Application for Individual Life Insurance

Genworth Life and Annuity Insurance Company (GLAIC)
[*Attn: Worksite Administration, 3100 Albert Lankford Drive , Lynchburg, VA 24501*]

1. Proposed Insured *Please print all answers.*

a. Full name (First, Middle, Last include maiden name.)	b. Sex ◯ F ◯ M	c. Date of birth *mm/dd/yyyy*	d. State of birth
e. Home address (give number, street, state and zip)		f. Social security number	
g. Home phone number	h. Work phone number	i. Occupation	j. Employer name and time with employer

k. Is the Proposed Insured a United States citizen? ◯ Yes ◯ No **If "No,"** complete the *Resident Alien Supplement* form.

2. Owner *Complete if other than Proposed Insured. If Trust, give name of trust and date of trust agreement.*

a. **Primary** Owner (Full name)		b. Home address (give number, street, state and zip)	
c. Rel. to Proposed Insured	d. SSN or TIN	e. Date of birth/ Trust *mm/dd/yyyy*	f. Select one ◯ Individual ◯ Partnership ◯ Corporation ◯ Trust ◯ Other (*Specify*):
g. Home phone number	h. Work phone number	i. Is the Owner a United States citizen? ◯ Yes ◯ No **If "No,"** complete the *Owner Resident Alien Supplement* form.	
j. **Contingent** Owner (Full name)		k. Home address (give number, street, state and zip)	
l. Rel. to Proposed Insured	m. SSN or TIN	n. Date of birth/ Trust *mm/dd/yyyy*	o. Select one ◯ Individual ◯ Partnership ◯ Corporation ◯ Trust ◯ Other (Specify):
p. Home phone number	q. Work phone number	r. Is the Contingent Owner a United States citizen? ◯ Yes ◯ No **If "No,"** complete the *Owner Resident Alien Supplement* form.	

3. Beneficiary *If percentage shares are not given, they will be equal. Use DETAILS to name additional beneficiaries.*

a. **Primary** (Full name and address)	b. Share %	c. Rel. to Prop. Ins.	d. SSN or TIN
e. Date of birth *mm/dd/yyyy*	f. Home phone number	g. Work phone number	
h. **Contingent** (Full name and address)	i. Share %	j. Rel. to Prop. Ins.	k. SSN or TIN
l. Date of birth *mm/dd/yyyy*	m. Home phone number	n. Work phone number	

4. Plan, Amount of Insurance and Premium Mode

a. Plan of Insurance:	b. Amount of Insurance:
c. *Premium Mode *Select one*: ◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Monthly	d. Premium remitted with application $

* The semi-annual, quarterly and monthly premium modes have a higher yearly total premium than the annual premium mode. If you would like information about the cost of any premium mode, please contact your insurance agent or the Insurer.

5. Proposed Insured's Existing Insurance/ Replacement

a. Does the Proposed Insured have existing life insurance policies or annuity contracts?..... ◯ Yes ◯ No
b. **If "Yes,"** to question 5.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities?...◯ Yes ◯ No
c. **If "Yes,"** to question 5.a. list all existing life insurance policies and annuity contracts.

Full name of company	Kind	To be replaced?	Amount	Issue Year	Purpose
	◯ Annuity ◯ Life Insurance	◯ Yes ◯ No			◯ Business ◯ Personal
	◯ Annuity ◯ Life Insurance	◯ Yes ◯ No			◯ Business ◯ Personal
	◯ Annuity ◯ Life Insurance	◯ Yes ◯ No			◯ Business ◯ Personal
	◯ Annuity ◯ Life Insurance	◯ Yes ◯ No			◯ Business ◯ Personal

6. Proposed Insured's Tobacco and Nicotine Use

In the past 12 months, has the Proposed Insured used tobacco or any other product containing nicotine?.....◯ Yes ◯ No
If "Yes," indicate kind and frequency:

7. Proposed Insured's History

a. In the past 90 days has the Proposed Insured been at work on a full-time basis performing all duties of his/her regular occupation at his/ her customary place of employment for at least 30 hours each week? **If "No,"** provide reasons and dates in **DETAILS**.....◯ Yes ◯ No

b. In the past 90 days has the Proposed Insured been absent from his/her customary place of employment for 5 or more work days due to illness or medical treatment? **If "Yes,"** explain in **DETAILS**.....◯ Yes ◯ No

c. In the past 90 days has the Proposed Insured been treated at a hospital on an inpatient or outpatient basis for any reason? **If "Yes,"** explain in **DETAILS**.....◯ Yes ◯ No

8. Proposed Insured's History *Complete only if age 71 or older. Provide explanations for "YES" answers in DETAILS.*

Medical facility includes medical center, hospital, mental health facility or any facility for drug or alcohol treatment. **Care Provider** means persons licensed as: medical physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors.

a. In the past 5 years has the Proposed Insured had his/her driver's license suspended or revoked, or been the driver of a motor vehicle involved in an accident and found to be at fault?.....◯ Yes ◯ No

b. In the past 5 years has the Proposed Insured been examined or treated by a care provider, been examined or treated at a hospital or other medical facility, or been counseled or treated for alcohol or other drug use?.....◯ Yes ◯ No

c. In the past 10 years, have you ever been diagnosed, treated or advised by a Care Provider that you have or had any of the following:

i. Stroke, high blood pressure, chest pain, or disease of the heart or blood vessels?.....◯ Yes ◯ No
ii. Cancer?.....◯ Yes ◯ No
iii. Respiratory disease, kidney disease, liver disease, or diabetes?.....◯ Yes ◯ No
iv. Mental or nervous disorder?.....◯ Yes ◯ No

9. DETAILS *If necessary, attach an additional sheet of paper. Use for additional beneficiaries, if any.*

Question # Explanation: include reasons, dates, diagnoses, duration, names and addresses of medical facilities/ care providers.

10. Representations

The application includes the Application for Life Insurance and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance agent is authorize to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests. The Licensed Insurance Agent is not an authorized officer of the Insurer.

I represent: (1) the statements and answers given in this Application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is appropriate for the Owner's insurance needs. **I agree that:** (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and (2) **except as provided in the Conditional Receipt, if any, insurance will not begin unless the Proposed Insured is living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid. Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

State in which Owner signs Application

State of Policy Delivery

Proposed Insured's Signature

Date Signed

Owner's Signature *If other than Proposed Insured*

Date Signed

11. Licensed Insurance Agent's Statement

Does the Proposed Insured have existing life insurance policies or annuities?..... ◯ Yes ◯ No
If "Yes," will the insurance applied for in this application replace, end or change any existing life insurance or annuities?..... ◯ Yes ◯ No
If "Yes," attach a full explanation to the application. Include copies of any replacement forms or any other special forms required by state law. Explain to the Owner and Proposed Insured that new suicide and contestable periods may apply. I understand that I do not have authority to waive or change the Insurer's requirements.

Signature of Licensed Insurance Agent	Date Signed	Licensed Insurance Agent's Printed Name

Agent's Co. Code Number	Managing Agency/ Brokerage Name & Number	Licensed Insurance Agent Number

12. Authorization to Collect and Disclose Information

Information Information means facts about the Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as HIV (Human Immunodeficiency Syndrome) infection, AIDS (Acquired Immune Deficiency Syndrome), tuberculosis, and sexually transmitted diseases; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation.

Source Medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; facilities or offices staffed or run by care providers; insurers; reinsurers; MIB; consumer reporting agencies; financial sources; employers; the Social Security Administration; and the Division of Motor Vehicles.

Insurer Genworth Life and Annuity Insurance Company.

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

The following parties may need to collect Information in regard to proposed coverage; the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following; other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of the Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing the Authorization, the Proposed Insured: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

In all states this Authorization will be valid for twenty-four (24) months after the Date Signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

Signature of Proposed Insured	Date Signed