

Application for Life Insurance

Genworth Life Insurance Company of New York

Please complete this application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. If special mailing envelopes have been provided, submitting the application in such an envelope will help avoid delays in processing your client's application. We sincerely appreciate your business.

LICENSED INSURANCE AGENT CHECKLIST

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

DO

- ▶ Give the *Notice to Proposed Insured and Owner* to the Proposed Insured or Owner before completing the application.
- ▶ Ask all questions and fully and accurately record all answers given — the application will be part of any policy issued.
- ▶ Enter each beneficiary's SSN — it will help us locate the beneficiary at claim time.
- ▶ Print in dark ink.
- ▶ Obtain all the necessary signatures.
- ▶ Complete and sign the Licensed Insurance Agent's Report.
- ▶ Promptly schedule any required medical exam.
- ▶ Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- ▶ If you accept payment with the application:
 - Accept payment only in the form of a currently dated check or money order made payable to the Insurer.
 - Enter the full amount accepted in Section 7.f. on Page 1.
 - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered "No."
 - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
 - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
 - Give the Owner the COPY of the TIAA. Keep the ORIGINAL with the application.
 - Promptly send the payment and the Application – Part I, including the ORIGINAL of the TIAA to the Insurer.
- ▶ For Term plans — explain that for premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses.

DO NOT

- ▶ DO NOT use pencil or correction fluid.
- ▶ DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- ▶ DO NOT promise or imply that we will provide insurance.
- ▶ DO NOT accept payment in the form of cash/currency or Traveler's checks.
- ▶ DO NOT accept a check or money order made payable to you or with the payee left blank.
- ▶ DO NOT do the following:
 - Do not accept payment when the amount applied for plus existing insurance with the Insurer exceeds \$1,000,000.
 - Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.
 - Do not accept payment if any question on the Temporary Insurance Application is answered "Yes" or left blank.

Application for Life Insurance – Part I



Genworth Life Insurance Company of New York
Home Office: 666 Third Avenue, 9th Floor • New York, NY 10017

1. Proposed Insured **Please print all answers.**

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Sex <input type="radio"/> F <input type="radio"/> M	c. Date of Birth Mo. Day Yr.	d. State/Country of Birth	e. Social Security Number
f. Home Address (Number, Street, City, State, and Zip Code.) e-mail:			How Long At Address?	g. U.S. Citizenship <input type="radio"/> Yes <input type="radio"/> No If "No," complete Resident Alien Supplement.
h. Any previous addresses within the past 5 years? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> If "Yes," list (Number, Street, City, State and Zip Code):				
i. Driver's License Number/State	j. Marital Status <input type="radio"/> M <input type="radio"/> S <input type="radio"/> W <input type="radio"/> D		k. Home Phone Number	l. Work Phone Number
m. Occupation (Include duties.)	n. Employer Name and Address		o. How Long w/ Employer?	

2. Ownership (Complete if Owner is other than Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address) e-mail:	b. Rel. to Prop. Ins.	c. SSN or TIN	d. Date of Birth/Trust Mo. Day Yr.
e. Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			
f. Contingent Owner: (Full Name and Address) e-mail:	g. Rel. to Prop. Ins.	h. SSN or TIN	i. Date of Birth/Trust Mo. Day Yr.
j. Contingent Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trust <input type="radio"/> Other (Specify):			

3. Beneficiary (If percentage shares are not given, they will be equal. Use REMARKS 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/Trust Mo. Day Yr.
f. Primary: (Full Name and Address)	g. % Share	h. Rel. to Prop. Ins.	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr.
k. Contingent: (Full Name and Address)	l. % Share	m. Rel. to Prop. Ins.	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr.
p. Contingent: (Full Name and Address)	q. % Share	r. Rel. to Prop. Ins.	s. SSN or TIN	t. Date of Birth/Trust Mo. Day Yr.

4. Amount and Plan of Insurance	5. Death Benefit Option (Universal Life only)	6. Riders (If available with Plan)
a. Amount of Insurance: \$	<input type="radio"/> Level (Specified Amount only) <input type="radio"/> Increasing (Specified Amount plus cash value) <input type="radio"/> Scheduled Increases (if available): <input type="radio"/> Simple _____% <input type="radio"/> Compound _____%	<input type="radio"/> Waiver of Premium (term) <input type="radio"/> Waiver of Monthly Deduction (UL) <input type="radio"/> Children's Term Ins.: Units <input style="width: 50px;" type="text"/> <input type="radio"/> Other (Amount and Description):
b. Plan of Insurance:		
c. If underwriting cannot give you the lowest rate for this Plan, will you consider a higher rate? <input type="radio"/> Yes <input type="radio"/> No		

7. Premiums

a. Payment Method: <input type="radio"/> Pre-Arranged Withdrawal (PAW) <input type="radio"/> Direct Bill <input type="radio"/> Other (Specify):					
b. Payment Mode:	Frequency	<input type="radio"/> Monthly (PAW only)	<input type="radio"/> Quarterly	<input type="radio"/> Semiannual	<input type="radio"/> Annual <input type="radio"/> Single
	Modal Factor*	.0875	.26	.51	1.0 n/a
	Annual Percentage Rate*	10.8%	10.8%	8.2%	0% n/a
*Information does not apply to universal life plans.					
c. Automatic Premium Loan: (if available) <input type="radio"/> Yes <input type="radio"/> No	d. Send Premium Notices to: <input type="radio"/> Insured (Section 1.f.) <input type="radio"/> Owner (Section 2.a.) <input type="radio"/> Other (Specify):		e. For Universal Life Plans: Planned Period Premium: \$ _____ Initial Premium Amount: \$ _____		
e. Premium Source: <input type="radio"/> Salary <input type="radio"/> Investments <input type="radio"/> Savings <input type="radio"/> Gifts/Inheritance <input type="radio"/> Other (Specify):			f. Amount Remitted in Exchange for Temporary Insurance: \$		

8. Proposed Insured's Tobacco and Nicotine Use

- a. Mark the **one** item that best describes your history of tobacco and other nicotine product use: Never Used Totally Stopped Use Now
- b. If you "Use Now," for all that apply, indicate all forms used and the quantity used: Cigarettes ___ packs/day Cigars ___ cigars/year
 Other (describe): _____
- c. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in **REMARKS**.
 Less than 1 1 or more/less than 2 2 or more/less than 3 3 or more/less than 5 5 or more

9. Proposed Insured's Insurance Needs (Complete either the Personal or Business section. Explain "Yes" answers in REMARKS.)

- a. How long (years) do you plan to maintain this insurance in force? _____
- b. **Personal:** Income Replacement Debt Repayment Estate Conservation Other _____
1. Personal Finances: Gross Annual Income \$ _____ Total Assets \$ _____ Total Liabilities \$ _____
2. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? Yes No
- c. **Business:** Buy-Sell Key Employee Secure Credit Other _____
1. Business Finances: Total Assets \$ _____ Total Liabilities \$ _____ Net Worth \$ _____
2. What percentage of the business do you own? _____ % 3. Your Gross Annual Salary (include bonus) \$ _____
4. Is business insurance applied for or in force on other key members of the business? (Explain either answer in **REMARKS**.) Yes No
5. Within the past 5 years, has the business filed for bankruptcy or had any lien or judgments filed against it? Yes No

10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)

- a. Do you have existing life insurance or annuities? Yes No
- b. If "Yes," to Question 10.a. will the insurance applied for in this application replace, end or change any existing life insurance or annuities? Yes No
 (If "Yes," you may be required to review and sign additional forms.)
- c. If "Yes," to Question 10.a. list all existing life insurance policies and annuity contracts. For additional policies/contracts, use **REMARKS**.

Full Name of Company	To Be Replaced?	Amount	Year Issued	Beneficiary(ies)
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/>	\$		

11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)

- a. Do you have any other application or informal inquiry for life insurance pending in any company or society? Yes No
- b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited or cancelled, or have you ever withdrawn an application or been asked to pay a higher premium rate? Yes No
- c. Have you ever been convicted of a misdemeanor or felony? Yes No
- d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment? Yes No
- e. In the past 5 years, has your driver's license been suspended or revoked? Yes No
- f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? Yes No
- g. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.) Yes No
- h. In the past 2 years have you engaged in, or do you intend to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? (If "Yes," complete appropriate activities Supplement[s].) Yes No
- i. Do you intend to travel or reside outside of the U.S. for more than 4 consecutive weeks? (If "Yes," complete Foreign Residence/Travel Supplement.) Yes No

12. REMARKS (For explanations and special requests. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

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 AIDS and tuberculosis; 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. Information does not include facts about previously administered tests for HIV Antibodies, T-Cell Counts, or AIDS.

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; neighbors; friends; and relatives.

Insurer Genworth Life Insurance Company of New York

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

Authorization The Authorization is this 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 that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured’s behalf: (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 or the person authorized to act on the Proposed Insured’s behalf 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.

This Authorization will be valid for twenty-four (24) months after the date this Application – Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization. I authorize the Company to procure an investigative consumer report, if required. If a minor child is proposed for coverage, the authorizations, acknowledgements and representations are made by the person authorized (parent or legal guardian) to act on behalf of the minor child named in the application.

Representations

The application includes the Application – Parts I and II 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 authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable 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 Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are 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.**

State in which Owner Signed Application

State in which Policy will be Delivered

Signature of Proposed Insured

Date

Owner (if not Proposed Insured: Signature and any Title)

Signature of Parent or Legal Guardian, if applicable

Date

Signature of Licensed Insurance Agent

Signature of Licensed Insurance Agent

Licensed Insurance Agent’s Printed Name

Licensed Insurance Agent’s Printed Name

Social Security No.

License No.

Managing Agency/
Brokerage No.

Social Security No.

License No.

Managing Agency/
Brokerage No.

1. Licensed Insurance Agent's Report (Not part of the Application)

a. Full Name (Please print)	b. Agent's Company Code No.*	c. SSN or Tax ID No.	d. Phone and FAX Numbers Phone: FAX:
-----------------------------	------------------------------	----------------------	--

e. 1. Does the proposed insured have any existing life insurance or annuity? Yes No
 2. Is this insurance applied for intended to replace, end or change any existing insurance or annuity? Yes No
 If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods may apply.

f. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? Yes No

g. Has a medical or paramedical exam been scheduled? If "Yes," give date and Provider with whom scheduled..... Yes No

Date (Mo. Day Yr.): _____ Provider's Name: _____

h. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: \$ _____ Reason: _____

i. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father	Mother	Siblings (Name and Amount)
\$ _____	\$ _____	_____

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Signature(s) of Licensed Insurance Agent (s) _____

Date _____

2. Managing Agency/Brokerage Report (Not part of the Application)

a. Managing Agency/Brokerage Name (Please print) e-mail: _____	b. Managing Agency/Brokerage No.	c. Date
---	----------------------------------	---------

3. Licensed Insurance Agents to Receive Commission (Please print)

Complete for each licensed agent to receive commission.

Total Commission Share(s) to equal 100%. Each licensed agent will share equally unless otherwise indicated.

a. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	b. Agent's Commission Share %	c. Agent's Company Code No.
d. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	e. Agent's Commission Share %	f. Agent's Company Code No.
g. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	h. Agent's Commission Share %	i. Agent's Company Code No.
j. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	k. Agent's Commission Share %	l. Agent's Company Code No.
m. Full Name, Address, and SSN or TIN (Please print)	e-mail: _____	n. Agent's Commission Share %	o. Agent's Company Code No.

Notice to Proposed Insured and Owner

Genworth Life Insurance Company of New York

Home Office: 666 Third Avenue, 9th Floor • New York, NY 10017

Thank you for your application. We greatly appreciate your completing each part truthfully and accurately. This Notice tells you what to expect after completing the Application – Part I and provides other important information, including information required by state law and regulation. If you have any questions, please ask the soliciting licensed insurance agent (licensed agent). The licensed agent should gather information about your personal situation, insurable needs, and financial objectives and explain how the insurance recommendations are appropriate to fulfill those needs and objectives. When deciding insurance needs, consider the following: the losses you want to protect against; the kind of insurance; how long you will need the coverage; your future liquidity needs, e.g., college funding; your ability to pay the planned premium; taxes; and your other financial assets, e.g., Social Security, pension plans.

Policies Available Only in English

Our insurance applications, illustrations, disclosures and our insurance policies are available only in English. In addition, all of our servicing to our policyholders is only in English. You are responsible for fully understanding these English materials. We do not permit our insurance agents to translate these materials to a different language and you may not rely on any translation by our insurance agent.

What Happens Next

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may seek information from other sources to help us in our evaluation. During underwriting we may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate. For example, if you have ever used any kind of tobacco or other nicotine product, you may not be eligible for our lowest rate.

Physical Exam

Virtually all Proposed Insureds are required to take a physical exam. The exam is done by a qualified examiner and takes approximately 30 minutes. During the exam, you should expect the following: to provide your medical history; to be weighed and measured; to have an EKG (not always required); to provide a blood or saliva sample and a urine sample; to have your blood pressure and pulse taken.

Here are some of the ways you can help with the exam process:

- Schedule your exam within 24 hours after you complete the Application – Part I
- Have a list of the names and addresses of all licensed health care providers and facilities seen during the past 20 years and be prepared to provide reasons, dates and any treatments received as a result of those visits
- Do not eat or drink (except water) for 12 hours prior to your scheduled exam time
- Have a photo ID ready, e.g., driver's license, passport, or greencard

Other Important Information

Contestability

Because your application will be our primary source of information, we strongly urge you to review the completed application closely for accuracy. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. In addition, you may be violating state law if you knowingly conceal material facts or submit an application that contains materially false information.

Replacement of Existing Coverage

If you have existing coverage, answer "yes" to this question in the application. If you intend to replace existing coverage, tell the licensed agent of your intention and answer "yes" to the replacement question in the application. State law may require the licensed agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, answer the replacement question "yes." Doing so may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. Stopping premium payments, surrendering, or borrowing from an existing policy as a result of applying for this policy could be considered replacement. State law may define replacement to include other situations. Ask the licensed agent if you are unsure about replacement.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to P.O. Box 461, Lynchburg, Virginia 24505-0461.

Premium Payments on Term

For premiums not paid on an annual basis at the beginning of a policy year, we adjust the annual premium by a modal factor to compensate for the lost investment earnings, additional administrative costs, and expected early lapses. These modal factors and associated APRs are available and will be provided. Ask the licensed agent for this information.

Federal Fair Credit Reporting Act

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) Disclosure

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc. MIB, Inc. is a non-profit membership organization of life insurance companies. It operates an information exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. To contact MIB, Inc., you may: write P.O. Box 105, Essex Station, Boston, MA 02112; phone toll free (866) 692-6901 (TTY 866 346-3642 for hearing impaired); or use the website <http://www.mib.com>.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Temporary Insurance Application and Agreement (TIAA)



Genworth Life Insurance Company of New York

Home Office: 666 Third Avenue, 9th Floor • New York, NY 10017

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

Temporary Insurance Application (Answer all Questions.)

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? | <input type="radio"/> | <input type="radio"/> |
| 2. Is the Policy applied for a joint life insurance policy? | <input type="radio"/> | <input type="radio"/> |
| 3. Does the total amount of insurance in force and applied for with the Insurer on the Proposed Insured's life exceed \$1,000,000 under any, some, or all of the following: policy(ies), conditional receipt(s), temporary insurance agreement(s), application(s)? | <input type="radio"/> | <input type="radio"/> |
| 4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? | <input type="radio"/> | <input type="radio"/> |
| 5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? | <input type="radio"/> | <input type="radio"/> |
| 6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? | <input type="radio"/> | <input type="radio"/> |

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.

Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) \$1,000,000 reduced by the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, and temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 60 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines provided the Insurer has mailed notice at least five calendar days prior to this date; (3) the date the Owner refuses to accept any policy issued or offered; (4) five calendar days after the Insurer mails notice that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date. All notices required under this "Stop Date - 90 Day Maximum" section will be mailed to the Owner at the address shown in the Application - Part I and to the applicant, if other than the Owner.

Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

Licensed Insurance Agent's Statement

Amount Remitted \$

Person from Whom Received

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

Signature(s) of Licensed Insurance Agent(s)

Licensed Insurance Agent Number(s)

Temporary Insurance Application and Agreement (TIAA)



Genworth Life Insurance Company of New York

Home Office: 666 Third Avenue, 9th Floor • New York, NY 10017

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part I and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to the Insurer. Do not make it payable to the licensed insurance agent or leave the payee blank. Do not pay cash.**

Temporary Insurance Application (Answer all Questions.)

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the Date of this TIAA? | <input type="radio"/> | <input type="radio"/> |
| 2. Is the Policy applied for a joint life insurance policy? | <input type="radio"/> | <input type="radio"/> |
| 3. Does the total amount of insurance in force and applied for with the Insurer on the Proposed Insured's life exceed \$1,000,000 under any, some, or all of the following: policy(ies), conditional receipt(s), temporary insurance agreement(s), application(s)? | <input type="radio"/> | <input type="radio"/> |
| 4. In the past 90 days, has the Proposed Insured been admitted, or medically advised to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed? | <input type="radio"/> | <input type="radio"/> |
| 5. In the past 5 years, has the Proposed Insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? | <input type="radio"/> | <input type="radio"/> |
| 6. Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? | <input type="radio"/> | <input type="radio"/> |

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question above is answered "Yes" or left blank; (3) the answers given above are true to the best of my knowledge and belief, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; and (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA.

Signature of Proposed Insured

Date of this TIAA

Signature of Owner (if other than Proposed Insured)

Temporary Insurance Agreement

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part I upon receipt of due proof that the Proposed Insured died while temporary insurance was in effect. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for.

Limited Amount. The Limited Amount is the lesser of: (1) the Amount of Insurance applied for in the Application - Part I; and (2) \$1,000,000 reduced by the amount of any insurance on the Proposed Insured's life in force with the Insurer under any policies, conditional receipts, and temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date - 90 Day Maximum. Temporary insurance automatically ends on the Stop Date and the entire amount remitted will be returned without interest to or for the benefit of the Owner. The Stop Date is the earliest of the following: (1) the date the Owner withdraws the application; (2) 60 days after the Start Date if the Insurer has **not** received a properly completed and signed Application Part II – Medical History and all medical examinations and tests required by the Insurer as set forth in its Initial Submission Guidelines provided the Insurer has mailed notice at least five calendar days prior to this date; (3) the date the Owner refuses to accept any policy issued or offered; (4) five calendar days after the Insurer mails notice that the Insurer has declined to issue insurance; and (5) 90 days after the Start Date. All notices required under this "Stop Date - 90 Day Maximum" section will be mailed to the Owner at the address shown in the Application - Part I and to the applicant, if other than the Owner.

Policy Date. The Policy Date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The Amount Remitted will be applied to the first modal premium for the policy. Upon policy delivery, the policy will replace this TIAA and coverage will continue under the policy without interruption.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

Licensed Insurance Agent's Statement

Amount Remitted \$

Person from Whom Received

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part I. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left the Copy with the Owner.

Signature(s) of Licensed Insurance Agent(s)

Licensed Insurance Agent Number(s)



Genworth®
Financial

Genworth Life Insurance Company
of New York
666 Third Avenue, 9th Floor
New York, NY 10017
Phone: 888 265.5433

Electronic funds transfer (EFT) authorization for Life Insurance new business

Page 1 of 2

- Complete, sign, date and return this form to us with your application materials
- Keep a copy of the form for your records

Application information

Proposed Insured's name

•

File or application number(s) (if available)

•

Premium payment

For most products, frequencies other than annual include an additional cost. In those cases, the year's total premiums will be higher than if you paid one annual premium.

If you have a question about your product, contact your agent.

Select payment frequency:

Monthly* **Quarterly** **Semi-Annually** **Annually**

We will withdraw the scheduled premium amount based on the frequency you select.

*If you choose monthly payment frequency, you need to authorize two months of premium payment. This amount will be drafted only for the initial premium payment.

Payment amount authorized

• \$

Account information

If you do not check the initial payment selection, you must submit another form of payment to cover the initial premium payment, and we will use this electronic funds transfer for subsequent premiums only.

I want my initial payment to be made via EFT.

Note: We will draft your account when we receive your application if the Temporary Insurance Application and Agreement (TIAA) is properly completed, signed and dated. If we do not receive the TIAA, or if the TIAA is not properly completed, signed and dated, we will draft your account when we receive all delivery requirements.

Account owner name (if different from proposed insured above – see "A" below)

•

Account owner street address (see "A" below)

•

Account owner City, State, ZIP (see "A" below)

•

Financial institution name (see "B" below)

•

Bank routing number (see "C" below)

•

Checking account number (see "D" below)

•



This is an example of a personal check. A business check may be different. The circled letters show you where on the check to find the information required to process your electronic funds transfer.

The nine-character bank routing number appears between the ⑆ symbols, usually at the bottom left corner of the check.

The account number is 5-22 characters long and appears next to the ⑆ symbol at the bottom of the check and usually to the right of the bank routing number.

John Henry Dough
PH. 000-000-0000
1234 Any Street
Mycity, VA 00000

Date _____

Pay to the Order of _____ \$ _____ Dollars

★ Local Savings Bank
Mycity, VA

For _____

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊀ ㊁ ㊂ ㊃ ㊄ ㊅ ㊆ ㊇ ㊈ ㊉ ㊐ ㊑ ㊒ ㊓ ㊔ ㊕ ㊖ ㊗ ㊘ ㊙ ㊚ ㊛ ㊜ ㊝ ㊞ ㊟ ㊠ ㊡ ㊢ ㊣ ㊤ ㊥ ㊦ ㊧ ㊨ ㊩ ㊰ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺ ㊻ ㊼ ㊽ ㊾ ㊿

Electronic funds transfer (EFT) authorization
for Life Insurance new business

Page 2 of 2

Acknowledgement

By signing below, I (the policyowner) understand and accept these terms and conditions (if applicable):

- Signing the Electronic funds transfer authorization does not mean that insurance is effective. Insurance is effective only as stated in the Application for Life Insurance or in the Temporary Insurance Application Agreement (TIAA).
- We will not provide coverage if the financial institution does not honor the withdrawal, even if we receive all other requirements.
- We will initiate payment of the first premium only after:
(1) we receive the completed and signed Application – Part I and a TIAA has been properly issued; or
(2) we receive and review for proper dates and signatures the Policy Delivery and Acknowledgement form and all requirements we requested when we delivered the policy to you.
- We may issue the policy at a premium rate different from the rate for which you applied. In that case, we will give the payer advance notice of the new premium amount before we withdraw premiums, if there was a TIAA. After the first withdrawal, we will withdraw premiums on the day of the month that corresponds to the policy's effective date. The policy effective date is the date the policy owner signs the TIAA, or the Policy Delivery and Acknowledgement form.
- Coverage is effective under the TIAA only if the premium amount withdrawn equals one premium for the plan and payment frequency (two premium payments must be withdrawn if the premium frequency is monthly).
- If TIAA coverage ends as described in the TIAA's 'Stop Date,' we will return the amount withdrawn to the bank account shown on page 1.

Authorization

By signing below, I (the bank account owner) understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay your insurance premiums.
- If your financial institution does not honor a withdrawal request, we will NOT consider your premium paid.
- We have the right to end withdrawals at any time and bill you directly either quarterly or less frequently for premiums due.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.

Signatures

Signature of premium payer (*bank account owner*)

Date

X

.

Signature of policyowner (*if different from premium payer*)

Date

X

.



Insurer Name and Address:

GENWORTH LIFE INSURANCE COMPANY OF NEW YORK

666 Third Avenue, 9th Floor, New York, NY 10017
Mail to: Service Center, P.O. Box 10717, Lynchburg, VA 24506-0717

AUTHORIZATION AND INFORMED CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluid (saliva) for testing and analysis. In order to adequately perform all testing procedures, it may be necessary for you to provide more than one sample of your blood and/or oral fluid (saliva).

The consent you give by signing this form authorizes the Insurer to withdraw blood from you and/or obtain a sample of your oral fluid (saliva), and order laboratory tests. This consent for testing only pertains to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, or other physical conditions.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

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

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. If your test results are positive, you may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

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



I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing.
 My consent for testing shall be valid for six (6) months from the date of the authorized signature below.
 I voluntarily consent to provide an oral fluid (saliva) sample and/or to the withdrawal of blood from me, the testing of that oral fluid (saliva) and/or blood, and the disclosure of the test results as described.

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

 Proposed Insured (Please Print) _____
 Date of Birth

Name and address of designated recipient of other than normal test results (Designee may be a physician, yourself, or other party at your discretion):

 Signature of Proposed Insured _____
 Date
 or Other Authorized Person _____
 State of Residence

For further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services, you may call the New York Department of Health's statewide toll free

AIDS HOTLINE telephone number:
 1-800-541-AIDS