PARTNERSHIP PLUS APPLICATION BOOKLET

LONG TERM CARE INSURANCE

Underwritten by Genworth Life Insurance Company of New York

New York

Approved under the New York State Partnership for Long Term Care

NEW YORK

PARTNERSHIP PLUS APPLICATION INSTRUCTIONS

Step 1 – Ensure basic underwriting eligibility.
Check applicant height and weight to see if they meet the Basic Eligibility Requirements in the table provided in the right-hand column.

Step 2 – Complete the *entire* application to avoid returned applications and processing delays. Do NOT use correction fluid. Cross out and initial changes.

CONDITIONAL INSURANCE AGREEMENT

A minimum of 3 months premium must be submitted with the application in order to be eligible for the Conditional Insurance Agreement. If eligible, coverage begins on the date the application is signed, unless a later effective date is requested on page A-7. For EFT payments, use the EFT authorization form.

FAMILY HISTORY PROFILE

Information obtained in Section E "Family History Profile" will not be used to decline an application or deny a Preferred Health Discount.

DISCOUNTS

Couples Discounts will be provided to applicants in one of two situations: 1) when both submit valid applications, together or within 12 months of each other, correctly answering NO to questions 1 through 5; or 2) when one submits a valid application correctly answering NO to questions 1 through 5 and his or her partner is covered under a long term care insurance policy issued by Genworth Life Insurance Company. Preferred Health Discounts are given to applicants who accurately answer NO to all parts of questions 1 through 7. See the chart below for the discount amount(s) based on discount combinations. There is a 35% maximum discount per policy. (15% preferred health; 10% couples; 15% couples issued, reduced to 10% if combined with preferred health discount.)

	TOTAL DISCOUNT APPLICANT	
	1	2
1 Applicant with Preferred Health	15%	–
2 Applicants Both Issued/Both Preferred Health	35%	35%
2 Applicants Both Issued/One Preferred Health	35%	25%
2 Applicants Both Issued/No Preferred Health	25%	25%
2 Applicants One Issued/With Preferred Health	25%	–
2 Applicants One Issued/No Preferred Health	10%	–

COUPLES

In addition to married couples, applicants who are not married but meet certain criteria may be eligible to apply for the couples discount and benefits. Please refer to the "Affidavit of Domestic Partnership" form for an explanation of the state criteria and instructions on how to access these couples' benefits.

BASIC ELIGIBILITY REQUIREMENTS

If over or under limits below, do not take the application. For diabetic or osteoporosis height/weight tables, please see the underwriting guide.

HEIGHT	WEIGHT MIN.	MAX. *Female*	MAX. *Male*
4′ 6″	71	149	157
4′ 7″	73	155	163
4′ 8″	76	160	169
4′ 9″	79	166	175
4′ 10″	82	172	182
4′ 11″	84	178	188
5′ 0″	87	184	194
5′ 1″	90	190	201
5′ 2″	93	197	208
5′ 3″	96	203	214
5′ 4″	99	210	221
5′ 5″	102	216	228
5′ 6″	106	223	235

HEIGHT	WEIGHT MIN.	MAX. *Female*	MAX. *Male*
5′ 7″	109	230	243
5′ 8″	112	237	250
5′ 9″	115	244	257
5′ 10″	119	251	265
5′ 11″	122	258	272
6′ 0″	126	265	280
6′ 1″	129	273	288
6′ 2″	133	280	296
6′ 3″	136	288	304
6′ 4″	140	296	312
6′ 5″	144	304	321
6′ 6″	147	312	329

PHONE AND IN-PERSON HEALTH INTERVIEW REQUESTS

When needed, phone and in-person health interviews will be ordered by the Home Office.

Please provide applicants with the Guide and Checklist For Your Long Term Care Insurance Application (available online or by ordering form #81707NY), which explains both interviews. Let applicants know all costs associated with the interviews are paid for by us.

The interviews include questions about daily activities and a brief cognitive exercise. The in-person health interview takes approximately 1 hour, and the phone health interview takes about 30 minutes. The Phone Cognitive Interview is a cognitive screen given over the phone which takes 15 to 20 minutes.

SUBMIT TO HOME OFFICE CHECKLIST

Use this checklist to help ensure that you send in all necessary information.

- ○ Application *(fully completed using blue or black ink. Must be received at Genworth Home Office within 30 days of the date the application was signed by the client)*
- ○ Outline of Coverage *(leave applicant(s) the Outline of Coverage)*
- ○ EFT Authorization *(if paying by this method)*
- ○ Health Information Authorization
- ○ Replacement Notice *(when required)*
- ○ Suitability form
- ○ Potential Rate Increase Disclosure Notice
- ○ State specific forms *(when required)*
- ○ Affidavit of Domestic Partnership form *(when required)*
- ○ Beneficiary Designation Form for Return of Premium rider *(when chosen; not required if beneficiary will be estate).*

Please complete the above forms, provide agent and client signatures, date all forms, and mail (with any collected premium payment made payable to):

Genworth Life Insurance Company of New York, Administrative Office
3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

MINIMUM UNDERWRITING REQUIREMENTS Pre Qualification 800 354-6892

		Doctor Visit in Last 2 Years				**No Doctor Visit in 2 Years**			
	Age	18-54	55-64	65-71	72-79	18-54	55-64	65-71	72-79
Preferred Health	Phone Cognitive Interview			x					
	Medical Records Request			x	x				
	In Person Health Interview				x			x	x
	Phone Health Interview	x*	x			x*	x		
	Prescription Drug Report	x**				x**			
Standard Health	Phone Cognitive Interview			x					
	Medical Records Request	x	x	x	x				
	In Person Health Interview				x	x	x	x	x

*Only If Unlimited Benefit Multiplier Requested   **For All Other Benefit Multipliers Requested

1. COVERAGE SELECTION

DOLLAR FOR DOLLAR 50 – INDIVIDUAL ONLY

Complete and submit only one Coverage Selection page.

APPLICANT A	**APPLICANT B**
Print Name **Age**	**Print Name** **Age**

BASIC BENEFIT SELECTIONS

Applicant A	Applicant B
Daily Maximum* $________________________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 50% of this amount.	**Daily Maximum*** $________________________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 50% of this amount.
Benefit Multiplier ○ 548 Days	**Benefit Multiplier** ○ 548 Days
Elimination Period ○ 30 days ○ 60 days	**Elimination Period** ○ 30 days ○ 60 days
Inflation Protection: The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.	**Inflation Protection:** The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.
Waiver of Premium Benefit - Coverage will include a Waiver of Premium Benefit unless rejected below. ○ Waiver of Premium Rejected	**Waiver of Premium Benefit** - Coverage will include a Waiver of Premium Benefit unless rejected below. ○ Waiver of Premium Rejected

OPTIONS/RIDERS

Applicant A	Applicant B
Nonforfeiture Benefit ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Nonforfeiture Benefit** ○ Yes ○ No Optional Benefit for which you pay an additional premium

DISCOUNTS

Applicant A	Applicant B
Eligible for Preferred Health Discount ○ Yes** ○ No	**Eligible for Preferred Health Discount** ○ Yes** ○ No

Must accurately answer* ***No *to all parts of questions 1-7. If medical history is found inconsistent with your answers, premium will be adjusted accordingly.*

Eligible for Couples Discount ○ Yes ○ No *Criteria must be met. See "Application Instructions." If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.*

Second Applicant Name ____

Second Applicant Social Security Number ____________________ *Second Applicant Existing Policy Number* ____________________

PREMIUM INFORMATION

Applicant A	Applicant B
Submitted Full Modal Premium $________________________	**Submitted Full Modal Premium** $________________________
Premium Payments ○ Standard ○ 10-Pay ○ Pay-to-65$^{\Delta}$ $^{\Delta}$*Only available for ages 55 and younger.*	**Premium Payments** ○ Standard ○ 10-Pay ○ Pay-to-65$^{\Delta}$ $^{\Delta}$*Only available for ages 55 and younger.*
Premium Payment Mode ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) ‡*Automatic draft of checking account required. Must complete EFT form.*	**Premium Payment Mode** ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) ‡*Automatic draft of checking account required. Must complete EFT form.*
Replacement Is this to replace an existing policy with us? ○ Yes ○ No	**Replacement** Is this to replace an existing policy with us? ○ Yes ○ No

Applicant A	Applicant B
MultiLife/List Bill Number	**MultiLife/List Bill Number**
List Bill: ○ Yes ○ No	**List Bill:** ○ Yes ○ No

Agent Name	**Agent Producer Code**	**State in which application is signed**

For Internal Use Cell Code
67318

2. COVERAGE SELECTION

DOLLAR FOR DOLLAR 100 – INDIVIDUAL ONLY

Complete and submit only one Coverage Selection page.

APPLICANT A		APPLICANT B	
Print Name	**Age**	**Print Name**	**Age**

BASIC BENEFIT SELECTIONS

Applicant A	Applicant B
Daily Maximum* $________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 100% of this amount.	**Daily Maximum*** $________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 100% of this amount.
Benefit Multiplier ○ 730 Days	**Benefit Multiplier** ○ 730 Days
Elimination Period ○ 30 days ○ 60 days	**Elimination Period** ○ 30 days ○ 60 days
Inflation Protection: The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.	**Inflation Protection:** The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.
Waiver of Premium Benefit - Coverage will include a Waiver of Premium Benefit unless rejected below. ○ Waiver of Premium Rejected	**Waiver of Premium Benefit** - Coverage will include a Waiver of Premium Benefit unless rejected below. ○ Waiver of Premium Rejected

OPTIONS/RIDERS

Applicant A	Applicant B
Nonforfeiture Benefit ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Nonforfeiture Benefit** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Monthly Home Care Maximums ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Monthly Home Care Maximums** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Independent, Informal and Supplementary Benefits ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Independent, Informal and Supplementary Benefits** ○ Yes ○ No Optional Benefit for which you pay an additional premium

DISCOUNTS

Applicant A	Applicant B
Eligible for Preferred Health Discount ○ Yes** ○ No	**Eligible for Preferred Health Discount** ○ Yes** ○ No

***Must accurately answer* **No** *to all parts of questions 1-7. If medical history is found inconsistent with your answers, premium will be adjusted accordingly.*

Eligible for Couples Discount ○ Yes ○ No *Criteria must be met. See "Application Instructions." If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.*

Second Applicant Name ________________________________

Second Applicant Social Security Number ________________ *Second Applicant Existing Policy Number* ________________

PREMIUM INFORMATION

Applicant A	Applicant B
Submitted Full Modal Premium $________	**Submitted Full Modal Premium** $________
Premium Payments ○ Standard ○ 10-Pay ○ Pay-to-65^Δ^ *^Δ^Only available for ages 55 and younger.*	**Premium Payments** ○ Standard ○ 10-Pay ○ Pay-to-65^Δ^ *^Δ^Only available for ages 55 and younger.*
Premium Payment Mode ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) *‡Automatic draft of checking account required. Must complete EFT form.*	**Premium Payment Mode** ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) *‡Automatic draft of checking account required. Must complete EFT form.*
Replacement Is this to replace an existing policy with us? ○ Yes ○ No	**Replacement** Is this to replace an existing policy with us? ○ Yes ○ No

MultiLife/List Bill Number	**MultiLife/List Bill Number**
List Bill: ○ Yes ○ No	**List Bill:** ○ Yes ○ No

Agent Name	Agent Producer Code	State in which application is signed

For Internal Use Cell Code
67319

3. COVERAGE SELECTION

TOTAL ASSET 50 - INDIVIDUAL ONLY

Complete and submit only one Coverage Selection page.

APPLICANT A	**APPLICANT B**
Print Name **Age**	**Print Name** **Age**

BASIC BENEFIT SELECTIONS

Applicant A	Applicant B
Daily Maximum* $______________________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 50% of this amount unless the Full Daily Maximum Benefits is purchased.	**Daily Maximum*** $______________________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 50% of this amount unless the Full Daily Maximum Benefits is purchased.
Benefit Multiplier ○ 1095 Days	**Benefit Multiplier** ○ 1095 Days
Elimination Period ○ 30 days ○ 90 days	**Elimination Period** ○ 30 days ○ 90 days
Inflation Protection: The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.	**Inflation Protection:** The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.
Waiver of Premium Benefit - Coverage will include a Waiver of Premium Benefit unless rejected below. ○ Waiver of Premium Rejected	**Waiver of Premium Benefit -** Coverage will include a Waiver of Premium Benefit unless rejected below. ○ Waiver of Premium Rejected

OPTIONS/RIDERS

Applicant A	Applicant B
Nonforfeiture Benefit ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Nonforfeiture Benefit** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Independent and Informal Care Benefit ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Independent and Informal Care Benefit** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Full Daily Maximum Benefits ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Full Daily Maximum Benefits** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Return of Premium Benefit ○ 10-Year ○ Decreasing after age 65 ○ No Optional Benefit for which you pay an additional premium	**Return of Premium Benefit** ○ 10-Year ○ Decreasing after age 65 ○ No Optional Benefit for which you pay an additional premium

Decreasing Return of Premium after age 65 only available up to age 64. Beneficiary Designation for Return of Premium Benefit is Your estate unless otherwise designated and submitted on a separate form.

Survivorship Benefit - 7-Year option is only available if a couple both apply for and are issued policies. Check only one box. ○ Yes ○ No
Optional Benefit for which you pay an additional premium

DISCOUNTS

Applicant A	Applicant B
Eligible for Preferred Health Discount ○ Yes** ○ No	**Eligible for Preferred Health Discount** ○ Yes** ○ No

***Must accurately answer* No *to all parts of questions 1-7. If medical history is found inconsistent with your answers, premium will be adjusted accordingly.*

Eligible for Couples Discount ○ Yes ○ No *Criteria must be met. See "Application Instructions." If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.*

Second Applicant Name ____

Second Applicant Social Security Number ______________________ *Second Applicant Existing Policy Number* ______________________

PREMIUM INFORMATION

Applicant A	Applicant B
Submitted Full Modal Premium $______________________	**Submitted Full Modal Premium** $______________________
Premium Payments ○ Standard ○ 10-Pay ○ Pay-to-65$^{\Delta}$ $^{\Delta}$*Only available for ages 55 and younger.*	**Premium Payments** ○ Standard ○ 10-Pay ○ Pay-to-65$^{\Delta}$ $^{\Delta}$*Only available for ages 55 and younger.*
Premium Payment Mode ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) ‡*Automatic draft of checking account required. Must complete EFT form.*	**Premium Payment Mode** ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) ‡*Automatic draft of checking account required. Must complete EFT form.*
Replacement Is this to replace an existing policy with us? ○ Yes ○ No	**Replacement** Is this to replace an existing policy with us? ○ Yes ○ No
MultiLife/List Bill Number	**MultiLife/List Bill Number**
List Bill: ○ Yes ○ No	**List Bill:** ○ Yes ○ No

Agent Name	**Agent Producer Code**	**State in which application is signed**

For Internal Use Cell Code 67320

4. COVERAGE SELECTION

TOTAL ASSET 100 - INDIVIDUAL ONLY

Complete and submit only one Coverage Selection page.

APPLICANT A		APPLICANT B	
Print Name	**Age**	**Print Name**	**Age**

BASIC BENEFIT SELECTIONS

Applicant A	Applicant B
Daily Maximum* $________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 100% of this amount.	**Daily Maximum*** $________ * Minimum is $230 in 2010. The Home Care Daily Maximum is 100% of this amount.
Benefit Multiplier ○ 1460 Days	**Benefit Multiplier** ○ 1460 Days
Elimination Period ○ 30 days ○ 90 days	**Elimination Period** ○ 30 days ○ 90 days
Inflation Protection: The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.	**Inflation Protection:** The Partnership requires the inclusion of 5% Compound Inflation Protection in all policies issued to individuals under 80 years of age. Your policy must include that protection.
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OPTIONS/RIDERS

Applicant A	Applicant B
Nonforfeiture Benefit ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Nonforfeiture Benefit** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Monthly Home Care Maximums ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Monthly Home Care Maximums** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Independent, Informal and Supplementary Benefits ○ Yes ○ No Optional Benefit for which you pay an additional premium	**Independent, Informal and Supplementary Benefits** ○ Yes ○ No Optional Benefit for which you pay an additional premium
Return of Premium Benefit ○ 10-Year ○ Decreasing after age 65 ○ No Optional Benefit for which you pay an additional premium	**Return of Premium Benefit** ○ 10-Year ○ Decreasing after age 65 ○ No Optional Benefit for which you pay an additional premium

Decreasing Return of Premium after age 65 only available up to age 64. Beneficiary Designation for Return of Premium Benefit is Your estate unless otherwise designated and submitted on a separate form.

Survivorship Benefit - 7-Year option is only available if a couple both apply for and are issued policies. Check only one box. ○ Yes ○ No
Optional Benefit for which you pay an additional premium

DISCOUNTS

Applicant A	Applicant B
Eligible for Preferred Health Discount ○ Yes** ○ No	**Eligible for Preferred Health Discount** ○ Yes** ○ No

***Must accurately answer* No *to all parts of questions 1-7. If medical history is found inconsistent with your answers, premium will be adjusted accordingly.*

Eligible for Couples Discount ○ Yes ○ No *Criteria must be met. See "Application Instructions." If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.*

Second Applicant Name ____________________

Second Applicant Social Security Number ____________________ *Second Applicant Existing Policy Number* ____________________

PREMIUM INFORMATION

Applicant A	Applicant B
Submitted Full Modal Premium $________	**Submitted Full Modal Premium** $________
Premium Payments ○ Standard ○ 10-Pay ○ Pay-to-65^Δ^ *^Δ^Only available for ages 55 and younger.*	**Premium Payments** ○ Standard ○ 10-Pay ○ Pay-to-65^Δ^ *^Δ^Only available for ages 55 and younger.*
Premium Payment Mode ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) *‡Automatic draft of checking account required. Must complete EFT form.*	**Premium Payment Mode** ○ Annual (1.0) ○ Semi-annual (.51) ○ Quarterly (.26) ○ Monthly‡ (.09) *‡Automatic draft of checking account required. Must complete EFT form.*
Replacement Is this to replace an existing policy with us? ○ Yes ○ No	**Replacement** Is this to replace an existing policy with us? ○ Yes ○ No
MultiLife/List Bill Number	**MultiLife/List Bill Number**
List Bill: ○ Yes ○ No	**List Bill:** ○ Yes ○ No

Agent Name	Agent Producer Code	State in which application is signed

For Internal Use Cell Code	67321

APPLICATION For NYS Partnership Long Term Care Insurance

Genworth Life Insurance Company of New York
Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501

A. INSURABILITY PROFILE

Applicant A YES	Applicant A NO	Question	Applicant B YES	Applicant B NO
☐	☐	**1.** Are you covered by Medicaid (not the same as Medicare)?	☐	☐
☐	☐	**2** A. Do you use a Walker, Wheelchair or Quad Cane; Hospital Bed; Oxygen, Respirator or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair, Bathing, Dressing, Eating, Toileting, Bowel/Bladder control, or Walking?	☐	☐
☐	☐	B. Have you been advised to: receive home care, use an adult day care facility, enter a nursing home, enter an assisted care facility, or enter any other long term care facility?	☐	☐
☐	☐	**3.** To the best of your knowledge and belief, have you had, do you currently have, or have you ever been medically diagnosed as having any of the following: • ALS (Lou Gehrig's disease) • Alzheimer's Disease • Congestive Heart Failure (CHF) *in combination* with any of the following: Heart Attack or Angina; Emphysema/ Chronic Obstructive Pulmonary Disease (COPD); Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis • Cirrhosis of the Liver • Cystic Fibrosis • Dementia • Diabetes under treatment with Insulin or with a history of TIA, Heart Disease, or Circulatory/ Vascular Disease • Frequent or persistent forgetfulness or memory loss • Huntington's Chorea • Metastatic Cancer (spread from original site/location) • Multiple Sclerosis (MS) • Muscular Dystrophy • Organic Brain Syndrome • Parkinson's Disease • Senility • Stroke • Transient Ischemic Attack (TIA) within the past 5 years • TIA *in combination* with Diabetes or Heart Surgery • TIA two or more times	☐	☐
☐	☐	**4.** To the best of your knowledge and belief, in the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, or Stomach?	☐	☐
☐	☐	**5.** To the best of your knowledge and belief, have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐	☐

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION: If you answered YES to any of the questions in Part A, we suggest that you do not submit this application. If you answered NO to every question, please continue.

B. PERSONAL PROFILE

Print clearly - Use black ink

APPLICANT A

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other Title: ____________

Name ____________
(As it should appear on your policy)

☐ Married ☐ Single ☐ Widowed

Social Security Number ____________

Birthdate ________ Age ____ Birthplace (state) ________

☐ Male ☐ Female Height: ft. ____ in. ____ Weight: lbs. ____

Daytime Phone ( ) ____________

Evening Phone ( ) ____________

Best time to call ____________ ☐ a.m. ☐ p.m.

APPLICANT B

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other Title: ____________

Name ____________
(As it should appear on your policy)

☐ Married ☐ Single ☐ Widowed

Social Security Number ____________

Birthdate ________ Age ____ Birthplace (state) ________

☐ Male ☐ Female Height: ft. ____ in. ____ Weight: lbs. ____

Daytime Phone ( ) ____________

Evening Phone ( ) ____________

Best time to call ____________ ☐ a.m. ☐ p.m.

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

City ____________ State ________ Zip ________

Mailing Address (if different) ____________

City ____________ State ________ Zip ________

Print Name of Applicant A ____________________ Print Name of Applicant B ____________________

C. MEDICAL PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	**6**. To the best of your knowledge and belief, in the past 5 years (10 years for cancer) have you: received medical advice or treatment; been medically diagnosed; or consulted with a health professional for any of the following conditions? If 'YES,' please check appropriate boxes for ***each applicant (A and B)*** and explain under the DETAILS section**.**	☐	☐

A	Condition	B	A	Condition	B	A	Condition	B
☐	Alcoholism	☐	☐	Epilepsy, Seizures, or Convulsions	☐	☐	Myasthenia Gravis	☐
☐	Amputation	☐	☐	Fainting Spells or Blacking Out	☐	☐	Organ Transplant	☐
☐	Angioplasty or Heart Surgery	☐	☐	Fibromyalgia	☐	☐	Osteoporosis	☐
☐	Asthma or Chronic Bronchitis	☐	☐	Heart Attack, Angina or Atrial Fibrillation	☐	☐	Post-Polio Syndrome	☐
☐	Brain Disorder	☐	☐	Hodgkin's Disease	☐	☐	Paralysis	☐
☐	Cancer (excl. Basal Cell of the Skin)	☐	☐	Immune System Disorders	☐	☐	Rheumatoid Arthritis	☐
☐	Carotid or other Arterial Surgery	☐	☐	Injury due to Falls or Imbalance	☐	☐	Scleroderma	☐
☐	Congestive Heart Failure	☐	☐	Joint Replacement Surgery	☐	☐	Skin Ulcers	☐
☐	CREST Syndrome	☐	☐	Kidney Failure	☐	☐	Tremor	☐
☐	Depression	☐	☐	Leukemia	☐	☐	Other Conditions Causing Crippling or Limited Motion, or Requiring Adaptive Devices	☐
☐	Diabetes not treated with Insulin	☐	☐	Lupus	☐			
☐	Disabling Back or Spine Condition	☐	☐	Mental Illness	☐			
☐	Drug Addiction	☐	☐	Mental Retardation	☐			
☐	Emphysema/COPD	☐	☐	Multiple Myeloma	☐			

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

Applicant A YES	Applicant A NO	**7**. Within the past 5 years, have you:	Applicant B YES	Applicant B NO
☐	☐	A. Smoked or used other tobacco products?	☐	☐
☐	☐	B. Required assistance with managing medications, shopping, using transportation, or housekeeping/cooking? *If YES* to any, please explain.	☐	☐

Applicant A	Applicant B	Type of assistance	Reason
☐	☐		
☐	☐		

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	C. Received home health care; used an adult day care facility; been confined to a nursing home, assisted care facility, or other long term care facility? *If YES* to any, please explain.	☐	☐

Applicant A	Applicant B	Date	Reason
☐	☐		
☐	☐		

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	D. Been medically advised to have surgery which has not been performed? *If YES*, please explain (including dates of scheduled surgeries).	☐	☐

Applicant A	Applicant B	Date	Surgery Type	Reason
☐	☐			
☐	☐			

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	E. Received Social Security Disability Insurance benefits?	☐	☐
☐	☐	F. Taken any prescription medications for High Blood Pressure and/or any form of Arthritis? *If YES*, list each medication *and why it's needed*.	☐	☐

Applicant A	Applicant B	Medication	Why needed?
☐	☐		
☐	☐		
☐	☐		
☐	☐		

Print Name of Applicant A ______________________ Print Name of Applicant B ______________________

Applicant **A** YES	NO		Applicant **B** YES	NO
		8. Within the past 2 years, have you:		
☐	☐	A. Received Disability Income, Worker's Compensation, or any state disability benefit?	☐	☐
☐	☐	B. Had another Long Term Care insurance application denied by us or any other company? *If YES*, by what company?	☐	☐

Applicant A
Company: ______________________

Applicant B
Company: ______________________

☐	☐	**9**. Within the past 3 years have you: A. Taken *any* prescription medications (not previously listed in this application)? *If YES*, list each medication *and why it's needed*.	☐	☐

Applicant A	Applicant B	Medication	Why needed?
☐	☐		
☐	☐		
☐	☐		
☐	☐		
☐	☐		

☐	☐	B. Been medically advised to enter or been confined to a hospital or other health care facility? *If YES*, please explain (including dates and reasons).	☐	☐

Applicant A	Applicant B	Date	Facility	Reason
☐	☐			
☐	☐			
☐	☐			

10A. Who is your primary care physician with most of your medical records?

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

☐	☐	B. Within the past 3 years have you consulted with or been treated by a licensed health care provider, ***other than your primary care doctor*** for any reason excluding eye doctors, podiatrists, and dentists? *If YES*, please complete the following.	☐	☐

Applicant A	Applicant B	Physician's Name	City, State	Specialty	Reasons Consulted/Treated	Date(s)
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Print Name of Applicant A ______________________ Print Name of Applicant B ______________________

D. DETAILS

Provide condition, reason consulted/treated, dates from/to, and name, address and phone # of Health Care Professional/Facility. For medications, please provide only the name and reason for taking. Include the question number for the details being provided.

Applicant A Ques.#		Applicant B Ques.#	

⚠ *If you need more room to write, use a separate signed and dated sheet, and check here:* ☐

Print Name of Applicant A ____________________ Print Name of Applicant B ____________________

E. FAMILY HISTORY PROFILE

Applicant A YES	Applicant A NO	Applicant A UNKNOWN		Applicant B YES	Applicant B NO	Applicant B UNKNOWN
☐	☐	☐	**11**A. Is your mother living?	☐	☐	☐
			B. What is your mother's current age, or her age at death?			
			C. Did/Does your mother have any of the following illnesses?			
☐	☐	☐	• Diabetes	☐	☐	☐
☐	☐	☐	• Coronary Artery Disease or any other form of Vascular Disease	☐	☐	☐
☐	☐	☐	• Alzheimer's or any other form of Dementia	☐	☐	☐
☐	☐	☐	**12**A. Is your father living?	☐	☐	☐
			B. What is your father's current age, or his age at death?			
			C. Did/Does your father have any of the following illnesses?			
☐	☐	☐	• Diabetes	☐	☐	☐
☐	☐	☐	• Coronary Artery Disease or any other form of Vascular Disease	☐	☐	☐
☐	☐	☐	• Alzheimer's or any other form of Dementia	☐	☐	☐

F. CLIENT PROFILE

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

Print Name of Applicant A ____________ Print Name of Applicant B ____________

G. OTHER COVERAGE AND REPLACEMENT

Applicant **A** YES NO | Applicant **B** YES NO

☐ ☐ **16**A. Do you have any accident and sickness, Long Term Care, Nursing Home only, Home Care only or Nursing Home and Home Care insurance policy or certificate (including health care service contract, health maintenance organization contract, or life insurance with Long Term Care coverage) in force or applied for? ☐ ☐

If YES, provide DETAILS below.

Applicant A
Company: ____________
Long Term Care? ☐No ☐Yes Daily Benefit: $ ______

Applicant B
Company: ____________
Long Term Care? ☐No ☐Yes Daily Benefit: $ ______

☐ ☐ B. If you have Long Term Care Insurance coverage with us, please list policy/certificate number(s): ☐ ☐

Applicant A
Policy/certificate number(s): ____________

Applicant B
Policy/certificate number(s): ____________

☐ ☐ C. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy/certificate in force during the last 12 months? ☐ ☐

If YES, with which company?

Applicant A
Company: ____________

Applicant B
Company: ____________

If that insurance lapsed, when did it lapse?

Applicant A
Lapse Date: ____________

Applicant B
Lapse Date: ____________

☐ ☐ D. Do you intend to replace ***any*** of your Long Term Care, Nursing Home only, Home Care only, Nursing Home and Home Care, medical, or health insurance coverage with this policy? ☐ ☐

If YES, name company being replaced:

Applicant A
Company: ____________

Applicant B
Company: ____________

Agent: *If YES*, be sure to fill out the Replacement Notice. Leave one copy with applicant; send one copy with application.

H. PROTECTION AGAINST UNINTENTIONAL LAPSE

*One of the boxes **must be** checked.*

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A

☐ I elect NOT to designate any person to receive such notice.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Applicant B (Complete whenever there is a second applicant)

☐ Same as applicant A.

☐ I elect NOT to designate any person to receive such notice.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

If selecting this option, we recommend designating someone other than a spouse or agent.

Applicant A:

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title:

Full Name ____________

Home Address ____________

City ____________ State ______ Zip ______

Phone ( ) ____________ Relationship ____________

Applicant B:

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title:

Full Name ____________

Home Address ____________

City ____________ State ______ Zip ______

Phone ( ) ____________ Relationship ____________

Print Name of Applicant A ______________________ Print Name of Applicant B ______________________

I. DECLARATIONS

No agent is authorized to: change, waive, or alter the terms and conditions of this application; accept risks; pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

AUTHORIZATION: I authorize Genworth Life Insurance Company of New York, its insurance support organizations (such as EMSI), affiliates, and any reinsurers, to obtain information as to the diagnosis, treatment or prognosis of my physical and mental condition, other coverage and any other information needed to evaluate my application for insurance. Upon presentation of this authorization, or copy of it, they may request preparation and procurement of such information or records thereof from any physician, health professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, consumer reporting agency or insurance support organization or other person or organization which has such information. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This authorization includes information about drugs, alcoholism, and mental illness. I understand, in order to complete the underwriting process, Genworth Life Insurance Company of New York may require an attending physician's statement, medical records, an underwriting assessment, or a medical examination. I agree that this authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

RECEIPT: I have received and read the Privacy Notice. When I applied for insurance under this policy to be issued by Genworth Life Insurance Company of New York, I also received the Outline of Coverage (called Disclosure Form in some states) and the applicable Shopper's or Buyer's Guide. ☐ **Yes** ☐ **No**

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

AGREEMENT: I agree that:

1) the answers contained herein are full, complete and true to the best of my knowledge and belief; and
2) this application will be part of the insurance policy for which I am applying; and
3) if I qualify, and an Initial Premium is paid, the policy will take effect on the date I sign the application, or on a date set by the Company if I request a later policy effective date.

REQUEST FOR A LATER POLICY EFFECTIVE DATE:

*Check box **only** to request your policy become effective at a date later than the date you sign this application.*

INDIVIDUAL PLANS: ☐* Applicant **A** ☐* Applicant **B**

* By checking this box I acknowledge that, if my application is approved, the effective date of my coverage will be a later date to be set by the Company. I understand that the Company will consider any changes to my health *after* the Date of this Application in their underwriting decision, and that the Initial Premium will begin as of the Effective Date set by the Company. I understand that I may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement.

X ______________________
Signature of Applicant **A**

X ______________________
Signature of Applicant **B**

If you have chosen a premium payment option of 10 year or to age 65, please note that, after the premium payment period, your policy cannot be lapsed and may never pay benefits if long term care services are never needed.

CAUTION: If your answers on this application are incorrect or untrue, Genworth Life Insurance Company of New York may have the right to deny benefits or rescind your insurance, subject to the Time Limit on Certain Defenses provision in the Policy.

Print Name of Applicant A ______________________ Print Name of Applicant B ______________________

I. DECLARATIONS (Continued)

Agent Certification: I have reviewed the current accident and health insurance coverage of the applicant(s) and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant's needs. According to the requirements of the NYS Partnership for long term care program, I also certify that: 1. I have offered the applicant(s) the opportunity to purchase either (applicants choice) the 1.5/3/50 or 2/2/100 basic policy coverages with minimum Partnership regulatory benefit levels without options for added premium, and 2. I have offered the applicant(s) a basic policy coverage with minimum Partnership regulatory benefit levels without options for added premium for the design the applicant(s) has chosen.

X ______________________
Signature of Licensed and Appointed Insurance Producer/Agent/ Representative

Applicant(s) Acknowledgment

I (We) acknowledge that I (we) have been offered (my/our choice) the 1.5/3/50 or 2/2/100 basic policy coverages with minimum Partnership regulatory benefit levels without options for added premium.

Applicant A - I do ☐ I do not ☐ (check whichever box is applicable) choose to purchase either the 1.5/3/50 or 2/2/100 (circle appropriate design if check "I do" box) basic policy coverage with minimum Partnership regulatory benefits without options for added premium.

Applicant B - I do ☐ I do not ☐ (check whichever box is applicable) choose to purchase either the 1.5/3/50 or 2/2/100 (circle appropriate design if check "I do" box) basic policy coverage with minimum Partnership regulatory benefits without options for added premium.

Complete the next area only if checked "I do not" in the immediately preceding area.

I (We) acknowledge that I (we) have been offered a basic policy coverages with minimum Partnership regulatory benefit levels without options for added premium for the design(s) I (we) chose to apply for.

Applicant A - I do ☐ I do not ☐ (check whichever box is applicable) choose to purchase a basic policy coverage with minimum Partnership regulatory benefit levels without options for added premium for the design I have chosen to apply for.

Applicant B - I do ☐ I do not ☐ (check whichever box is applicable) choose to purchase a basic policy coverage with minimum Partnership regulatory benefit levels without options for added premium for the design I have chosen to apply for.

I/We have reviewed and been given copies of the Disclosure (Outline of Coverage) and Illustration (Rate Quote). The Disclosure shows my/our daily or monthly coverage, total lifetime benefit amount, and an explanation of available inflation protection options. I/We have reviewed the graph which shows the effect of inflation protection on my daily/monthly and lifetime coverage limits. The Illustration shows the average nursing home cost of care in the Metropolitan New York City area, Upstate New York and the overall statewide average.

X ______________________
Signature of Applicant **A**

X ______________________
Signature of Applicant **B**

____
Date Signed

____
Date Signed

Print Name of Applicant A ______________________ Print Name of Applicant B ______________________

J. AGENT INFORMATION

Name of Licensed and Appointed Agent (Please print) | Street Address

Producer Code # or Soc. Sec. #/Tax ID | E-mail Address | City, State, Zip

X

Signature of Soliciting Agent | ( ) Phone No. | ( ) Fax No.

Name of Licensed and Appointed Brokerage General Agency (if applicable) | **Producer Code #** of Brokerage General Agency

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

Name of Licensed and Appointed Agent | Percentage | **Name** of Licensed and Appointed Agent | Percentage

Producer Code # or Soc. Sec. #/Tax ID | E-mail Address | **Producer Code #** or Soc. Sec. #/Tax ID | E-mail Address

K. AGENT'S REPORT

To ensure against delays in processing please provide complete details.

Applicant **A** YES	NO		Applicant **B** YES	NO
☐	☐	**1**. Did you personally interview the applicant face to face and witness his or her signature? *If NO*, give details. Applicant **A**: ______________ Applicant **B**: ______________	☐	☐
☐	☐	**2**. Did you observe any physical or mental impairments with walking or talking, or any form of tremor? *If YES*, please explain. Applicant **A**: ______________ Applicant **B**: ______________	☐	☐
		3. List other health insurance policies sold by you to the applicant. Applicant **A**: ______________ Applicant **B**: ______________		
		4. List health insurance policies sold by you to the applicant in the last five years that are no longer in force. Applicant **A**: ______________ Applicant **B**: ______________		

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—APPLICANT COPY—

L. PREMIUM RECEIPT

Genworth Life Insurance Company of New York
Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501
(Herein called "We," "Us," and "Our")

Do not pay cash or leave the payee blank.
Make check payable to: Genworth Life of New York.

RECEIPT FOR INITIAL PREMIUM: This acknowledges receipt of the initial premium to be applied in connection with your application to Us for insurance. We will return your premium payment if we do not approve your application. This receipt will be void and of no affect if your check is not payable to Genworth Life Insurance Company of New York or is not paid upon presentation.

Print Name of **Applicant A** Application Date

Print Name of **Applicant B** Application Date

$
Initial Premium (Minimum 3 months premium)

$
Initial Premium (Minimum 3 months premium)

Printed Name of Agent

Agent's Business Address (please print)

X
Signature of Agent Date Signed

( )
Phone Number

M. CONDITIONAL INSURANCE AGREEMENT

If you requested an Effective Date that is later than your Application Date, the following Agreement will not apply and Our underwriting will consider any changes in your health status which occur after the Application Date.

AGREEMENT: This Agreement applies only if all of the following requirements have been satisfied:

1. You submit your check payable to Genworth Life Insurance Company of New York for the Initial Premium set forth above; and
2. You did not request in writing, an Effective Date that is later than your Application Date; and
3. To the best of your knowledge and belief, you truthfully answered NO to all parts of questions #1 through #5 in the application; and
4. To the best of your knowledge and belief, the answers in the application truthfully indicate that:
   A. Within the past 5 years you HAD NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Epilepsy, Convulsions, Seizures, Fainting Spells, Black Outs, Mental Illness, or Paralysis.
   B. Within the past 5 years you 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.
5. Subject to the Time Limit on Certain Defenses NO material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, you and We agree that:

1. In underwriting your application We may conduct a telephone or personal interview to confirm your health status as of the Application Date. We will not disapprove your application based on any change in your health status that occurs after the Application Date. Any information obtained will be limited to the written information provided by you in your signed application form. Any changes we desire to make on the application form resulting from the telephone or personal interview must be reduced to writing and signed by you unless such changes are for administrative purposes only.
2. If We approve your application, We will provide insurance under the policy for which application was made, and the Policy will be Effective as of the Application Date.
3. If We disapprove your application, We will provide temporary insurance for loss which begins between the Application Date and the date your application is disapproved. Your application shall be deemed disapproved if We do not approve it within 120 days of the Application Date. The temporary insurance will provide the same benefits and be subject to the same provisions, 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 Us under the temporary insurance exceed the lesser of: (a) $10,000; and (b) the actual expenses incurred.

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

I understand that I may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement.

X
Signature of Applicant **A**

X
Signature of Applicant **B**

61232NY

N. PRIVACY NOTICE

Although your application is our initial source of information, we also collect information pertaining to your health history through copies of your medical records and may conduct telephone or in-person interviews.

Information regarding your insurability will be treated as confidential. Genworth Life Insurance Company of New York, its affiliates or its reinsurer(s) may collect information from the Medical Information Bureau, a non-profit organization of life insurance companies, which provides an information exchange for its members. If you apply for coverage or file a claim with another Bureau member company, the Bureau, upon request, will supply the company with information in its file. At your request, the Bureau will arrange disclosure to you of the information in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of the information, you may seek a correction in accordance with the Federal Fair Credit Reporting Act, and by contacting the Bureau at: P.O. Box 105, Essex Station, Boston, MA 02112, 1-866-692-6901.

The company, its affiliates, or its reinsurer(s) may also release information in its file to other insurance companies to whom you submit a claim, provided you have authorized them to obtain such information. Upon your written request, we will provide you with information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in our file which you believe is inaccurate, please contact us and we will advise you of the necessary procedures.

For more information about any of the above, please write to:

Genworth Life Insurance Company of New York
Administrative Office
3100 Albert Lankford Drive
Lynchburg, Virginia 24501

Genworth Life Insurance Company of New York

Administrative Office: 3100 Albert Lankford Drive
Lynchburg, Virginia 24501-4948
Phone 1-800-456-7766

Complete and Retain for Your Records

LONG TERM CARE INSURANCE
REQUIRED DISCLOSURE STATEMENT- POLICY FORMS 51015 Rev, 51015F Rev

Approved under the New York State Partnership for Long Term Care Program

NOTICE ABOUT MEDICAID ELIGIBILITY AND THE NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE: Although this Partnership policy may be used outside of New York State, the special Medicaid eligibility is available only if applied for in New York State.

FEDERAL TAX CONSEQUENCES: This Policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

CAUTION: The issuance of this long term care insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application will be attached to Your issued Policy. If Your answers fail to include all material medical information requested, We have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the company at this address: 3100 Albert Lankford Drive, Lynchburg, Virginia 24501-4948.

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

1. POLICY DESIGNATION. This is an individual Policy of insurance to be issued in the State of New York.

2. PURPOSE OF DISCLOSURE STATEMENT. This disclosure statement provides a very brief description of the important features of the Policy. You should compare this disclosure statement to disclosure statements for other policies or certificates available to You. This is not an insurance contract, but only a summary of coverage. Only the individual or group Policy contains governing contractual provisions. This means that the Policy or group Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.
Unconditional 30 Day Free Look: You have 30 days to return the policy to the company if You are not satisfied with it for any reason. All premiums paid will be returned within 30 days after return of the Policy or denial of the application.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither Genworth Life Insurance Company of New York nor its agents represent Medicare, the federal government or any state government.

5. LONG TERM CARE INSURANCE. Policies of this category are designed to provide coverage for each covered person on an expense incurred, indemnity, prepaid or other basis and provides all levels of care in a nursing home and home care benefits.

This policy is approved as providing long term care meeting requirements under the New York State Partnership for Long Term Care (the Public/Private Project to promote such insurance).

6. BENEFITS PROVIDED BY THIS POLICY.

COVERAGE SELECTION

Name of Applicant - ______________

Daily Maximum - $______________
Minimum of $230 in 2010

Benefit Multiplier ______________
1.5 or 2 or 3 or 4 Years

Lifetime Maximum - ______________

Home Care Daily Maximum - $ ______________

Elimination Period - _____ Days

Benefit Increases Mandatory 5% Compound

Waiver of Premium - ☐ Yes ☐ No

Optional Riders *For which an additional premium is charged.*

Nonforfeiture Benefit - ☐ Yes ☐ No

Monthly Home Care Maximums - ☐ Yes ☐ No (applies only to 2 and 4 year plans)

Full Daily Maximum Benefits - ☐ Yes ☐ No (applies only to 3 year plan)

Independent, Informal Care and Supplemental Benefits - ☐ Yes ☐ No (applies only to 2 and 4 year plans)

Independent and Informal Care - ☐ Yes ☐ No (applies only to 3 year plan)

7-Year Survivorship Benefit - ☐ Yes ☐ No (applies only to 3 and 4 year plans)

Return of Premium after 10 Years - ☐ Yes ☐ No (applies only to 3 and 4 year plans)

Graded Return of Premium - ☐ Yes ☐ No (applies only to 3 and 4 year plans)

BENEFIT ELIGIBILITY: For You to be eligible for the Benefits provided by this Policy We must have both:
- A Current Eligibility Certification; and
- On-going proof which demonstrates that the Covered Care You receive is needed due to Your continually being a Chronically Ill Individual.

The proof can be based on information from care providers, personal physicians and other Licensed Health Care Practitioners.

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

A *"Chronically Ill Individual"* is a person who has been certified by a Licensed Health Care Practitioner as:
- Being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- Requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

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

"Substantial Assistance" is either:
- *"Hands-on Assistance,"* which is the physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living; or
- *"Standby Assistance,"* which is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to Yourself while You are performing the Activity of Daily Living.

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

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

A *"Plan of Care"* is a written, individualized plan for care and support services for You that:
- Has been developed as a result of an assessment and incorporates any information provided by Your personal physician; and
- Has been prescribed by a Licensed Health Care Practitioner; and
- Fairly, accurately and appropriately addresses Your long term care and support service needs; and
- Specifies: (1) the type, frequency and duration of all services required to meet those needs; (2) the providers appropriate to furnish those services; and (3) an estimate of the appropriate cost of such services.

CONDITIONS: Benefits will be paid only as reimbursement for expenses incurred for care and services that:
- Are Qualified Long Term Care Services; and
- Are consistent with, and received pursuant to, Your Plan of Care as prescribed by a Licensed Health Care Practitioner; and
- Meet the requirements for payment in accordance with the Benefits, services, and all other provisions of the Policy; and
- Except as stated in the Policy's Extension of Benefits provision, are received while Your insurance under the Policy is in force. An expense, fee or charge is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

Benefit payments cease when the Lifetime Maximum is exhausted and are subject to: the Elimination Period requirements; and all other limits determined from the specific Benefits and other provisions of this Policy.

"Coverage Month" is the monthly period that begins and ends on the same day of the month as the Policy Effective Date.

"Covered Care" is only those Qualified Long Term Care Services for which the Policy pays benefits or would pay benefits in the absence of an Elimination Period.

The "*Daily Maximum*" is the combined total amount. We will pay for all expenses which are incurred on a calendar day and are covered by: the Nursing Home Benefit; the Assisted Living Benefit; the Bed Reservation Feature; and the Home Care Benefit. It is also used to determine limits for other Benefits. This amount will increase over time in accordance with any Benefit Increases that apply.

The "*Elimination Period*" is the number of days that You must receive Covered Care before benefits are payable under: the Nursing Facility Benefit; the Assisted Living Facility Benefit, the Alternate Care Benefit; the Hospice Care Benefit; the Home Care Benefit; and the Supplementary Benefits. It can be satisfied by days for which payment would otherwise be made under those Benefits. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for the Policy.

A "*Licensed Health Care Practitioner*" is any of the following who is not a family member: a physician, as defined in section 1861(r)(1) of the Social Security Act; a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury, has any appropriate State license, and is acting within the scope of that license.

The "*Lifetime Maximum*" is the maximum amount of benefits the Policy will pay. The Lifetime Maximum available reduces as benefits are paid; increases when a Benefit Increase applies; and is exhausted when there is no remaining amount available.

A "*Nurse*" is a licensed Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN).

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which: are required by a Chronically Ill Individual; and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. "Maintenance or Personal Care Services" as used in this definition means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the person is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

NURSING FACILITY BENEFIT: We will pay for expenses You incur for care and support services (including room and board, but not prescription drugs) provided by a Nursing Facility while You are confined there as a resident inpatient. This includes expenses for: private duty nursing care provided by a Nurse who is not employed by the facility; and all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that facility.

Bed Reservation Feature: We will continue to pay benefits, or give Elimination Period credit, under this Benefit for up to 20 days per Policy Year when You:
- Are temporarily absent during a stay in the Nursing Facility; and
- Are charged to reserve Your accommodations in that Nursing Facility.

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

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

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

Payment of this Benefit is subject to: the Daily Maximum; the Lifetime Maximum; and the Elimination Period.

ASSISTED LIVING FACILITY BENEFIT: We will pay for expenses You incur for care and support services (including room and board, but not prescription drugs) provided by an Assisted Living Facility while You are confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Bed Reservation Feature: If the Schedule states that this feature applies to the Assisted Living Facility Benefit, We will continue to pay benefits, or give Elimination Period credit, under this Benefit for up to 20 days per Policy Year when You:
- Are temporarily absent during a stay in the Assisted Living Facility; and
- Are charged to reserve Your accommodations in that Assisted Living Facility.

An *"Assisted Living Facility"* is a facility, (including one for people with Alzheimer's) not excluded below, and is engaged primarily in providing nursing care, maintenance or personal care, therapy services and room and board accommodations to its residents. It must also be legally operated as an Assisted Living Facility under the laws of the jurisdiction in which it is located, or it must perform all of the following:
- Provide 24 hour care and services sufficient to assist residents with needs which result from the inability to perform Activities of Daily Living or from Severe Cognitive Impairment;
- Have a minimum of 3 residents;
- Use aides trained or certified to provide maintenance or personal care consistent with any laws or regulations applicable to the provision of such care;
- Provide 24-hour supervision of residents by trained and awake staff;
- Have formal arrangements for emergency medical care;
- Maintain written records of the services provided to each resident;
- Provide residents with at least 2 meals per day; and
- Have appropriate methods and procedures for the administration of prescribed drugs where allowed by law.

Where a jurisdiction has a law and/or regulation which governs whether an entity providing Assisted Living Facility coverage is legally operating in that jurisdiction, the requirements of the law and/or regulation in that jurisdiction shall exclusively govern whether Assisted Living Facility coverage is being provided by a legally operating entity.

Excluded Places: An Assisted Living Facility is NOT any of the following:
- A hospital, rehabilitation hospital, or clinic.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.

- A Nursing Facility.
- Your Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- A substantially similar adult residence establishment or environment.

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

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

ALTERNATE CARE BENEFIT: *For hospital stays while awaiting other Covered Care.* We will pay the expenses You incur for care and support services (including room and board, but not prescription drugs) provided by a Hospital when You are:
- Confined there while awaiting the availability of services that are otherwise covered by the Nursing Facility, Assisted Living Facility, or Home Care Benefits of the Policy, but for which You are unable to obtain access; and
- Your attending physician has determined that You are in such an alternate care status.

The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in the Hospital. You must be confined there as a resident inpatient.

A "*Hospital*" is an institution that is licensed as a hospital in the jurisdiction in which it is located; and is operating within the scope of its license.

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

CARE COORDINATION SERVICES: *This is an option You may choose to use when You become a Chronically Ill Individual.* We will provide Information and Referral Services and pay for Consultation Services You receive while the Policy is in force or continued in accordance with the Policy's Extension of Benefits provision. When Consultation Services are provided by a Privileged Care Coordinator, Our payment is not limited; and will not count against the Policy's Lifetime Maximum. In all other instances the maximum amount payable under this Benefit for all expenses You incur for Consultation Services during a Policy Year is 2 times the applicable Daily Maximum; and such payments will count against the Policy's Lifetime Maximum.

"*Information and Referral Services*" consist of information concerning Policy coverage, including but not limited to coverage, benefits and the names of potential providers.

"*Consultation Services*" are the assistance and advice You receive in choosing and applying for long term care services based on Your needs. These services must be received from individuals with professional training and experience in arranging and managing long term care services. These services will generally include: determining the degree to which You are disabled; assessing the circumstances in Your residence; working with You to determine the specific services You require; and developing and suggesting a plan to address Your needs. When You choose to use the services of a Privileged Care Coordinator, he or she will:
- Provide the initial and subsequent Current Eligibility Certifications.
- Suggest a variety of formal and informal care and support service providers. This may include negotiating service and care provider rates for You; and identifying other financial resources available to meet the needs specified in Your Plan of Care.
- Help in completion of claims forms required to get payment under the Policy.
- Assist with implementing the Plan of Care by scheduling and coordinating the care and support service providers chosen by You.
- Monitor the care and support services being received. This will include periodic re-assessments to determine revisions to Your Plan of Care warranted by changing needs.

Every ***Privileged Care Coordinator*** is a Licensed Health Care Practitioner provided by Us. He or she will assist You in identifying Your long term care needs and matching those needs with available care and service providers and resources. The Privileged Care Coordinator will be a professional whose duties are to: gather objective information specific to Your circumstances; use the information gathered to help develop Your Plan of Care; and identify qualified providers that can deliver the needed care and services.

Privileged Care Coordinators are familiar with the care and service providers available in Your area. Those providers vary greatly from skilled professionals to lay caregivers, based on the degree and type of assistance needed. Privileged Care Coordinators will help identify qualified caregivers that are acceptable to You and Your family. In all cases, You are responsible for choosing the actual care and service providers to be used. If for any reason You are not satisfied with a Privileged Care Coordinator or care or service provider, You can request that an alternative be identified.

Payment for these Care Coordination Services is not subject to, and cannot be used to satisfy, the Elimination Period.

HOME CARE BENEFIT: We will pay for expenses You incur for the following care and services received while You are living at Home: (a) Adult Day Care; (b) Nurse and Therapist Services; (c) Home Health Aide or Personal Care Services; and (d) Incidental Homemaker and Chore Care. The care and services must be: (a) necessary, except when in a Hospice Care Facility, to enable You to continue to stay independent and safe at Home; and (b) provided because You alone are not able to perform them due to Your being a Chronically Ill Individual; and (c) consistent with the needs addressed in Your Plan of Care; and (d) provided by a Qualified Home Care Provider.
- ***Adult Day Care:*** This is a program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside Your Home.

- ***Nurse and Therapist Services*:** These are health care services provided in Your Home by a Nurse, or a licensed physical, occupational, respiratory or speech therapist.
- ***Home Health Aide or Personal Care Services:*** This is assistance provided in Your Home You receive from a Qualified Home Care Provider with: simple health care tasks; personal hygiene; managing medications; help in performing Activities of Daily Living; and supervision needed when You have Severe Cognitive Impairment.
- ***Incidental Homemaker and Chore Care*:** This is assistance with Homemaker and Chore Tasks that are provided in Your Home:
  - During the same Qualified Home Care Provider visit in which You receive Home Health Aide or Personal Care Services; and
  - By the same person providing Home Health Aide or Personal Care Services.
- ***Homemaker and Chore Tasks:*** This is assistance with: meal planning and preparation; doing laundry; light house cleaning (such as: vacuuming, dry mopping, dishwashing, cleaning the kitchen or bath, and changing soiled bedding); minor household repairs related to Your safety at Home (such as to handrails and safety rails, stairs or floors); taking out the garbage; and simple cleaning tasks to remove unsafe debris or dirt in Your Home. These tasks do not include any type of: residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; vehicle or equipment maintenance; or similar tasks.

Qualified Home Care Provider: This means any of the following:
- An agency that, in the jurisdiction in which care is:
  - Provided by an entity licensed and/or certified by the New York State Department of Health or agencies exempt from licensure or certification in accordance with the applicable provisions of the New York State Public Health or Social Services laws and regulations; and
  - Provided by entities licensed to provide such services in the jurisdiction where the services are rendered if the care and services are received outside of New York State.
- Any of the following who do not normally reside in Your Home and is not an Immediate Family Member:
  - A licensed Nurse; or
  - A licensed therapist.

Payment of this Benefit is subject to: the Lifetime Maximum; the Elimination Period; and the payment limits determined from the Schedule for this Benefit. No payment will be made under this Benefit for any period for which You are receiving payment under the Nursing Facility Benefit, the Hospice Care Benefit and the Assisted Living Facility Benefit.

HOSPICE CARE BENEFIT: We will pay a Benefit for each day in which You incur an expense for Hospice Care.

"Hospice Care" is services (including room and board, but not prescription drugs) that are designed to provide palliative care to You or to alleviate Your physical, emotional and spiritual discomforts because You are experiencing the last phases of life due to a terminal disease (diagnosed with six months or less to live). These services must be provided by an entity that is licensed or certified to provide Hospice Care by the State in which the service is provided.

Payment for this Benefit is subject to the Elimination Period; the Lifetime Maximum; and the payment limits determined from the Schedule for this Benefit.

RESPITE CARE BENEFIT: We will pay for Respite Care You receive:
- after You have met the Eligibility for Payment of Benefits requirements for a period of six consecutive months; and
- that otherwise qualifies under the Policy.

The six consecutive month requirement can be satisfied whether or not You have received Covered Care or satisfied the Elimination Period and needs only be satisfied once while the Policy is in force.

"Respite Care" is temporary care that is provided to You when those who normally care for You at Home need relief from helping You to perform Activities of Daily Living. Your Plan of Care must state: the name of the unpaid caregiver for whom the respite is being provided; the period of respite; and the Covered Care You will require to be replaced that was normally provided by the unpaid caregiver. Covered days of respite care need not be consecutive.

Payment of this Benefit is subject to the Lifetime Maximum; and is paid at an amount equal to the Daily Maximum per day but not for more than 14 days per Policy Year. Payment of this Benefit is not subject to, and days of Covered Care under it cannot be used to satisfy, the Elimination Period.

WAIVER OF PREMIUM BENEFIT: If the Schedule indicates that "You Have this Benefit," We will waive the premium payments for each Coverage Month that begins after You have satisfied the Elimination Period and during a period for which benefits are paid or payable under: (a) the Nursing Facility Benefit; or (b) the Assisted Living Facility Benefit; or (c) the Alternate Care Benefit; or (d) the Home Care Benefit; or (e) the Hospice Care Benefit.

This waiver will NOT apply to such benefits payable under the Respite Care Benefit.

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

If You have this Benefit, premium waiver stops when You cease to receive Covered Care during any period for which benefits are paid under the Nursing Facility Benefit, the Assisted Living Facility Benefit, the Alternate Care Benefit, the Home Care Benefit, or the Hospice Care Benefit. When Your premium waiver stops, We will give credit for any premium paid for periods during which the waiver applied, against future premiums when due. You will be required: to pay the remaining premiums due in accordance with the Policy's previous premium payment mode; and to continue to make future premium payments as they become due.

OPTIONAL NONFORFEITURE BENEFIT: *This is an optional Benefit for which an additional premium is charged.* It provides continued coverage in the event the Policy terminates (lapses) due to a default in the payment of any premium after it has been in force for at least 3 years. If the lapse occurs while this Benefit is in force, the Policy will be continued (without further premium payments) with a reduced Lifetime Maximum. The amount of the continued reduced coverage will be the greater of: the maximum benefit amount applicable, at the time of lapse, under the Nursing Facility Benefit for one month (30 days); or the total of all premiums actually paid and attributed to You for Your insurance under the Policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

OPTIONAL MONTHLY MAXIMUMS RIDER: *This is an optional rider for which an additional premium is charged. It is available only if Your Home Daily Care Maximum is 100% of the Daily Maximum.* It provides that while this Rider is in force We will pay up to 31 times the benefit otherwise payable for one day of Home Care for all expenses that are incurred during a calendar month.

OPTIONAL INDEPENDENT, INFORMAL AND SUPPLEMENTARY BENEFITS RIDER: *This is an optional rider for which an additional premium is charged and is only available with the 2 and 4 year plans.*

INDEPENDENT AND INFORMAL HOME CARE BENEFIT: Under the Home Care Benefit We will also pay for expenses You incur for care by either an Independent Provider or Informal Provider.

An *Independent Provider* is a person who provides Home Care in accordance with Your Plan of Care, does not normally reside in Your Home, is not an Immediate Family Member and is currently qualified as a certified home health care aide or certified nurse aide, or included in a government sponsored nurse aide registry.

An *Informal Provider* is a Non-Licensed/Non-Certified person who provides Home Care in accordance with Your Plan of Care and who does not normally reside in Your Home and is not an Immediate Family Member.

You will qualify for any applicable Waiver of Premium Benefit while payments are made under the terms of this Rider.

SUPPLEMENTARY BENEFITS:
CAREGIVER TRAINING COVERAGE: We will pay up to 5 times the Daily Maximum for expenses You incur for training an informal (unpaid) caregiver to care for You in Your Home. All the following conditions apply to this Benefit:

- We will not pay to train someone who will be paid to care for You.
- The training can be received while You are confined in a hospital, Nursing Facility or Assisted Living Facility (if You have that Benefit) only if it is reasonably expected that the training will make it possible for You to go Home where You can be cared for by the person receiving the training.

ADDITIONAL CARE AND SERVICES: *For expenses not otherwise covered, prior approval by Us is required.* We will pay for expenses You incur for Covered Care listed below when not specifically covered by another Benefit of the Policy if all of the following conditions are met:

- You, Your personal physician and We mutually agree that they are cost-effective alternatives to Benefits specifically available under the Policy.
- They are clearly specified in Your Plan of Care and in the written mutual agreement.
- They are for Qualified Long Term Care Services.
- They are incurred while such mutual agreement is in effect.
- They are incurred while Your insurance is in force under the Policy.

Agreement to use these alternatives will not waive any of the rights You or We have under this Policy. The agreement may be discontinued at any time without affecting Your right to the Benefits otherwise available under the Policy.

COVERED CARE. Covered Care is limited to the following:

- Additional Nursing Facility Bed Reservation and Assisted Living Facility Bed Reservation.
- Additional Respite Care.
- Additional Care Management.
- Home modifications to Your Home that will enable You to remain there after renovation or remodeling. This includes such items as:
  - Ramps to permit movement from one level of a residence to another;
  - Grab bars to assist in toileting, bathing or showering; and
  - Stair lifts for going between levels in Your Home.
- Emergency response system including the installation and any ongoing fees for any type of emergency response system to enable You to remain at Home.
- Therapeutic devices.
- Supportive/durable medical equipment.
- Specialized transportation, such as specialized transportation to and from adult day care.

Payment of these Supplementary Benefits does not qualify You for the Waiver of Premium Benefit.

Payment Limitations: No payment will be made under this Benefit for any period for which payment is made under: the Nursing Facility Benefit; or the Assisted Living Facility Benefit. Payment of this Benefit is subject to: the Lifetime Maximum; and the payment limits determined from the Schedule for this Benefit. When expenses covered under the Supplementary Benefit are used to satisfy the Elimination Period, We will count each full multiple of the then current Daily Maximum as one (1) Elimination Period day.

OPTIONAL INDEPENDENT AND INFORMAL CARE RIDER: *This is an optional rider for which an additional premium is charged and is only available with the 3 year plan.*

INDEPENDENT AND INFORMAL HOME CARE BENEFIT: Under the Home Care Benefit We will also pay for expenses You incur for care by either an Independent Provider or Informal Provider.

An *Independent Provider* is a person who provides Home Care in accordance with Your Plan of Care, does not normally reside in Your Home, is not an Immediate Family Member and is currently qualified as a certified home health care aide or certified nurse aide, or included in a government sponsored nurse aide registry.

An *Informal Provider* is a Non-Licensed/Non-Certified person who provides Home Care in accordance with Your Plan of Care and who does not normally reside in Your Home and is not an Immediate Family Member.

You will qualify for any applicable Waiver of Premium Benefit while payments are made under the terms of this Rider.

OPTIONAL FULL DAILY MAXIMUM BENEFITS RIDER: *This is an optional Benefit for which an additional premium is charged.* It provides an increase in the Home Care Daily Maximum and the Assisted Living Facility Benefit at an amount equal to the Daily Maximum of the Policy. Benefit amounts payable under the provisions of this Rider will NOT count against the Policy's Lifetime Maximum.

OPTIONAL 7-YEAR SURVIVORSHIP BENEFIT RIDER: *This is an optional rider for which an additional premium is charged.* It provides that, if a couple have been insured under this Policy, or separate policies issued by Us, for at least 7 years when one of them dies, no further premium payments will be required for this Policy if:

- The survivor is insured under this Policy; and
- Both persons continuously had long term care insurance coverage in force with Us, other than under a Nonforfeiture Benefit, on the date of the deceased person's death and for at least the prior 7 year period; and
- Both persons were a couple with coverage that included a similar 7-Year Survivorship Benefit for the entire period of concurrent coverage; and
- We receive due written proof of such death.

This waiver applies to the premium for this Policy and all attached riders in force on the date of such death.

OPTIONAL RETURN OF PREMIUM UPON DEATH BENEFIT: *A choice of two optional riders is available for an additional premium.* Each option provides a Benefit if You die while the Policy and Rider are in force. The Benefit will be paid to Your designated beneficiary. If no beneficiary is named or survives You, this Benefit will be paid to Your estate. In calculating this Benefit, premiums considered are premiums actually paid and not waived or refunded. Claims considered are claims already paid or payable.

Return of Premium Upon Death After 10 Years Benefit: This Benefit pays a Return of Premium Benefit Amount equal to the total premium paid less claims if You have been insured for 10 years when You die.

Graded Return of Premium Upon Death Benefit: This Benefit considers Your age on Your most recent Policy Anniversary Date. If You are age 65 or younger when You die, We will pay a Return of Premium Benefit Amount equal to the total premium paid less claims. If age 66 when You die, We will pay an amount equal to 90% of the premium paid less claims. Each Policy Year thereafter, the percentage of premium considered is reduced by 10%. On the Policy Anniversary Date on or next following the date You reach age 75, the rider terminates, its benefits cease, and You are no longer charged the additional premium.

Important Note About Return of Premium Benefits: Return of Premium Benefits may have tax implications for Your estate or designated beneficiary. You may wish to consult a qualified tax professional.

7. LIMITATIONS AND EXCLUSIONS.

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: A Nursing Facility or Assisted Living Facility is not covered unless it meets the applicable definition for such a facility. Your "Home" is Your primary place of residence in an area used principally for independent residential living. This could be a house, condominium, apartment, unit in a congregate care community, or similar residential environment. Your Home does not include a hospital, Nursing Facility, or Assisted Living Facility.

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

Exclusions/Exceptions and Limitations: No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- Provided by an Immediate Family Member, unless: (1) the Immediate Family Member is a regular employee of the organization that is providing the services; and (2) such organization receives payment for the services; and (3) the Immediate Family Member receives no compensation other than the normal compensation for employees in her or his job category.
- For which no charge is normally made in the absence of insurance.
- Provided outside of the United States of America, its territories and possessions.
- Provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to You or Your estate.
- Resulting, directly or indirectly, from:
  - War or act of war, whether declared or not.
  - Attempted suicide or an intentionally self-inflicted injury.
  - Your alcoholism or addiction to drugs or narcotics; but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

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

Non-Duplication: Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid under Medicare (including amounts that would be reimbursed but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid). However, this Non-Duplication provision will not disqualify an expense for Covered Care from being used to satisfy the Elimination Period.

If a National long term care program is created through public funding and that National program duplicates benefits provided by the policy, We may, based on mutual agreement between Us and the New York State Department of Insurance, implement changes in the premiums and/or benefits of the Policy. THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the cost of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. Unless You are at least 80 years of age and reject Compound Benefit Increases when You apply for the policy, Your daily and lifetime limits will increase by 5% on a compound basis. Any increases will occur on each anniversary of the policy's effective date.

Increased amounts will apply to each day benefits are payable on or after the date of the increase. If You decline Compound Benefit Increases, Your premiums will be lower. Premiums will not increase due to a change in age or the automatic benefit increases.

At the end of this Disclosure Statement is a graphic comparison of the benefit levels of a Policy that increases benefits over the Policy period with a policy that does not increase benefits.

9. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE**.** This means You have the right, subject to the terms of the Policy, to continue this Policy by paying Your premiums on time until the Lifetime Maximum is exhausted. Genworth Life Insurance Company of New York cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

10. PREMIUM. The following shows the annual premium for the base Policy and any chosen benefit options; Your premium payment mode; and the corresponding modal premium.

Annual Premium

Basic Policy with Waiver of Premium	$ ________
Basic Policy without Waiver of Premium	$ ________
Optional Riders	
Nonforfeiture -	$ ________
Monthly Home Care Maximums -	$ ________
Independent, Informal and Supplemental Benefits-	$ ________
Independent and Informal Care -	$ ________
Full Daily Maximum Benefits -	$ ________
7-Year Survivorship Benefit -	$ ________
Return of Premium Benefit -	$ ________
Subtotal Before Discounts	**$** ________
Anticipated Discounts	$ ________
Total Annual Payment Mode Premium	**$** ________

Mode Factor ____(Factor from table below)

Modal Premium **$**________

(Annual Payment Mode Premium x Factor)

Annual Total of Modal Premiums $________

(Modal Premium times 1, 2, 4 or 12)

Premium Payment Mode (Factor)

☐ Annual (1.0) ☐ Semi-annual (.51) ☐ Quarterly (.26)
☐ Monthly (.09) - requires Electronic Funds Transfer

How Long Premium Will Be Payable

☐ Lifetime ☐ 10 Years*
☐ Until the Policy Anniversary coinciding with or next following the date You reach 65 years of age.*

*Please note that if this option is chosen, after the premium payment period Your Policy cannot be lapsed and may never pay Benefits if long term care services are never needed.

Terms Under Which We Can Change Premiums: Premiums will not change due to a change in Your age or health. Subject to approval of the New York State Insurance Department, We can change premiums based on premium class; but only if We change them for all similar policies issued in the same state and on the same form as this Policy. Premium changes will only be made as of a Policy Anniversary Date. We will give You at least 45 days written notice before We change premiums.

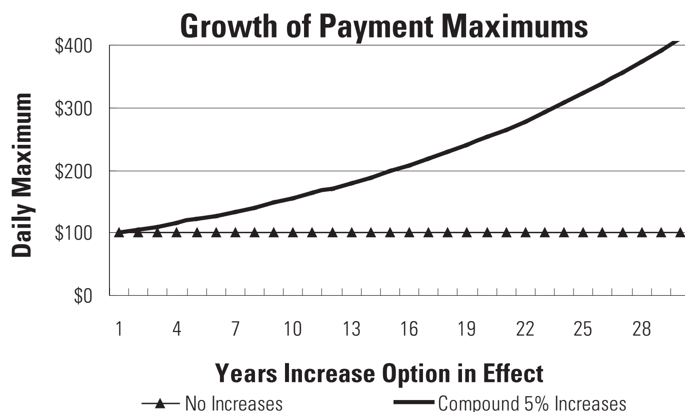
Unearned Premium Refunds: The Policy provides for the refund of unearned premium in the event it terminates due to: death; or surrender or cancellation of the Policy.

11. ADDITIONAL FEATURES. As described above, there is an optional Nonforfeiture Benefit. Applications are subject to medical underwriting; and are approved only if We are provided evidence of insurability which is satisfactory and acceptable to the company. Insurance is not available to those who are 80 years of age or older when applying.

The expected benefit ratio for this policy is 65 percent for ages 65 and older and 60 percent for ages 64 and younger. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy.

Once insurance goes into force, coverage is provided if You are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses and meet the Benefit Eligibility requirements.

Continuation for Lapse Due to Alzheimer's Disease and Other Forms of Cognitive or Functional Impairment: We will provide a retroactive continuation of coverage if the Policy terminates due to nonpayment of premiums (lapse) and within 7 months after termination We are given proof that You met the Benefit Eligibility requirements. We must receive proof of Your impairment or incapacity and all past due premiums within that 7 month period. Any benefits for which You qualified during the continuation period will be paid to the same extent they would have been paid if the Policy and its riders had remained in force from the date of termination.



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.

Genworth Life Insurance Company of New York, Administrative Offices: Richmond, Virginia

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