



Genworth®
Financial

LONG TERM CARE INSURANCE FORMS BOOK

New York Underwritten by Genworth Life Insurance Company

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- Rate Disclosure
- Designation of Beneficiary
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Genworth Life Insurance Company of New York
 Long Term Care Insurance Division
 Administrative Office:
 3100 Albert Lankford Drive Lynchburg, VA 24501-4948

**This is a HIPAA
 Compliant Authorization**

HEALTH INFORMATION AUTHORIZATION

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company of New York; its insurance support organizations; its affiliates and reinsurers. A copy of my application may also be attached to any policy of a co-applicant who is issued coverage as a result of the same application.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; and determine premium amounts.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to Genworth Life Insurance Company of New York at its Administrative Office, the company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Signature of Applicant A	Date Signed
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Printed Name of Applicant A

Address of Applicant A

Signature of Applicant B	Date Signed
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Printed Name of Applicant B

Address of Applicant B

COMPANY COPY (Return signed copy with the application.)

62397NY 08/31/06

Other Important Information

Producer Compensation: When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.



Genworth Life Insurance Company of New York
 Long Term Care Insurance Division
 Administrative Office:
 3100 Albert Lankford Drive Lynchburg, VA 24501-4948

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 Compliant Authorization**

HEALTH INFORMATION AUTHORIZATION

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Genworth Life Insurance Company of New York; its insurance support organizations; its affiliates and reinsurers. A copy of my application may also be attached to any policy of a co-applicant who is issued coverage as a result of the same application.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; and determine premium amounts.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to Genworth Life Insurance Company of New York at its Administrative Office, the company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Signature of Applicant A	Date Signed
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Printed Name of Applicant A

Address of Applicant A

Signature of Applicant B	Date Signed
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Printed Name of Applicant B

Address of Applicant B

APPLICANT COPY

62397NY 08/31/06

Other Important Information

Producer Compensation: When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

ACKNOWLEDGMENT OF RELEASE OF CERTAIN HEALTH RELATED INFORMATION

By signing below, I hereby acknowledge that Genworth Life Insurance Company of New York ("Company") may release, and/or make available, certain information regarding my health or medical records to the Company Sales Representative/Agent ("Representative") referenced below. I understand that the purpose of providing this information to my Representative is to better assist my Representative in the processing of my application for Long Term Care Insurance¹, including certain premium pricing and underwriting considerations.

In the event that coverage is declined, I understand that information related to the declination of coverage will be provided to my Representative, including certain medical information. I further understand that information regarding Sensitive Medical Histories will not be released or made available to my Representative. This includes, but is not limited to, HIV, alcohol or drug abuse, mental and psychiatric disorders, cognitive impairments or medical information that may be restricted by state law.

All Medical information provided to your Representative will also be provided to you, as the applicant(s) for coverage.

I hereby acknowledge that the Company may release the information described above to the Representative identified below:

Representative Name	Phone Number
Address of Representative	

In addition, I understand that:

- At any time prior to the disclosure of my health or medical records to my Representative, I may send a written notice to the Company, at the address shown below, requesting that the Company not disclose my health or medical records to my Representative.

Printed Name of Applicant	Application Date
Applicant's Signature	Today's Date

Printed Name of Applicant	Application Date
Applicant's Signature	Today's Date

Return completed form to:
Medical Records – NB
Long Term Care Insurance Division
P. O. Box 40004
Lynchburg, Virginia 24506
or fax to 800 456.8329.

¹Products underwritten by Genworth Life Insurance Company of New York



SUITABILITY STATEMENT

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG TERM CARE INSURANCE

Long Term Care Insurance – A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

You should *not* buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.

The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare – Medicare does *not* pay for most long term care.

Medicaid – Medicaid will generally pay for long term care if you have very little income and few assets. You probably should *not* buy this policy if you are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.

When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide – Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long Term Care Insurance." Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling – Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities – Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

ADDITIONAL INFORMATION TO HELP YOU WITH THE LONG TERM CARE INSURANCE PERSONAL WORKSHEET

As part of your application for long term care insurance, your state long term care insurance regulations require that we ask you to provide us with documentation that would demonstrate the purchase of this insurance is appropriate in relation to your financial resources.

The inclusion of your financial information in this form, **the Long Term Care Insurance Personal Worksheet**, is voluntary. Your decision to provide or not provide the income and asset information will not affect your right as an individual to choose to purchase any form of insurance.

Completion of **the Long Term Care Insurance Personal Worksheet** will help you determine whether the purchase of this insurance will affect your standard of living. Again, the final choice to purchase or not remains with you. *Please be assured that all of your answers will be held in strictest confidence.*

As your long term care insurance provider, we have established some reasonable guidelines to help you in your considerations. If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long term care. While the purchase of long term care insurance can help you maintain your independence, help preserve your assets, and give you more freedom of choice as to nursing home or other care providers, we would advise against purchasing any policy that would create a financial hardship for you. The purchase of long term care insurance should be viewed as a commitment that may extend over many years. Your ability to pay the initial premium and renewal premiums must be taken into account in your decision to buy.

Your long term care insurance representative is well qualified to discuss **the Long Term Care Insurance Personal Worksheet** with you as well as appropriateness of your planned purchase. Thank you very much for considering us as your long term care insurance provider.

Long Term Care Insurance is underwritten by Genworth Life Insurance Company of New York.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and *ask* you to fill out the rest to help you and the company decide if you should buy this policy.

SECTION A

Premium Information

Policy Form #: 51012 Rev 51014 Rev 51015 Rev Partnership Plan
 51012F Rev 51014F Rev 51015F Rev Partnership Plan

The premium for the coverage you are considering will be: (Complete *only* the premium for the desired payment frequency.)

\$ _____ annually \$ _____ semi-annually \$ _____ quarterly \$ _____ monthly

Type of Policy Guaranteed renewable.

The Company's Right to Increase Premiums The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History The company has sold long-term care insurance since 1974 and has sold policy forms 51012 Rev, 51012F Rev, 51014 Rev, 51014F Rev, 51015 Rev and 51015F Rev since 2008. The company has not raised its rates on these policy forms in this or any other state, but in the past 10 years it has raised its rates on similar policy forms that are no longer available for sale. *Following is a summary of the rate increases:*

Policy Form Series - Not every policy form series was available in every state	Years Available for sale	Percentage of Increase ¹	Effective Year ²
6465, 6026, 6318, 6322, 6328, 6394, 6395	1974-1989	0-8%	2007-2013
6484, 6667, 7003, 7012, 7021, 50000, 50001, 50003, 50004, 50013, 50018, 50020, 50021, 50022, 50023, 50024, 50029, 50100, 50107, 51000	1988-1998	0-9%	2007-2013
7000, 7002, 7011, 7020, 7022, 50024, 50027, 50109, 50110, 51001, 51002	1993-1999	0-12%	2007-2013
		0-18%	2011-2013
7011, 7012, 7030, 7031, 7032, 7033, 7034, 50024, 51005, 51006, 51007	1997-2003	0-11%	2007-2013
		0-18%	2011-2013

¹Varies by state

²Future effective date reflects rate increases requested, but not yet implemented

Questions Related to Your Income

How will you pay each year's premium? From my Income From my Savings/Investments My Family will Pay

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

Yes No — *If you have not considered this possibility, please do not proceed with the application until doing so.*

SECTION B

What is your annual income? (check one)

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

How do you expect your income to change in the next 10 years? (check one) No change Increase Decrease

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

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

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

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

The national average annual cost of care in 2007 was \$74,806 (\$205 per day), but this figure varies across the country. In ten years the national average annual cost would be about \$121,851, if costs increase 5% annually.

What Elimination Period are you considering?

Number of days

Approximate cost for that period of care: \$

[\$205 (national average) X Elimination Period]

How are you planning to pay for your care during the Elimination Period? (check one)

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

Questions Related to Your Savings and Investments

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

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

How do you expect your assets to change over the next ten years? (check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET *continued***DISCLOSURE STATEMENT**

- Check one:** The answers to the preceding questions accurately describe my financial situation.
 I choose not to complete this information (in section B on the prior page), and I have signed the Verification of Financial Non-Disclosure below.

NOTE: Section A on the prior page must be completed even if you do not disclose your financial information.

Check the box to acknowledge you have read the following statement and sign below.

- (this box must be checked) I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures.
 I understand that the rates for this policy may increase in the future.

Applicant A Signature X	Printed Name	Date mm/dd/yyyy
Applicant B Signature X	Printed Name	Date mm/dd/yyyy

I explained to the applicant the importance of completing this information.

Agent's Signature X	Agent's Printed Name	Date mm/dd/yyyy
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Complete this section ONLY if your agent has advised you that this policy may not be suitable for you.

My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Applicant A Signature X	Date mm/dd/yyyy	Applicant B Signature X	Date mm/dd/yyyy
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In order for us to process your application, please return this signed statement to Genworth Life Insurance Company of New York, along with your application. The company may contact you to verify your answers.

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Worksheet - Page 3 of 3

VERIFICATION OF FINANCIAL NON-DISCLOSURE

Please check below and return this form with your signed Personal Worksheet.

- Yes, I wish to purchase this coverage. I still choose not to complete the financial information required in the **Long Term Care Insurance Personal Worksheet**. Please resume your review of my application.
 No, I have decided not to buy a policy at this time.

Applicant A Signature X	Printed Name	Date mm/dd/yyyy
Applicant B Signature X	Printed Name	Date mm/dd/yyyy

An approved policy WILL NOT BE ISSUED until the Long Term Care Insurance Personal Worksheet (and if applicable, the Verification of Financial Non-Disclosure) has been fully completed and received by the company.

Complete and submit this form with the application to:

**Genworth Life Insurance Company of New York
 Long Term Care Insurance Division
 3100 Albert Lankford Drive
 Lynchburg, Virginia 24501-4948**

LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

1. The **annual premium rate** that is applicable to you and that will be in effect until a request is made and approved for an increase is \$ _____.
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective on the next policy anniversary date.
4. **Potential Rate Revisions:** *This policy is Guaranteed Renewable.* This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

I have read the above information concerning "Potential Rate Increases."

Applicant A's Signature	Date
Applicant B's Signature	Date

Retain a copy for your records and return a signed copy with your application.

LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

1. The **annual premium rate** that is applicable to you and that will be in effect until a request is made and approved for an increase is \$ _____.
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective on the next policy anniversary date.
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- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

I have read the above information concerning "Potential Rate Increases."

Applicant A's Signature	Date
Applicant B's Signature	Date

Retain a copy for your records and return a signed copy with your application.

DESIGNATION OF BENEFICIARY

Payment will default to the estate of the deceased if no beneficiary is named, or if form is submitted incomplete. Please complete all fields for a Primary and Contingent Beneficiary. If more details are needed, please provide details in a signed and witnessed separate document.

Beneficiaries may be changed at any time unless made Irrevocable by checking here: Irrevocable

Primary Beneficiary

Name (Last, First, MI - or - Name of Trust)		Trustee Name		
DOB or Trust Date (mm-dd-yy)	Address	City	State	Zip
SSN/Tax ID	Gender	<input type="radio"/> Male <input type="radio"/> Female		Allocated (Proceeds will be split evenly amongst named beneficiaries if no allocation provided) %

Additional Beneficiary (Optional) Primary Contingent

Name (Last, First, MI - or - Name of Trust)		Trustee Name		
DOB or Trust Date (mm-dd-yy)	Address	City	State	Zip
SSN/Tax ID	Gender	<input type="radio"/> Male <input type="radio"/> Female		Allocated (Proceeds will be split evenly amongst named beneficiaries if no allocation provided) %

Signature of Applicant	Printed Name of Applicant	Date
 X		
Witness Signature	Printed Name of Witness	Date

**Submit completed form, along with application, to:
 Long Term Care Insurance Division, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948**

DESIGNATION OF BENEFICIARY

Payment will default to the estate of the deceased if no beneficiary is named, or if form is submitted incomplete. Please complete all fields for a Primary and Contingent Beneficiary. If more details are needed, please provide details in a signed and witnessed separate document.

Beneficiaries may be changed at any time unless made Irrevocable by checking here: Irrevocable

Primary Beneficiary

Name (Last, First, MI - or - Name of Trust)		Trustee Name		
DOB or Trust Date (mm-dd-yy)	Address	City	State	Zip
SSN/Tax ID	Gender <input type="radio"/> Male <input type="radio"/> Female	Allocated (Proceeds will be split evenly amongst named beneficiaries if no allocation provided) %		

Additional Beneficiary (Optional) Primary Contingent

Name (Last, First, MI - or - Name of Trust)		Trustee Name		
DOB or Trust Date (mm-dd-yy)	Address	City	State	Zip
SSN/Tax ID	Gender <input type="radio"/> Male <input type="radio"/> Female	Allocated (Proceeds will be split evenly amongst named beneficiaries if no allocation provided) %		

Signature of Applicant	Printed Name of Applicant	Date
X		
Witness Signature	Printed Name of Witness	Date

**Submit completed form, along with application, to:
Long Term Care Insurance Division, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948**

Electronic Fund Transfer (EFT) Authorization Form for LTC Insurance

1. Initial Premium modal payment with EFT for all payment modes
2. EFT renewal premium payments are required with monthly payment mode

Instructions:

- **Monthly Payment Mode: Initial & Renewal** - complete section A, B & C. For **Renewal Only**- complete sections A & C
- **All other Payment Modes for initial only:** Complete sections A, B & C. All future premiums will be billed directly
- Attach a copy of a Voided Check from your checking account
- For Shared and Two Individual Policies, please provide signatures for both applicants
- Renewal amount is equal to one modal premium

Section A:

Print Name of Proposed Insured(s) below:

*Applicant A Signature:

Date:

*Applicant B Signature:

Date:

*By signing above, I am agreeing to the terms and conditions listed on page two (2) of this form

Section B: (Initial Premium Only)

Initial Premium Amount (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required)

Applicant A:

\$, .

Applicant B: (to be used for 2 Individual policies only)

\$, .

*****TOTAL: (The Total amount below is the amount we will deduct for the initial premium.)**

\$, .

Section C: (Please complete the below required fields)

Account Holder's Name:

Street Address:

State:

Zip Code:

Name of Financial Institution:

ABA/Routing/Transit Number:

Bank Account Number:

Bank Account Holder(s) Signature:

Date:

____ / ____ / ____
 mm dd yyyy

*By signing above, I am agreeing to the terms and conditions listed on page two (2) of this form

____ / ____ / ____
 mm dd yyyy

Print Name of Agent:

Agent Signature:

Office Use Only

A R

EFT Form (cont.)

Terms & Conditions
<p>I authorize Genworth Life Insurance Company of New York (Company) its successors and/or assigns to collect the Initial Premium and renewal for monthly mode, stated above from the Bank Account described above. I understand and agree that this Authorization is subject to the following conditions:</p> <ul style="list-style-type: none"> ▪ This Authorization form must be completed in its entirety in order to be valid. ▪ Signing this Authorization does not mean that coverage is effective; coverage is effective only as stated in the application. ▪ Payment by EFT does not alter any contract issued by the company. ▪ Any refund for coverage not taken or declinations will be made directly via check, not as a credit to the Bank Account. Otherwise, refunds will be applied in accordance with applicable laws. ▪ If the EFT charge request is not honored for any reason, no further attempt to use the EFT to collect premium will be made and Conditional Insurance Agreement (CIA) will not apply. A bill will be issued for the required premium. See CIA box of this form for additional information regarding CIA. ▪ Your Bank Account will be charged for the Initial Premium promptly after receiving authorization. ▪ Any refund of the premium will NOT include reimbursements for interest, fees or other obligations that the Financial Institution company may impose. ▪ If the appropriate premium split between applicants is not indicated, the Company will determine the split in the manner most appropriate. Please note that it may affect conditional insurance coverage. ▪ For questions regarding your EFT payment, please contact us at 1-(800) 309-0047.

Conditional Insurance Agreement
<p>If you requested an Effective Date that is later than your Date of Application, the following Agreement will not apply and our underwriting decision will consider any changes in your health status which occur after the Date of Application.</p> <p>Agreement: This Agreement applies only if all of the following requirements have been satisfied:</p> <ol style="list-style-type: none"> 1. The EFT authorization is approved for at least the full three (3) months of Premium set forth in the application for insurance; and 2. Applicant(s) did not request in writing, an Effective Date that is later than the Application Date; and 3. Applicant(s) accurately answered NO to all parts of questions #1 through #5 in the application; and 4. The answers in the application accurately indicate that: <ol style="list-style-type: none"> A. Within the past 5 years applicant(s) HAD NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Convulsions, Seizures, Fainting Spells, Black Outs, Mental Illness, or Paralysis. B. Within the past 3 years applicant(s) HAD NOT: been medically advised to have surgery that has not been performed; or received home health care; or been medically advised to enter or been confined to a nursing home, assisted care facility, or other long term care facility; and 5. NO material misrepresentation or misstatement was made in the application. <p>When all of these requirements are satisfied, the applicant(s) and the Company agree that:</p> <ol style="list-style-type: none"> 1. In underwriting the application Company may conduct a telephone or personal interview to determine your health status as of the Application Date. The Company will not disapprove your application based on any change in the applicant(s) health status that occurs after the Application Date. 2. If Company approves the application, Company will provide insurance under the policy for which application was made, and the Policy will be Effective as of the Application Date. 3. If Company disapproves the application, Company will provide temporary insurance for loss which begins between the Application Date and the date the application was disapproved. The application shall be deemed disapproved if Company does not approve the application within 120 days of the Application Date. The temporary insurance will provide the same benefits and be subject to the same provision, conditions, limitations and exclusions as found in the policy for which application is being made; except that it will only pay benefits for expenses that are incurred within 180 days following the Application Date. In no event will the total of the benefits payable by Company under the temporary insurance exceed the lesser of: (a) \$10,000; and (b) the actual expenses incurred.

<p>Initial Premium Amount <u>Applicant A</u>: (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required.) Same premium amount as section "B".</p> <p style="text-align: center;">\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>	<p>Initial Premium Amount <u>Applicant B</u> - to be used for 2 individual policies only: (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required.) Same premium amount as section "B".</p> <p style="text-align: center;">\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>Signature of Agent: _____</p>	<p>Date Signed: _____</p>
<p>Print Agent's Business Address: _____</p>	

No applicant, agent, producer or representative has any power or authority to change any of the provisions of this Agreement.

Genworth Life Insurance Company of New York
Administrative Office: 3100 Albert Lankford Dr.
Lynchburg, VA 24501-4948
Phone: 1-800-456-7766

AFFIDAVIT OF DOMESTIC PARTNERSHIP

In order for domestic partners to be eligible for Couples premium rate discounts, or shared benefit plan coverage, they must satisfy the following requirements, complete this affidavit, have it notarized, and return it with their application for long term care insurance.

- The domestic partners are both 18 years of age or older and are mentally competent to consent to contract;
- The domestic partners are not married to or legally separated from anyone else;
- The domestic partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
- The domestic partners have been living together on a continuous basis prior to the date of the application for insurance;
- Neither domestic partner has been registered as a member of another domestic partnership within the last six months; and
- The domestic partners must be financially interdependent

Under oath and upon penalty of perjury, the undersigned hereby certify the above information is true and correct.

Signature of Applicant A: _____ Print Name _____

Date: _____

Signature of Applicant B: _____ Print Name _____

Date: _____

STATE OF NEW YORK)
) SS:
COUNTY OF _____)

On the ____ day of _____ in the year _____, before me, a Notary Public in and for the state of New York, personally appeared _____ and _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within Affidavit, and being duly sworn by me acknowledged to me that the contents of this Affidavit are true and correct.

Notary Public

My Commission Expires:

(SEAL)

**NOTICE TO APPLICANT(S) REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH AND THE PURCHASE OF
MULTIPLE ACCIDENT AND HEALTH POLICIES**

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Genworth Life Insurance Company of New York. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy.
2. You should be aware that the premium rate for the replacement policy may be higher than what you are paying for the existing policy that you plan to replace. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information requested on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I have reviewed the current health insurance coverage of the applicant and find that replacement and/or additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Signature of Insurance Producer, Agent, Broker, or other Representative Agent X	Type Name and Address of Insurance Producer, or other Representative of Agent or Broker.
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Signature of Applicant A X	The above "Notice to Applicant" was delivered to me on:	Date / /
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Signature of Applicant B X	The above "Notice to Applicant" was delivered to me on:	Date / /
------------------------------------------	---------------------------------------------------------	-------------

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I have reviewed the current health insurance coverage of the applicant and find that replacement and/or additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Signature of Insurance Producer, Agent, Broker, or other Representative Agent <input checked="" type="checkbox"/>	Type Name and Address of Insurance Producer, or other Representative of Agent or Broker.
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Signature of Applicant A <input checked="" type="checkbox"/>	The above "Notice to Applicant" was delivered to me on:	Date / /
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Signature of Applicant B <input checked="" type="checkbox"/>	The above "Notice to Applicant" was delivered to me on:	Date / /
----------------------------------------------------------------------------	---------------------------------------------------------	------------------

Insurance and annuity products: • **Are not** deposits. • **Are not** insured by the FDIC or any other federal government agency.
• **May** decrease in value. • **Are not** guaranteed by the bank or its affiliates.