 17. Paralysis | <input type="checkbox"/> 37. Kidney Transplant |
| <input type="checkbox"/> 18. Cancer (excluding Basal Cell of the Skin) | <input type="checkbox"/> 38. Skin Ulcers |
| <input type="checkbox"/> 19. Hodgkin's Disease | <input type="checkbox"/> 39. Other Conditions Causing Crippling or Limited Motion or Requiring Adaptive Devices |
| <input type="checkbox"/> 20. Leukemia | <input type="checkbox"/> NONE OF THE ABOVE |

Please give details below to all boxes checked in Question #1.

Condition Number	Dates From/To	Physician's Name / Address / Phone	Describe

2. In the past 3 years, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If Yes, please describe. _____

E. Medical History (Continued)

If you need more space to explain any answer below, please attach another sheet of paper.

3. In the past 3 years, have you:

- a. Taken any prescription medications (If Yes, please list)? Yes No

Medication	Dosage	Reason

- b. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If Yes, please explain and include dates and reasons. _____

- c. Consulted with or been treated for any reason by a Healthcare Professional OTHER THAN your Primary Care Physician, eye doctor, podiatrist, dentist or allergist? Yes No

If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

- d. Required assistance with shopping, using transportation, housekeeping, cooking or managing medications? Yes No

If Yes, please explain type of assistance required and include dates and reasons. _____

- e. Been advised by a Healthcare Professional to have surgery that has not been performed? Yes No

If Yes, please explain type of surgery, reason for surgery and scheduled surgery date. _____

- f. Received disability income, workers' compensation or any state or Social Security Disability Benefits? Yes No

If Yes, please explain type and cause: _____

- g. Used any form of tobacco or nicotine product? Yes No

Date last used:	List type of tobacco or nicotine products used:

- h. Had any Nursing Home or Long Term Care Insurance Application denied? Yes No

If Yes, by which company? _____

4. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

F. Family History Profile

1. Is your mother living?..... Yes No Unknown
a. What is your mother's current age or age at death? _____
b. Did/Does your mother have any of the following illnesses:
• Diabetes Yes No Unknown
• Coronary Artery Disease or any other form of Vascular Disease Yes No Unknown
• Alzheimer's or any other form of Dementia Yes No Unknown
2. Is your father living?..... Yes No Unknown
a. What is your father's current age or age at death? _____
b. Did/Does your father have any of the following illnesses:
• Diabetes Yes No Unknown
• Coronary Artery Disease or any other form of Vascular Disease Yes No Unknown
• Alzheimer's or any other form of Dementia Yes No Unknown

G. Applicant Profile

1. Do you perform volunteer work? Yes No
If Yes, please list type of work and list hours worked per week. _____

2. Do you have any hobbies, interests, or participate in any exercise program on a regular basis? Yes No
If Yes, please describe [in your own handwriting]. _____

3. Do you drive an automobile? Yes No
If Yes, please provide approximate annual mileage: _____ miles
4. With whom do you live? Alone Spouse Family Other
5. Do you live in some form of a residential retirement community?..... Yes No
If Yes, please list the specific services that you are receiving (e.g., housekeeping, laundry, meals). _____

H. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?..... Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months?..... Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

I. Your Authorization and Signature

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, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, consumer reporting agency or insurance support organization or other person or organization which has such information. [The Company and its reinsurers may also obtain such information from and share with the MIB.] 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 request a photocopy of it.

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

X Signature Applicant: _____ Date: _____
Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

J. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First)			(MI)	(Last)		
Street Address				-		
City	State	ZIP code	Phone Number			

³[any/voluntary] coverage under the Group Policy. I understand that any misstatements or failure to report information that is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify the Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by the Company, the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any applicable [Actively At Work/Active Service] requirements. [I also understand and agree that no insurance will be in effect pursuant to this application, or under any group policy or certificate issued by the Company unless or until the Group Policy [and Certificate have been delivered and accepted /is in effect] and there has been no change in the health of the applicant that would change the answer to any of the questions in the application.]
³ [I request to be insured under the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and, there has been no change in my health that would change the answer to any of the questions in this application; and, the Group Policy is in effect.]

² I have received a copy of the Notice to The Applicant regarding [the MIB;] Insurance Information Practices; and Telephone Interview Information.

2

1

You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

K. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

Plan Package (Consult the enrollment materials for details of the coverage under each plan):

1 [Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following option:

I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

2 I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Simple Annual Increases Rider]

Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]

Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]

[Nonforfeiture Benefit:

2 Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X **Signature** Applicant: _____

Date: _____

2 [L. Premium Payment Authorization

Complete this section to authorize premium payment.

1. **AUTOMATIC PAYROLL DEDUCTION** (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event payroll deduction is not available.)

2 "I certify that I am an active employee. As such, I authorize my employer to deduct from my pay the required premium for my and/or my spouse's [or domestic partner's] long term care coverage."

Name (First) (MI) (Last) (provide name exactly as it appears on your payroll check)

X Signature of Employee Date Social Security Number Print Name of Employer Name of Department

OR

2. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

3. **MONTHLY ELECTRONIC FUNDS TRANSFER. How Monthly Electronic Funds Transfer Works:** Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement I authorize the Company to electronically withdraw money from my account Checking Savings at: name of bank bank address telephone for the payment of premiums and other charges on this coverage.

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect. This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

X Signature of Accountholder Print Name (First) (MI) (Last)

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

M. Notice To The Applicant

2 [MEDICAL INFORMATION BUREAU

The insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

1 Medical Information Bureau
[P.O. Box 105, Essex Station
Boston, Massachusetts 02111
(617) 426-3660]

The insurer, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

3 Insurance Information Practices

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write to us at:

1 Genworth Life Insurance Company
[ADDRESS LINE 1
ADDRESS LINE 2]

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]

1 Long Form Application [for Spouses or Domestic Partners of Employees]

This application is for: New Applicant Reinstatement Coverage Increase

A. Applicant Information

Print clearly – Use black ink

Name (First)

(MI)

(Last)

Address

City

State

ZIP code

Date of Birth

Social Security Number

Male Female
Sex

Married Single Widowed
Marital status

Work Phone Number

Home Phone Number

___ a.m. ___ p.m. Home Work
Best time to call

Eligibility Certification

2 "I certify that I am an eligible [spouse domestic partner surviving spouse of an eligible employee.]" 1

X

Applicant Signature

Date

Please check the appropriate box below regarding the eligible [employee's] coverage:

- 1 Eligible [employee] is also applying for coverage. (Please submit your applications together)
 Eligible [employee] is not applying for coverage at this time.

B. Eligible[Employee/Person] Information

Name (First)

(MI)

(Last)

Address (If different)

City

State

ZIP code

Date of Birth

[Employee/Member] Social Security Number

Male Female
Sex

Work Phone Number

Home Phone Number

[Employee Date of Hire]

Name of Eligible [Employee/Member]'s [Employer/Organization]

C. Insurability Profile

Please answer "Yes" or "No" by checking the box.

1. Within the past 12 months, have you used or been advised by a Healthcare Professional to use any of the following: Yes No
- Assistance or supervision with moving in or out of a bed or chair, bathing, dressing, eating, toileting, bowel or bladder control or walking;
 - Home Health Care, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
 - A Walker, Wheelchair, Quad Cane, Motorized Scooter, Hospital Bed, Oxygen or Kidney Dialysis?
2. Do you have or have you ever been diagnosed by a Healthcare Professional as having any of the following: Yes No
- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or positive HIV test • Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) • Alzheimer's Disease • Dementia • Frequent or persistent forgetfulness or memory loss • Organic Brain Syndrome • Senility | <ul style="list-style-type: none"> • Cancer of the following within the past 4 years: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas or Stomach • Metastatic Cancer (cancer that has spread from its original site) • Congestive Heart Failure (CHF) • Cirrhosis of the Liver • Cystic Fibrosis • Diabetes under treatment with insulin or with a history of Transient Ischemic Attack (TIA), Heart Disease, or Circulatory/Vascular Disease | <ul style="list-style-type: none"> • Huntington's Chorea • Multiple Sclerosis (MS) • Muscular Dystrophy • Organ Transplant, other than Kidney or Cornea • Parkinson's Disease • Schizophrenia or other forms of Psychosis • Stroke • Transient Ischemic Attack (TIA) within past 5 years or more than one TIA |
|--|--|---|

In most cases, answering "Yes" to questions 1 or 2 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (the physician with most of your medical records).

Physician's Name (First) _____ (Last) _____

Street Address _____

City _____

State _____

ZIP code _____

Phone Number _____ - _____ - _____

Have you seen this physician in the last two years? Yes No

Date of last visit: ____ / ____ / ____

Reason: _____

E. Medical History

If you need more space to explain any answer below, please attach another sheet of paper.

1. In the past 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a Healthcare Professional for any of the following conditions (check all that apply or NONE OF THE ABOVE)

- | | |
|---|---|
| <input type="checkbox"/> 1. Alcoholism | <input type="checkbox"/> 21. Multiple Myeloma |
| <input type="checkbox"/> 2. Drug Addiction | <input type="checkbox"/> 22. CREST Syndrome |
| <input type="checkbox"/> 3. Amputation | <input type="checkbox"/> 23. Scleroderma |
| <input type="checkbox"/> 4. Angioplasty or Heart Surgery | <input type="checkbox"/> 24. Lupus |
| <input type="checkbox"/> 5. Carotid or other Arterial Surgery | <input type="checkbox"/> 25. Depression |
| <input type="checkbox"/> 6. Congestive Heart Failure | <input type="checkbox"/> 26. Mental Illness |
| <input type="checkbox"/> 7. Heart Attack, Angina, or Atrial Fibrillation | <input type="checkbox"/> 27. Mental Retardation |
| <input type="checkbox"/> 8. Peripheral Vascular Disease (PVD) in Combination with any form of Tobacco Use | <input type="checkbox"/> 28. Diabetes not treated with Insulin |
| <input type="checkbox"/> 9. Asthma or Chronic Bronchitis | <input type="checkbox"/> 29. Disabling Back or Spine Condition |
| <input type="checkbox"/> 10. Emphysema/Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> 30. Fibromyalgia |
| <input type="checkbox"/> 11. Brain Disorder | <input type="checkbox"/> 31. Injury due to Falls or Imbalance |
| <input type="checkbox"/> 12. Epilepsy, Seizures or Convulsions | <input type="checkbox"/> 32. Joint Replacement Surgery |
| <input type="checkbox"/> 13. Fainting Spells or Blacking Out | <input type="checkbox"/> 33. Osteoporosis |
| <input type="checkbox"/> 14. Tremor | <input type="checkbox"/> 34. Rheumatoid Arthritis |
| <input type="checkbox"/> 15. Myasthenia Gravis | <input type="checkbox"/> 35. Immune System Disorder |
| <input type="checkbox"/> 16. Post-Polio Syndrome | <input type="checkbox"/> 36. Kidney Failure |
| <input type="checkbox"/> 17. Paralysis | <input type="checkbox"/> 37. Kidney Transplant |
| <input type="checkbox"/> 18. Cancer (excluding Basal Cell of the Skin) | <input type="checkbox"/> 38. Skin Ulcers |
| <input type="checkbox"/> 19. Hodgkin's Disease | <input type="checkbox"/> 39. Other Conditions Causing Crippling or Limited Motion or Requiring Adaptive Devices |
| <input type="checkbox"/> 20. Leukemia | <input type="checkbox"/> NONE OF THE ABOVE |

Please give details below to all boxes checked in Question #1.

Condition Number	Dates From/To	Physician's Name / Address / Phone	Describe

2. In the past 3 years, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If Yes, please describe. _____

E. Medical History (Continued)

If you need more space to explain any answer below, please attach another sheet of paper.

3. In the past 3 years, have you:

- a. Taken any prescription medications (If Yes, please list)? Yes No

Medication	Dosage	Reason

- b. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If Yes, please explain and include dates and reasons. _____

- c. Consulted with or been treated for any reason by a Healthcare Professional OTHER THAN your Primary Care Physician, eye doctor, podiatrist, dentist or allergist? Yes No

If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

- d. Required assistance with shopping, using transportation, housekeeping, cooking or managing medications? Yes No

If Yes, please explain type of assistance required and include dates and reasons. _____

- e. Been advised by a Healthcare Professional to have surgery that has not been performed? Yes No

If Yes, please explain type of surgery, reason for surgery and scheduled surgery date. _____

- f. Received disability income, workers' compensation or any state or Social Security Disability Benefits? Yes No

If Yes, please explain type and cause: _____

- g. Used any form of tobacco or nicotine product? Yes No

Date last used:

List type of tobacco or nicotine products used:

- h. Had any Nursing Home or Long Term Care Insurance Application denied? Yes No

If Yes, by which company? _____

4. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

F. Family History Profile

1. Is your mother living?..... Yes No Unknown
a. What is your mother's current age or age at death? _____
b. Did/Does your mother have any of the following illnesses:
• Diabetes Yes No Unknown
• Coronary Artery Disease or any other form of Vascular Disease Yes No Unknown
• Alzheimer's or any other form of Dementia Yes No Unknown
2. Is your father living?..... Yes No Unknown
a. What is your father's current age or age at death? _____
b. Did/Does your father have any of the following illnesses:
• Diabetes Yes No Unknown
• Coronary Artery Disease or any other form of Vascular Disease Yes No Unknown
• Alzheimer's or any other form of Dementia Yes No Unknown

G. Applicant Profile

1. Do you work 20 or more hours a week outside your home? Yes No
If Yes, please list your occupation. _____
2. Do you perform volunteer work? Yes No
If Yes, please list type of work and list hours worked per week. _____
3. Do you have any hobbies, interests, or participate in any exercise program on a regular basis? Yes No
If Yes, please describe [in your own handwriting]. _____
4. Do you drive an automobile? Yes No
If Yes, please provide approximate annual mileage: _____ miles
5. With whom do you live? Alone Spouse Family Other
6. Do you live in some form of a residential retirement community? Yes No
If Yes, please list the specific services that you are receiving (e.g., housekeeping, laundry, meals). _____

H. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

K. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

Plan Package (Consult the enrollment materials for details of the coverage under each plan):

1 [Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]
[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]
[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following option:

- 2 I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]
- I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]
- Automatic Inflation Protection – 5% Simple Annual Increases Rider]
- Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]
- Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]
- Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]
- Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]
- Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]
- Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]]

2 [Nonforfeiture Benefit:

Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature Applicant: _____

Date: _____

2 [L. Premium Payment Authorization

Complete this section to authorize premium payment.

1. **AUTOMATIC PAYROLL DEDUCTION** (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event payroll deduction is not available.)

2 The eligible employee must complete this section: "I certify that I am an active employee. As such, I authorize my employer to deduct from my pay the required premium for my spouse's [or domestic partner's] long term care coverage."

Name (First) [grid] (MI) [grid] (Last) (provide name exactly as it appears on your payroll check) [grid]

X Signature of Employee _____ Date _____ Social Security Number [grid]

Print Name of Employer [grid] Name of Department [grid]

OR

2. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

3. **MONTHLY ELECTRONIC FUNDS TRANSFER.** How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement
I authorize the Company to electronically withdraw money from my account **Checking** **Savings** at:
name of bank _____
bank address _____

telephone _____
for the payment of premiums and other charges on this coverage.

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect.
This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

I authorize the Company to continue to make these withdrawals if there is a renewal, or other change in my

X Signature of Accountholder _____
Print Name (First) [grid] (MI) [grid] (Last) [grid]

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

M. Notice To The Applicant

2

[MEDICAL INFORMATION BUREAU

The insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau

1

[P.O. Box 105, Essex Station]

[Boston, Massachusetts 02111]

[(617) 426-3660]

The insurer, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

3 Insurance Information Practices

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write to us at:

Genworth Life Insurance Company

1

[ADDRESS LINE 1

ADDRESS LINE 2]

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]

Long Form Application [for Members, Retirees, Retirees' Spouses, Retirees' Domestic Partners, Parents, Grandparents]

This application is for: New Applicant Reinstatement Coverage Increase

A. Applicant Information

Print clearly – Use black ink

Name (First) (MI) (Last)

Address

City State ZIP code Date of Birth

Social Security Number Sex Male Female Marital status Married Single Widowed

Work Phone Number Home Phone Number Best time to call ___ a.m. ___ p.m. Home Work

I am applying as (check the appropriate box):

- [Retiree/ Member]
- Spouse of a [Retiree/ Member]
- Parent (including in-laws) of a[n Employee or Retiree/ Member]
- Grandparent (including in-laws) of a[n Employee or Retiree/ Member]
- Surviving Spouse of a [Retiree/ Member]
- Domestic Partner of a [Retiree/ Member]

Eligibility Certification: "I certify that I am an eligible [member, retiree, or the spouse, domestic partner, surviving spouse, parent, grandparent or parent/grandparent-in-law of an eligible individual OR the parent, grandparent or parent/grandparent-in-law of an eligible employee.]."

X _____
Applicant Signature

Date

B. Eligible [Employee or Retiree/ Member] Information

Name (First) (MI) (Last)

Address (If different)

City State ZIP code Date of Birth

Social Security Number Sex Male Female

Work Phone Number Home Phone Number Date of Hire

Name of Eligible [Employer/Association]

C. Insurability Profile

Please answer "Yes" or "No" by checking the box.

1. Within the past 12 months, have you used or been advised by a Healthcare Professional to use any of the following: Yes No
- Assistance or supervision with moving in or out of a bed or chair, bathing, dressing, eating, toileting, bowel or bladder control or walking;
 - Home Health Care, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
 - A Walker, Wheelchair, Quad Cane, Motorized Scooter, Hospital Bed, Oxygen or Kidney Dialysis?
2. Do you have or have you ever been diagnosed by a Healthcare Professional as having any of the following: Yes No
- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or positive HIV test • Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) • Alzheimer's Disease • Dementia • Frequent or persistent forgetfulness or memory loss • Organic Brain Syndrome • Senility | <ul style="list-style-type: none"> • Cancer of the following within the past 4 years: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas or Stomach • Metastatic Cancer (cancer that has spread from its original site) • Congestive Heart Failure (CHF) • Cirrhosis of the Liver • Cystic Fibrosis • Diabetes under treatment with insulin or with a history of Transient Ischemic Attack (TIA), Heart Disease, or Circulatory/Vascular Disease | <ul style="list-style-type: none"> • Huntington's Chorea • Multiple Sclerosis (MS) • Muscular Dystrophy • Organ Transplant, other than Kidney or Cornea • Parkinson's Disease • Schizophrenia or other forms of Psychosis • Stroke • Transient Ischemic Attack (TIA) within past 5 years or more than one TIA |
|--|--|---|

In most cases, answering "Yes" to questions 1 or 2 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (the physician with most of your medical records).

Physician's Name (First) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____ - _____ - _____

Have you seen this physician in the last two years? Yes No

Date of last visit: ____ / ____ / ____ Reason: _____

E. Medical History

If you need more space to explain any answer below, please attach another sheet of paper.

1. In the past 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a Healthcare Professional for any of the following conditions (check all that apply or NONE OF THE ABOVE.)

- | | |
|--|--|
| <input type="checkbox"/> 1. Alcoholism | <input type="checkbox"/> 21. Multiple Myeloma |
| <input type="checkbox"/> 2. Drug Addiction | <input type="checkbox"/> 22. CREST Syndrome |
| <input type="checkbox"/> 3. Amputation | <input type="checkbox"/> 23. Scleroderma |
| <input type="checkbox"/> 4. Angioplasty or Heart Surgery | <input type="checkbox"/> 24. Lupus |
| <input type="checkbox"/> 5. Carotid or other Arterial Surgery | <input type="checkbox"/> 25. Depression |
| <input type="checkbox"/> 6. Congestive Heart Failure | <input type="checkbox"/> 26. Mental Illness |
| <input type="checkbox"/> 7. Heart Attack, Angina, or Atrial Fibrillation | <input type="checkbox"/> 27. Mental Retardation |
| <input type="checkbox"/> 8. Peripheral Vascular Disease (PVD) in
Combination with any form of Tobacco Use | <input type="checkbox"/> 28. Diabetes not treated with Insulin |
| <input type="checkbox"/> 9. Asthma or Chronic Bronchitis | <input type="checkbox"/> 29. Disabling Back or Spine Condition |
| <input type="checkbox"/> 10. Emphysema/Chronic Obstructive Pulmonary
Disease (COPD) | <input type="checkbox"/> 30. Fibromyalgia |
| <input type="checkbox"/> 11. Brain Disorder | <input type="checkbox"/> 31. Injury due to Falls or Imbalance |
| <input type="checkbox"/> 12. Epilepsy, Seizures or Convulsions | <input type="checkbox"/> 32. Joint Replacement Surgery |
| <input type="checkbox"/> 13. Fainting Spells or Blacking Out | <input type="checkbox"/> 33. Osteoporosis |
| <input type="checkbox"/> 14. Tremor | <input type="checkbox"/> 34. Rheumatoid Arthritis |
| <input type="checkbox"/> 15. Myasthenia Gravis | <input type="checkbox"/> 35. Immune System Disorder |
| <input type="checkbox"/> 16. Post-Polio Syndrome | <input type="checkbox"/> 36. Kidney Failure |
| <input type="checkbox"/> 17. Paralysis | <input type="checkbox"/> 37. Kidney Transplant |
| <input type="checkbox"/> 18. Cancer (excluding Basal Cell of the Skin) | <input type="checkbox"/> 38. Skin Ulcers |
| <input type="checkbox"/> 19. Hodgkin's Disease | <input type="checkbox"/> 39. Other Conditions Causing Crippling or Limited
Motion or Requiring Adaptive Devices |
| <input type="checkbox"/> 20. Leukemia | <input type="checkbox"/> NONE OF THE ABOVE |

Please give details below to all boxes checked in Question #1.

Condition

Number	Dates From/To	Physician's Name / Address / Phone	Describe

2. In the past 3 years, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If Yes, please describe. _____

E. Medical History (Continued)

If you need more space to explain any answer below, please attach another sheet of paper.

3. In the past 3 years, have you:

- a. Taken any prescription medications (If Yes, please list)? Yes No

Medication	Dosage	Reason

- b. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No
If Yes, please explain and include dates and reasons. _____

- c. Consulted with or been treated for any reason by a Healthcare Professional OTHER THAN your Primary Care Physician, eye doctor, podiatrist, dentist or allergist? Yes No
If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

- d. Required assistance with shopping, using transportation, housekeeping, cooking or managing medications? Yes No
If Yes, please explain type of assistance required and include dates and reasons. _____

- e. Been advised by a Healthcare Professional to have surgery that has not been performed? Yes No
If Yes, please explain type of surgery, reason for surgery and scheduled surgery date. _____

- f. Received disability income, workers' compensation or any state or Social Security Disability Benefits? Yes No
If Yes, please explain type and cause: _____

- g. Used any form of tobacco or nicotine product? Yes No

Date last used:	List type of tobacco or nicotine products used:

- h. Had any Nursing Home or Long Term Care Insurance Application denied? Yes No
If Yes, by which company? _____

4. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

F. Family History Profile

1. Is your mother living?..... Yes No Unknown
a. What is your mother's current age or age at death? _____
b. Did/Does your mother have any of the following illnesses:
• Diabetes Yes No Unknown
• Coronary Artery Disease or any other form of Vascular Disease Yes No Unknown
• Alzheimer's or any other form of Dementia Yes No Unknown
2. Is your father living?..... Yes No Unknown
a. What is your father's current age or age at death? _____
b. Did/Does your father have any of the following illnesses:
• Diabetes Yes No Unknown
• Coronary Artery Disease or any other form of Vascular Disease Yes No Unknown
• Alzheimer's or any other form of Dementia Yes No Unknown

G. Applicant Profile

1. Do you work 20 or more hours a week outside your home? Yes No
If Yes, please list your occupation. _____
2. Do you perform volunteer work? Yes No
If Yes, please list type of work and list hours worked per week. _____
3. Do you have any hobbies, interests, or participate in any exercise program on a regular basis? Yes No
If Yes, please describe [in your own handwriting]. _____
4. Do you drive an automobile? Yes No
If Yes, please provide approximate annual mileage: _____ miles
5. With whom do you live? Alone Spouse Family Other
6. Do you live in some form of a residential retirement community?..... Yes No
If Yes, please list the specific services that you are receiving (e.g., housekeeping, laundry, meals). _____

H. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?..... Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months?..... Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

K. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

Plan Package (Consult the enrollment materials for details of the coverage under each plan):

1 [Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]
[Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]
[Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following option:

I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

2 Automatic Inflation Protection – 5% Simple Annual Increases Rider]

Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]

Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]

Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]

Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]]

2 [Nonforfeiture Benefit:

Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature Applicant: _____

Date: _____

2 [L. Premium Payment Authorization

Complete this section to authorize premium payment.

1. **AUTOMATIC PENSION DEDUCTION.** (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event pension deduction is not available.)

2 This payment option is available only to Eligible Retirees and Spouses [or Domestic Partners] of Retirees receiving pension benefits through the retirement plan of the group Policyholder. If you select this option, your premiums will be deducted from your pension benefits.

2 **The eligible retiree must complete this section:** "I certify that I am an Eligible Retiree. As such, I authorize the group Policyholder to deduct from my pension benefits the required premium for my and/or my spouse's [or domestic partner's] long term care coverage."

Name (First) (MI) (Last)

X Signature of Eligible Member Date Social Security Number

1 (retiree or annuitant currently receiving pension benefits)

Name of Retirement System

OR

2. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

3 **MONTHLY ELECTRONIC FUNDS TRANSFER. How Monthly Electronic Funds Transfer Works:** Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement

I authorize the Company to electronically withdraw money from my account **Checking** **Savings** at:

name of bank _____

bank address _____

telephone _____

for the payment of premiums and other charges on this coverage.

I authorize the Company to continue to make these withdrawals if there is a renewal, or other change in my

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect.

This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

X Signature of Accountholder

Print Name (First) (MI) (Last)

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

M. Notice To The Applicant

2 [MEDICAL INFORMATION BUREAU]

The insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
1 [P.O. Box 105, Essex Station]
[Boston, Massachusetts 02111]
[(617) 426-3660]

The insurer, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

3 Insurance Information Practices

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write to us at:

Genworth Life Insurance Company
1 [ADDRESS LINE 1
ADDRESS LINE 2]

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

Genworth Life Insurance Company

[Administrative Office: P. O. Box 947500, Maitland FL 32794-7500 800-416-3624 Tel.]

Short Form Application [for Spouses or Domestic Partners of Employees]

A. Applicant Information

Print clearly – Use black ink

Name (First) (MI) (Last)

Address

City State ZIP code Date of Birth

Social Security Number Sex Male Female Marital status Married Single Widowed

Work Phone Number Home Phone Number Best time to call a.m. p.m. Home Work

Eligibility Certification

[Actively At Work/Active Service] Certification: I certify that I am [an actively at work employee][in Active Service]. I understand that coverage will not go into effect for me unless I am [Actively at Work/in Active Service] for the prior 30 calendar day period. [Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a [full-time basis at least 30 hours each week]. I will be considered Actively at Work while on employer approved vacations, holidays and regularly scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, a sabbatical or retired from the same employer.] [“Active Service” means I am able to engage in substantially all of the usual activities of a person in good health of like age and sex, and am not: (1) confined in a hospital or nursing, assisted living, or custodial care facility; or (2) receiving home health care services.]

I also certify that I am an eligible spouse domestic partner surviving spouse of an eligible employee.]

X

Applicant Signature

Date

Please check the appropriate box below regarding the eligible [employee/member/person's] coverage:

- Eligible [employee/member/person's] is also applying for coverage. Please submit your applications together.
- Eligible [employee/member/person's] is not applying for coverage at this time.

B. Eligible [Employee/Member/Person] Information

Name (First) (MI) (Last)

Address (If different)

City State ZIP code Date of Birth

Employee Social Security Number Sex Male Female

Work Phone Number Home Phone Number [Employee Date of Hire]

Name of Eligible [Employee/Member/Person's] [Employer/Association]

E. Medical History

If you need more space to explain any answer below, please attach another sheet of paper.

1. In the past 3 years, have you:

a. Received advice, treatment, diagnosis or consultation from a Healthcare Professional for any of the following?

- Alcoholism Yes No
- Diabetes not treated with insulin Yes No
- Drug Addiction Yes No
- Kidney Transplant Yes No
- Mental Retardation Yes No
- Peripheral Vascular Disease (PVD) in combination with any form of tobacco use Yes No
- Rheumatoid Arthritis Yes No

b. Taken any prescription medications (If Yes, please list)? Yes No

Medication	Dosage	Reason

c. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No
If Yes, please explain and include dates and reasons. _____

d. Consulted with or been treated for any reason by a Healthcare Professional OTHER THAN your Primary Care Physician, eye doctor, podiatrist, dentist or allergist? Yes No
If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

e. Had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No
If Yes, please describe. _____

f. Required assistance with shopping, using transportation, housekeeping, cooking or managing medications? Yes No
If Yes, please explain type of assistance required and include dates and reasons. _____

g. Been advised by a Healthcare Professional to have surgery that has not been performed? Yes No
If Yes, please explain type of surgery, reason for surgery and scheduled surgery date. _____

h. Used any form of tobacco or nicotine product? Yes No
Date last used: _____ List type of tobacco or nicotine products used: _____

i. Had any Nursing Home or Long Term Care Insurance Application denied? Yes No
If Yes, by which company? _____

2. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

F. Your Authorization and Signature

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, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, consumer reporting agency or insurance support organization or other person or organization which has such information. [The Company and its reinsurers may also obtain such information from and share with the MIB.] 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 request a photocopy of it.

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of

[any/voluntary] coverage under the Group Policy. I understand that any misstatements or failure to report information that is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify the Company of any change in my medical condition while my enrollment application is pending. [I agree that if my application is approved by the Company, the effective date of [any/voluntary] coverage will be determined in accordance with the terms of the Group Policy, including any applicable [Actively At Work/Active Service] requirements. I also understand and agree that no insurance will be in effect pursuant to this application, or under any group policy or certificate issued by the Company unless or until the Group Policy [and Certificate have been delivered and accepted / is in effect] and there has been no change in the health of the applicant that would change the answer to any of the questions in the application.][I request to be insured under the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and, there has been no change in my health that would change the answer to any of the questions in this application; and, the Group Policy is in effect.]

I have received a copy of the Notice to The Applicant regarding [the MIB;] Insurance Information Practices; and Telephone Interview Information.

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

X Signature Applicant: _____ Date: _____

Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

G. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No

If Yes, provide details. Company Name: _____

Individual or Group Policy Number: _____ Type of Coverage: _____

2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No

If so, with which company? _____ If that policy lapsed, when did it lapse? _____

3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
 If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

H. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First)										(MI)		(Last)												
Street Address																								
City										State		ZIP code					Phone Number							

1 You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

I. Coverage Selections

Please select your coverage options.

1 Facility Care Maximum (FCM): \$100 \$200 \$300 [per day]

2 Plan Package (Consult the enrollment materials for details of the coverage under each plan):
 [Plan A 1095 x FCM, 1825 x FCM, 3650 x FCM]
 [Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM]
 [Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM]

[Inflation Protection/Future Purchase Options:
 I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following option:

- 2 I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]
- I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]
 - Automatic Inflation Protection – 5% Simple Annual Increases Rider]
 - Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]
 - Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]
 - Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]
 - Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]
 - Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]
 - Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]]

2 [Nonforfeiture Benefit:
 Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature Applicant: _____ Date: _____

2 [J. Premium Payment Authorization

Complete this section to authorize premium payment.

- 1. **AUTOMATIC PAYROLL DEDUCTION** (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event payroll deduction is not available.)

2 [The eligible employee must complete this section: "I certify that I am an active employee. As such, I authorize my employer to deduct from my pay the required premium for my spouse's [or domestic partner's] long term care coverage."

Name (First) (MI) (Last) (provide name exactly as it appears on your payroll check)

X

Signature of Employee Date Social Security Number Print Name of Employer Name of Department

OR

- 2. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

- 3. **MONTHLY ELECTRONIC FUNDS TRANSFER.** How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement

I authorize the Company to electronically withdraw money from my account **Checking** **Savings** at:

name of bank _____

bank address _____

telephone _____

for the payment of premiums and other charges on this coverage.

I authorize the Company to continue to make these withdrawals if there is a renewal, or other change in my

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect.

This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

X

Signature of Accountholder Print Name (First) (MI) (Last)

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

K. Notice To The Applicant

2 [MEDICAL INFORMATION BUREAU]

The insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
[P.O. Box 105, Essex Station]
[Boston, Massachusetts 02111]
[(617) 426-3660]

The insurer, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

3 [Insurance Information Practices]

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write to us at:

Genworth Life Insurance Company
[ADDRESS LINE 1
ADDRESS LINE 2]]

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

C. Insurability Profile

Please answer "Yes" or "No" by checking the box.

1. Within the past 12 months, have you used or been advised by a Healthcare Professional to use any of the following: Yes No
- Assistance or supervision with moving in or out of a bed or chair, bathing, dressing, eating, toileting, bowel or bladder control or walking;
 - Home Health Care, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
 - A Walker, Wheelchair, Quad Cane, Motorized Scooter, Hospital Bed, Oxygen or Kidney Dialysis?

In most cases, answering "Yes" to Question 1 above will disqualify you from having either the Core Plan or the Buy Up Option. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

2. Do you have or have you ever been diagnosed by a Healthcare Professional as having any of the following: Yes No
- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), or positive HIV test• Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease)• Alzheimer's Disease• Dementia• Frequent or persistent forgetfulness or memory loss• Organic Brain Syndrome• Senility | <ul style="list-style-type: none">• Cancer of the following within the past 4 years: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas or Stomach• Metastatic Cancer (cancer that has spread from its original site)• Congestive Heart Failure (CHF)• Cirrhosis of the Liver• Cystic Fibrosis• Diabetes under treatment with insulin or with a history of Transient Ischemic Attack (TIA), Heart Disease, or Circulatory/Vascular Disease | <ul style="list-style-type: none">• Huntington's Chorea• Multiple Sclerosis (MS)• Muscular Dystrophy• Organ Transplant, other than Kidney or Cornea• Parkinson's Disease• Schizophrenia or other forms of Psychosis• Stroke• Transient Ischemic Attack (TIA) within past 5 years or more than one TIA |
|--|---|--|

Answering "Yes" to Question 2 above will disqualify you from having the Buy Up Option. However, if you have satisfied the requirements of Section A and answered NO to Question 1 above, you are eligible for the base amount of coverage (the Core Plan) as described in the enrollment materials.

D. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
If Yes, provide details. Company Name: _____
Individual or Group Policy Number: _____ Type of Coverage: _____
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
If so, with which company? _____ If that policy lapsed, when did it lapse? _____
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No
If so, which company's coverage will you be replacing? _____
4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

E. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this 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.

Please check one of the following: I elect NOT to name an Authorized Designee to receive this notice. I elect to name an Authorized Designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First) (MI) (Last)
Street Address
City State ZIP code Phone Number

1 You may change the named designee at any time by notifying us in writing at the following address: Genworth Life Insurance Company, [Administrative Office, P. O. Box 947500, Maitland FL 32794-7500].

F. Declarations

I have read the above statements or they have been read to me. I represent that the statements contained in this application, including those made in response to any questions in this application and any attachments are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of [any/voluntary] coverage under the Group Policy. I understand that any misstatements or failure to report information that is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify the Company of any change in my medical condition while my enrollment application is pending.

3 [I agree that if my application is approved by the Company, the effective date of [any/voluntary] coverage will be determined in accordance with the terms of the Group Policy, including any applicable [Actively At Work/Active Service] requirements. I also understand and agree that no insurance will be in effect pursuant to this application, or under any group policy or certificate issued by the Company unless or until the Group Policy [and Certificate have been delivered and accepted / is in effect] and there has been no change in the health of the applicant that would change the answer to any of the questions in the application.] [I request to be insured in accordance with the terms of the Group Policy. I understand and agree that the insurance applied for shall not take effect unless and until my application is approved by the Company; and I have met the eligibility requirements of the Group Policy including the [Actively At Work/Active Service requirements noted in Section A]; and the Group Policy is in effect.]

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

Have you received the Outline of Coverage, the Potential Rate Increase Disclosure Form and the applicable Shopper's or Buyer's Guide? Yes No

I acknowledge that I have read the Fraud Warning below.

X Signature Applicant: _____ Date: _____
Signed at (city, county, state): _____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto, commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

G. Coverage Selections

The group policyholder is paying premiums for a base amount of coverage (called the Core Plan) as described in the enrollment materials. Please indicate below whether you wish to purchase additional coverage for which you would pay the premium and indicate below the coverage selection you prefer. The additional coverage for which you may apply is described in your enrollment materials.

- 2 [Please note that premium costs for the Buy Up Options [(Plans B, C and D)] as shown in your enrollment materials include a premium discount equal to the amount of the premium contribution cost your employer is making for the Core Plan (Plan A)]

Select one of the following:

- 2 [Plan A CORE PLAN ONLY
See your enrollment materials for a description of the Core Plan coverage amounts.]
- [Plan B 1095 x FCM, 1825 x FCM, 3650 x FCM
Select a Facility Care Maximum: \$100 \$200 \$300] [per day]
- 1 [Plan C 1095 x FCM, 1825 x FCM, 3650 x FCM
Select a Facility Care Maximum: \$100 \$200 \$300] [per day]
- [Plan D 1095 x FCM, 1825 x FCM, 3650 x FCM
Select a Facility Care Maximum: \$100 \$200 \$300] [per day]

[Inflation Protection/Future Purchase Options: I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the Group Policy with and without inflation protection. I select the following option:

I reject Automatic Inflation Protection; however, I understand that my coverage automatically includes Future Purchase Options]

- 2 I reject Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]
- Automatic Inflation Protection – 5% Simple Annual Increases for Life Rider]
- Automatic Inflation Protection – 5% Compound Annual Increases for Life Rider]
- Automatic Inflation Protection – 5% Compound Annual Increases To Age 70 Rider]
- Automatic Inflation Protection – [3/4/5% Compound Annual Increases To Age 76 Rider]
- Automatic Inflation Protection Age-Adjusted Protection: Ages 61 and 76 Rider]
- Automatic Inflation Protection Age-Adjusted Compound Protection: Ages 61 and 76 Rider]
- Automatic Inflation Protection Age-Adjusted Protection – Compound Through 65, Simple Thereafter Rider]]

[Nonforfeiture Benefit:

- 2 Yes No. I have reviewed the outline of coverage and compared the benefits and premiums of the Group Policy with and without Nonforfeiture benefits and I reject the Nonforfeiture Benefit.]

X Signature

Applicant: _____

Date: _____

2 [H. Premium Payment Authorization

Complete this section to authorize premium payment (Buy Up Option only).

1. **AUTOMATIC PAYROLL DEDUCTION** (Note: You must also complete either payment option 2 or option 3 to indicate an alternative payment choice in the event payroll deduction is not available.)

2 "I certify that I am an active employee. As such, I authorize my employer to deduct from my pay the required premium for my and/or my spouse's [or domestic partner's] long term care coverage."

Name (First) (MI) (Last) (provide name exactly as it appears on your payroll check)

X _____
Signature of Employee Date Social Security Number

Print Name of Employer Name of Department

OR

2. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

3. **MONTHLY ELECTRONIC FUNDS TRANSFER. How Monthly Electronic Funds Transfer Works:** Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. Genworth Life Insurance Company will collect the long term care insurance premiums from your bank account electronically — you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement
I authorize the Company to electronically withdraw money from my account **Checking** **Savings** at:
name of bank _____
bank address _____

telephone _____
for the payment of premiums and other charges on this coverage.

I authorize the Company to continue to make these withdrawals if there is a renewal, or other change in my

coverage. I will compensate the Company for any loss, claim, or liability caused by these withdrawals and will not hold the Company responsible for any such loss, claim, or liability. This authorization will not affect the terms of my coverage. Authorizing this automatic payment plan does not put this coverage into effect.

This authorization may be retracted by me or the Company at any time for any reason by giving written notice. The Company may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated above, for any reason.

X _____
Signature of Accountholder

Print Name (First) (MI) (Last)

PLEASE ATTACH VOIDED CHECK. REQUIRED TO PROCESS THIS PAYMENT OPTION!]

GENWORTH LIFE INSURANCE COMPANY

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND ANNUAL INCREASES TO AGE 70 RIDER

This rider is attached to and made part of Your Certificate as of Your Coverage Effective Date. It is issued in consideration of Your Application and premium submitted for this rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How this Rider Works

Until you reach 70 years of age, We will increase by 5%:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

Increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits. No increases will occur once You reach age 70.

Premiums for This Rider

Once You reach age 70, premiums for this rider will continue for as long as Your Coverage remains in effect, even though there will be no automatic annual inflation increases.

Termination

If You request that We remove this rider from Your Coverage:

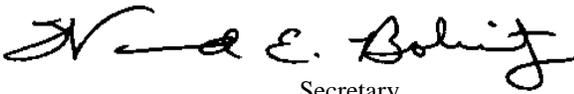
- The change will be effective as of the first day of the calendar month following Our receipt of Your request;
- Your benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. Premiums will be calculated based on Your original issue age.

Annual inflation protection increases stop when:

- You reach 70 years of age;
- This rider is terminated by You; or
- Your Coverage is continuing in effect under:
 - The Extension of Benefits provision;[or]
 - The Contingent Nonforfeiture Benefit[; or]
 - The Nonforfeiture Benefit Rider.]

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1 [
Secretary


President and CEO, Long Term Care Division]

1 GENWORTH LIFE INSURANCE COMPANY

[(ADMINISTRATIVE OFFICES: MAITLAND FL)]

AUTOMATIC BENEFIT INCREASE RIDER AGE-ADJUSTED PROTECTION: AGES 61 and 76

2 This Rider is attached to and made part of Your Certificate as of [the Effective Date of Rider shown in Your Certificate Schedule/Your Coverage Effective Date]. It is issued in consideration of Your Application and premium submitted for this Rider. It is subject to all the provisions of the Group Policy and Your Certificate unless otherwise provided below.

How this Rider Works While You Are Younger Than Age 61

Until the anniversary of Your Coverage Effective Date that next follows the date You reach age 61, We will increase by 5% on a Compound Basis:

- Your Facility Care Maximum;
 - The unused balance remaining in Your Policy Lifetime Maximum; and
 - All other maximums that are based on the Facility Care Maximum;
- on each anniversary of Your Coverage Effective Date.

2 How this Rider Works After You Are Age 61 [but Younger Than Age 76]

3 On each anniversary of Your Coverage Effective Date that next follows the date you reach age 61, [and until you reach age 76,] We will increase by [2%, 3%, 5%] on a Simple Basis:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum;

2 [How this Rider Works After You Are Age 76]

3 On each anniversary of Your Coverage Effective Date that next follows the date You reach age 76, We will increase by [2%, 3%, 5%] on a Simple Basis:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum.]

How Increases Are Determined

“Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by the appropriate percentage to determine the current benefit amounts.

[“Simple Basis” means that, with respect to an increase to your Facility Care Maximum that occurs:

- On the anniversary of Your Coverage Effective Date that follows Your 61st birthday and until you are age 76, the amount of the increase will be determined by multiplying 5% times your Facility Care Maximum in effect on that anniversary[; and]
- [On the anniversary of your Coverage Effective Date that follows Your 76th birthday and thereafter, the amount of the increase will be determined by multiplying [2%, 5%] times the Facility Care Maximum in effect on that anniversary.]]

2

["Simple Basis" means that, with respect to an increase to your Policy Lifetime Maximum that occurs:

- On the anniversary of Your Coverage Effective Date next following Your 61st birthday and on each such anniversary until you are age 76/thereafter, the amount of the increase will be determined by multiplying 5% times the lesser of:
 - The unused Policy Lifetime Maximum in effect on the anniversary of Your Coverage Effective Date next following your 61st birthday; or
 - The unused Policy Lifetime Maximum in effect on the effective date of the increase.
- On the anniversary of Your Coverage Effective Date next following Your 76th birthday and each such anniversary thereafter, the amount of the increase will be determined by multiplying [2%, 5%] times the lesser of:
 - the unused Policy Lifetime Maximum in effect on the Anniversary Date next following your 76th birthday; or
 - the unused Policy Lifetime Maximum in effect on the effective date of the increase.]

3

For additions to Your benefit amounts that are not the result of this Rider, the amount of the increase will be determined separately.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

While this Rider is in effect, increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

When Increases Stop

Annual benefit increases stop on the earliest of:

- The date Your Coverage ends; or
- The date this Rider is terminated by You; or
- The date Your Coverage is continued in effect under:
 - The Extension of Benefits provision;[or]
 - The Contingent Nonforfeiture Benefit[; or
 - The Nonforfeiture Benefit Rider.]

2

Premiums for This Rider

Premiums for this Rider are shown on Your Certificate Schedule and will continue for as long as Your Coverage remains in effect.

Rider Termination

If You request that We remove this Rider from Your Coverage:

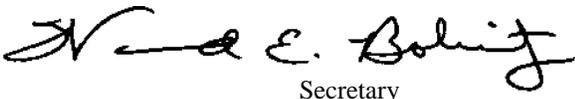
- The change will be effective as of the [Anniversary of Your Coverage Effective Date in the/first day of the calendar] month following Our receipt of Your request;
- All benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. These premiums will be calculated based on Your original issue age.

2

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1

[
Secretary


President and CEO, Long Term Care Division]

GENWORTH LIFE INSURANCE COMPANY

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND ANNUAL INCREASES

This rider is attached to and made part of Your Certificate as of Your Coverage Effective Date. It is issued in consideration of Your Application and premium submitted for this rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How This Rider Works

Every year on the anniversary of Your Coverage Effective Date We will increase by 5%:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

Increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

Termination

If You request that We remove this rider from Your Coverage:

- The change will be effective as of the first day of the calendar month following Our receipt of Your request;
- Your benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. Premiums will be calculated based on Your original issue age.

Annual inflation protection increases will terminate when requested by You or if Your Coverage is continuing in effect under:

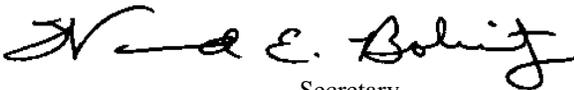
2

- The Extension of Benefits provision; [or]
- The Contingent Nonforfeiture Benefit [; or]
- The Nonforfeiture Benefit Rider.]

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1

[
Secretary


President and CEO, Long Term Care Division]

GENWORTH LIFE INSURANCE COMPANY

(ADMINISTRATIVE OFFICES: MAITLAND FL)

1

AUTOMATIC BENEFIT INCREASE RIDER – AGE-ADJUSTED COMPOUND PROTECTION: AGES 61 and 76

2

This Rider is attached to and made part of Your Certificate as of [the Effective Date of Rider shown in Your Certificate Schedule/Your Coverage Effective Date]. It is issued in consideration of Your Application and premium submitted for this Rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How This Rider Works While You Are Younger Than Age [61]

3

Until [the anniversary of Your Coverage Effective Date that next follows the date] You reach [age 61], We will increase:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum;

3

on each anniversary of Your Coverage Effective Date by [3%, 5%] on a Compound Basis.

2

How this Rider Works After You Are Age [61 but Younger Than Age [76]

On each anniversary of Your Coverage Effective Date that next follows the date You reach age [61, and until you reach age 76], We will increase:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum;

by 3% on a Compound Basis.

2

[How this Rider Works After You Are Age 76

On each anniversary of Your Coverage Effective Date that next follows the date You reach age 76, We will increase:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum;

3

by [2%, 3%] on a Compound Basis.]

How Increases Are Determined

“Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by the appropriate percentage to determine the current benefit amounts.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

While this Rider is in effect, increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

When Increases Stop

Annual benefit increases stop on the earliest of:

2

- The date Your Coverage ends; or
- The date this Rider is terminated by You; or
- The date Your Coverage is continued in effect under:
 - The Extension of Benefits provision;[or]
 - The Contingent Nonforfeiture Benefit[; or
 - The Nonforfeiture Benefit Rider.]

Premiums for This Rider

Premiums for this Rider are shown on Your Certificate Schedule and will continue for as long as Your Coverage remains in effect.

Rider Termination

2

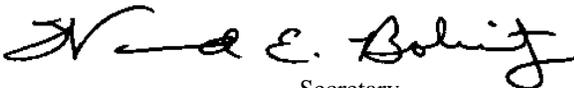
If You request that We remove this Rider from Your Coverage:

- The change will be effective as of the [day of the anniversary of Your Coverage Effective Date in the/first day of the calendar] month following Our receipt of Your request;
- All benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. These premiums will be calculated based on Your original issue age.

In all other respects, the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1

[
Secretary


President and CEO, Long Term Care Division]

GENWORTH LIFE INSURANCE COMPANY

[(ADMINISTRATIVE OFFICES: MAITLAND FL)]

AUTOMATIC BENEFIT INCREASE RIDER – AGE ADJUSTED PROTECTION: COMPOUND THROUGH AGE 65 – SIMPLE THEREAFTER

This Rider is attached to and made part of Your Certificate as of [the Effective Date of Rider shown in Your Certificate Schedule/Your Coverage Effective Date]. It is issued in consideration of Your Application and premium submitted for this Rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How This Rider Works While You Are Younger Than Age 66

Until the anniversary of Your Coverage Effective Date that next follows the date you reach age 66, We will increase:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum.

on each anniversary of Your Coverage Effective Date by 5% on a Compound Basis.

How this Rider Works After You Are Age 66

On each anniversary of Your Coverage Effective Date that next follows the date you reach age 66, We will increase:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum;

by 5% on a Simple Basis.

How Increases Are Determined

“Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by 5% to determine the current benefit amounts.

“Simple Basis” means that, with respect to the Facility Care Maximum and benefit maximums based on the Facility Care Maximum, other than the Policy Lifetime Maximum, the amount of the increase will be determined by multiplying 5% times those benefit amounts in effect on the anniversary of Your Coverage Effective Date next following Your 66th birthday.

With respect to the Policy Lifetime Maximum, “Simple Basis” means the amount of the increase will be determined by multiplying 5% times the lesser of:

- The unused Policy Lifetime Maximum in effect on [the anniversary of your Coverage Effective Date next following] your 66th birthday; or
- The unused Policy Lifetime Maximum in effect on the effective date of the increase.

For additions to Your benefit amounts that are not the result of this Rider, the amount of the increase will be determined separately.

The increased benefit amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

While this Rider is in effect, increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

When Increases Stop

Annual benefit increases stop on the earliest of:

- The date Your Coverage ends; or
- The date this Rider is terminated by You; or
- The date Your Coverage is continued in effect under:
 - The Extension of Benefits provision;[or]
 - The Contingent Nonforfeiture Benefit[; or]
 - The Nonforfeiture Benefit Rider.]

2

Premiums for This Rider

Premiums for this Rider are shown on Your Certificate Schedule and will continue for as long as Your Coverage remains in effect.

Rider Termination

If You request that We remove this Rider from Your Coverage:

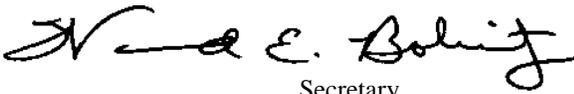
- The change will be effective as of the [anniversary of Your Coverage Effective Date in the/first day of the calendar] month following Our receipt of Your request;
- All benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. These premiums will be calculated based on Your original issue age.

2

In all other respects, the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1

[
Secretary


President and CEO, Long Term Care Division]

GENWORTH LIFE INSURANCE COMPANY

AUTOMATIC INFLATION PROTECTION – 5% SIMPLE ANNUAL INCREASES RIDER

This rider is attached to and made part of Your Certificate as of Your Coverage Effective Date. It is issued in consideration of Your Application and premium submitted for this rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How This Rider Works

Every year on the anniversary of Your Coverage Effective Date We will increase by 5% of the amounts in effect on Your Coverage Effective Date:

- Your Facility Care Maximum;
- All other maximums that are based on the Facility Care Maximum; and
- Your Policy Lifetime Maximum; however, increases to Your Policy Lifetime Maximum will be reduced to the lesser of 5% of the amount in effect on Your Coverage Effective Date, or 5% of Policy Lifetime Maximum reduced by benefits paid.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

Increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

Termination

If You request that We remove this rider from Your Coverage:

- The change will be effective as of the first day of the calendar month following Our receipt of Your request;
- Your benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. Premiums will be calculated based on Your original issue age.

2

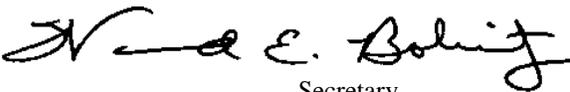
Annual inflation protection increases will terminate when requested by You or if Your Coverage is continuing in effect under:

- The Extension of Benefits provision;[or]
- The Contingent Nonforfeiture Benefit; or
- The Nonforfeiture Benefit Rider.]

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

1

[
Secretary


President and CEO, Long Term Care Division]

GENWORTH LIFE INSURANCE COMPANY

[(ADMINISTRATIVE OFFICES: MAITLAND FL)]

1

3

AUTOMATIC BENEFIT INCREASES – [3%/4%/ 5%]/ COMPOUND ANNUAL INCREASES TO AGE 76 RIDER

2

This rider is attached to and made part of Your Certificate as of [the Effective Date of Rider shown in Your Certificate Schedule/Your Coverage Effective Date]. It is issued in consideration of Your Application and premium submitted for this rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

How this Rider Works

3

Until the anniversary of Your Coverage Effective Date that next follows the date You reach age 76, We will increase by [3%/4%/5%] on a Compound Basis:

- Your Facility Care Maximum;
- The unused balance remaining in Your Policy Lifetime Maximum; and
- All other maximums that are based on the Facility Care Maximum.

“Compound Basis” means that the benefit amounts in effect on the date of the increase will be multiplied by the appropriate percentage to determine the current benefit amounts.

The increased amounts will be rounded to the nearest whole dollar.

When Increases Become Effective

Increases will be effective on each anniversary of Your Coverage Effective Date, even if You are receiving benefits.

Premiums for This Rider

Once You reach age 76, premiums for this rider will continue for as long as Your Coverage remains in effect, even though there will be no automatic annual benefit increases.

Termination

2

If You request that We remove this rider from Your Coverage:

- The change will be effective as of the [day of the anniversary of Your Coverage Effective Date in the/first day of the calendar month] following Our receipt of Your request;
- Your benefit amounts will be at the level they are as of that date; and
- Your premium will be changed to equal the premium for Your then current coverage choices at Your then current Facility Care Maximum. Premiums will be calculated based on Your original issue age.

Annual benefit increases stop:

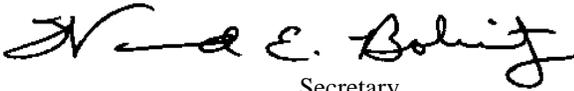
2

- On the anniversary of Your Coverage Effective Date that next follows the date You reach age 76;
- When this rider is terminated by You, as described above; or
- When Your Coverage is continued under:
 - The Extension of Benefits provision;[or]
 - The Contingent Nonforfeiture Benefit[; or]
 - The Nonforfeiture Benefit Rider.]

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

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[
Secretary


President and CEO, Long Term Care Division]

GENWORTH LIFE INSURANCE COMPANY

NONFORFEITURE BENEFIT RIDER

This rider is attached to and made part of Your Certificate as of Your Coverage Effective Date. It is issued in consideration of Your Application and premium submitted for this rider. It is subject to all the provisions of the Group Policy and Certificate unless otherwise provided below.

This benefit provides a continuation of Your Coverage, but on a reduced basis, in the event that Your Coverage terminates due to non-payment of premium.

Nonforfeiture Benefit

The Nonforfeiture Benefit provides a continuation of Your Coverage up to the Nonforfeiture Benefit Allowance determined below if Your Coverage terminates due to non-payment of premium before the Policy Lifetime Maximum has been exhausted. The conditions under which We will pay benefits under this rider are described below.

How This Benefit Works

If Your Coverage terminates due to non-payment of premium on or after the third anniversary of Your Coverage Effective Date, We will continue to pay benefits, subject to all of the terms and conditions of Your Coverage. Benefits for Covered Expenses You incur will be paid up to the Nonforfeiture Benefit Allowance subject to the then applicable daily, monthly, annual, and lifetime benefit maximums.

Nonforfeiture Benefit Allowance

The Nonforfeiture Benefit Allowance We will pay will be the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for Your Coverage, excluding any waived premiums; or (b) the maximum amount in effect at the time of lapse applicable to one month (30 days) of Nursing Facility Confinement.

In no event will the total of benefits payable under this rider exceed the Policy Lifetime Maximum applicable when Your Coverage terminates due to non-payment of premium.

Inflation Protection Stops

2

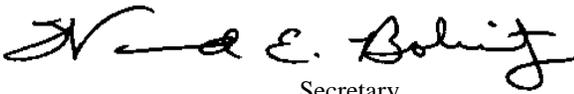
[Automatic Inflation Protection and Future Purchase Options Benefit offers] will not apply to this Benefit.

When the Benefit Ends

Coverage under this rider ceases if terminated by You or if You fail to pay the required premium when due. Otherwise, this Benefit will be paid as long as the Conditions for Receiving Benefits are met, the Nonforfeiture Benefit Allowance has not been reached and the Policy Lifetime Maximum has not been exhausted.

In all other respects the provisions and conditions of the Certificate remain the same.

Signed for Genworth Life Insurance Company

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Secretary


President and CEO, Long Term Care Division]