POLICY CHANGE FORM – PART II

Genworth Life Insurance Company
Service Center
P.O. Box 10720
Lynchburg, VA 24506-0720
888 325.5433

Genworth Life and Annuity Insurance Company
Service Center
P.O. Box 10720
Lynchburg, VA 24506-0720
888 325.5433

Policy Change forms are provided for your convenience in handling routine transactions concerning your policy. Please read and follow instructions carefully to avoid delays in processing changes. If you have any questions, contact the Company's home office or service center.

INSTRUCTIONS

- Return the policy ONLY for changes under Sections 1 and 6 (reissues).
- PRINT all fill-in information clearly and legibly to avoid errors.
- Select the applicable circle for each change.
- Sign using dark ink; black ink is preferred.
  - The owner must sign for all policy changes.
    1. If the owner is a corporation, an authorized officer must sign and indicate title.
    2. If the owner is a partnership, one general partner must sign and indicate title.
    3. If there is more than one owner, all owners must sign and indicate title.
    4. If the owner is a trust, unless the trust document specifies otherwise:
       all trustees must sign and indicate title if there are one or more trustees
       a majority of trustees must sign and indicate title if there are three or more trustees
  - In addition to the owner, the following must sign:
    1. The Insured must sign for changes that require completion of Section 8 (Evidence of Insurability).
    2. An irrevocable beneficiary must sign for policy changes under Sections 1, 2, 3, 4 and 6 (reissues).
    3. A collateral assignee must sign for changes under Sections 1, 2, 3, 4 and 6 (reissues).
    4. In community property states, you may wish to obtain the signature of the owner's spouse.
- If Section 8 (Evidence of Insurability) must be completed:
  - Complete and submit any application supplement that may be required.
  - Complete Section 7 (Replacement question).
  - Complete the Authorization to Collect and Disclose Information.
- The Insured must be given the "Notice to Insured."

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Insurer (Select one; otherwise your request will be rejected):

◯ **Genworth Life Insurance Company** ◯ **Genworth Life and Annuity Insurance Company**

INSURED: Name	Date of Birth (MM/DD/CCYY)	Social Security Number
OWNER: Name	Date of Birth (MM/DD/CCYY)	**POLICY NUMBER**
Permanent Mailing Address		Daytime Phone

I elect the following Policy Changes:

◯ **1. Conversion / Exchange**

Convert or exchange ◯ All ◯ $_____ of attached ◯ basic policy ◯ term rider.

Issue a new policy or rider as follows: Plan and amount: _____

Automatic Premium Loan Provision: If available on the new policy, provision will be in effect unless "No" is checked. ◯ No ◯ Yes

The balance of the original policy/rider is to be: ◯ continued ◯ discontinued

◯ The original policy was lost or destroyed. Issue a new policy or rider as specified above.

◯ **2. Change in Death Benefit Option, if available. Complete Section 8 for change from Option 1 to Option 2.**

◯ Change the Death Benefit Option to Option 1. ◯ Change the Death Benefit Option to Option 2. **(Complete Section 8.)**

◯ **3. Change in Amount. Complete Section 8 for Increases.**

◯ Decrease the Amount of Disability Income Monthly Benefit to: $ _____

◯ Decrease the Specified Amount or Amount of Insurance to: $ _____

◯ Increase the Specified Amount or Amount of Insurance to: $ _____ **(Complete Section 8.)**

◯ **4. Deletion or Addition of Benefits (Complete Section 8 for Addition of Benefits.)**

Delete:
◯ Waiver ◯ Accidental Death Benefit
◯ Children's Level Term Rider
◯ Disability Income Rider (see rider for restrictions)
◯ Other: _____

Add: **(Complete Section 8.)**
◯ Waiver ◯ Accidental Death Benefit
◯ Children's Level Term Rider
◯ Other: _____

◯ **5. Reinstatement (Complete Section 8.)**

Reinstate the policy. I understand that, with regard to answers given in Section 8 (Evidence of Insurability), the policy will not be contestable after it has been in force during the insured's lifetime for 2 years from the date of reinstatement except for non-payment of premium.

◯ **6. Reissue and Other Requests (Other requests such as for rate reduction.) (Outline requests below and complete Section 8.)**

◯ **7. Replacement of Existing Insurance**

Is this change to the policy intended to replace or change existing insurance or annuity in any company or society?

The Owner and Broker must answer this question: **Owner:** ◯ **Yes** ◯ **No** **Broker:** ◯ **Yes** ◯ **No**

(If "Yes," additional forms may be required for review and signature.)

Signed at (City and State)	Date (MM/DD/CCYY)
Owner (Signature)	Social Security Number/Tax I.D. #
Insured (Signature)	Other Required Signature (If applicable)

INSURED	**POLICY NUMBER**

○ 8. Evidence of Insurability of the Insured

a. Full Name	b. Date of Birth (MM/DD/CCYY)	c. Social Security Number	d. Height ft. in.	e. Weight lbs.

f. Primary Care Provider Name	g. Primary Care Provider Address

(If none, state "NONE". For the past 5 years, give dates and reasons consulted and any treatments or medications prescribed in DETAILS)

h. Medical Questions (Explain"Yes" answers in DETAILS.)

Professional health care provider (care provider) includes but is not limited to persons licensed as any of the following: physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Professional health care treatment facility (treatment facility)** includes but is not limited to : hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and facilities or offices staffed or run by care providers.

i. In the past 10 years, have you had, been treated for, or been medically advised to be treated for, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
(1) Angina	○	○	(8) Depression	○	○	(15) Lupus	○	○	(22) Seizures/Convulsions	○	○
(2) Asthma	○	○	(9) Diabetes	○	○	(16) Mental Illness	○	○	(23) Sleep Apnea	○	○
(3) Cancer	○	○	(10) Heart Disease	○	○	(17) Multiple Sclerosis	○	○	(24) Stroke	○	○
(4) Chest Pain	○	○	(11) Heart Murmur	○	○	(18) Muscular Dystophy	○	○	(25) Sugar, Protein, or		
(5) Cirrhosis	○	○	(12) Hepatitis	○	○	(19) Palpitations/Arrhythmia	○	○	Blood in Urine	○	○
(6) Clotting Disorder	○	○	(13) High Blood Pressure	○	○	(20) Peripheral Vascular Disease	○	○	(26) Suicide Attempt	○	○
(7) Chronic Lung Disorder	○	○	(14) Human Immunodeficiency Virus (HIV) Infection	○	○	(21) Rheumatoid Arthritis	○	○	(27) Tremors	○	○

DETAILS: Provide details for "Yes" answers. Identify question number and condition. Include diagnoses, dates, durations, treatments and medications prescribed, and names and addresses of all attending care providers and treatment facilities.

ii. Have you in the past 5 years: Yes No

(1) Consulted with or received treatment from a care provider or treatment facility? ..... ○ ○

(2) Had or been advised to have an EKG, X-ray, or other diagnostic test, other than an AIDS (Acquired Immune Deficiency Syndrome)-related test? ..... ○ ○

(3) Been a patient at a treatment facility? ..... ○ ○

If "Yes" to any of the above questions, provide details here and identify the question to which the response is given: _____

iii. (1) Have you ever used alcoholic beverages? ..... ○ ○

If "Yes," indicate the amount and frequency during the past 3 years: _____

(2) If "Yes," has the use ever been discontinued or reduced? ..... ○ ○

If discontinued or reduced, give date(s) and reason(s): _____

iv. Have you ever received, or been advised to receive, treatment or counseling for alcohol or drug use? ..... ○ ○

If "Yes," provide details: _____

v. (1) Have you ever used any kind of tobacco or any other product containing nicotine? ..... ○ ○

(2) If "Yes," has the use been discontinued? ..... ○ ○

If discontinued, give date(s) and reason(s): _____

8. Evidence of Insurability of the Insured – continued

i. Non-Medical History

	Yes	No
i. Have you in the past 5 years flown, or do you intend to fly, other than as: (1) as a passenger or (2) a crew member on a scheduled commercial airline? (If "Yes," complete Aviation Supplement.)	○	○
ii. Have you in the past 2 years engaged in, or do you expect to engage in: hang gliding; hot-air ballooning; ultra-light flying; mountain, rock, or ice climbing; motor vehicle or boat racing; or sky diving; scuba or skin diving; bungee jumping; or rodeo? (If "Yes," complete appropriate Hazardous Activities Supplement)	○	○
iii. In the past 5 years, have you had your driver's license suspended or had 3 or more moving violations or accidents?	○	○
iv. Do you have an application or informal inquiry for life, health or disability insurance pending with any other company, society or organization; or have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited or cancelled; or have you ever withdrawn an application or been asked to pay a higher premium?	○	○

If "Yes," provide details here, including the type of insurance applied for, the amount, and the company to whom application/inquiry is pending: _____

_____

Complete This Section Only If You Are Requesting To Reinstate a Disability Income Rider

j. Evidence of Insurability. Restricted to a Disability Income Rider lapsed within the prior 6 months.

	Yes	No
i. Are you currently disabled, have you applied for or do you plan to apply for disability benefits? If "Yes," indicate details on the disability and the benefits for which you have applied: _____	○	○
ii. Are you currently employed 30 or fewer hours per week with a different employer than indicated on your original insurance application? If "Yes," the number of hours _____ and the employer's name: _____ and address: _____	○	○
iii. Are you in a different occupation than the occupation as stated in your original application for coverage? If "Yes," state your current occupation: _____	○	○
iv. Is your current year annual gross income less than the amount stated in your original application for coverage? If "Yes," state your current annual gross income: $ _____	○	○
v. Have you in the past 5 years had surgery or received treatment from a treatment facility? If "Yes," provide details on the type of surgery or treatment, date(s), and name and address of the treatment facility: _____	○	○
vi. Have you in the past 10 years been treated for, or been medically advised to be treated for, back, neck or skeletal pain or disorder? If "Yes," complete the Back Disorder Supplement.	○	○
vii. Do you, within the next 90 days, intend to travel outside the United States? If "Yes," state the location(s): _____	○	○

I represent that the statements and answers given on this policy change form are true, complete, and correctly recorded to the best of my knowledge and belief. I understand that any change which the Insurer has the right to review and approve will not take effect unless the Insurer: (a) receives all medical information that it requests; (b) receives all premiums and any other amounts due; and (c) approves the request for policy change. I understand that any waiver of the Insurer's rights or requirements or any modification of any contract will bind the Insurer only if it is in writing and signed by the President or a duly authorized officer of the Insurer.

Signed at _____ Date _____
City and State (MM/DD/CCYY)

Owner _____ Policy Number _____
(Signature)

Insured _____
(Signature)

INSURED | **POLICY NUMBER**

Authorization to Collect and Disclose Information

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

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

Insurer Genworth Life Insurance Company, and Genworth Life and Annuity Insurance Company; as indicated on Page 1 of this form.

Authorization The Authorization is this Authorization to Collect and Disclose Information.

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

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

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

This Authorization will be valid for thirty (30) months after the date this request for policy change is signed. The Insured or an authorized representative of the Insured may ask to receive a copy of this Authorization.

Signature of Insured or other Authorized Person | Date | State where signed

NOTICE TO INSURED

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(Please detach and give to the Insured)

Insurance Information Practices

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

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, Genworth Life Insurance Company, Administrative Office, P.O. Box 461, Lynchburg, Virginia 24505-0461.

Federal Fair Credit Reporting Act

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

MIB (Medical Information Bureau) Disclosure

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is toll free (866) 692-6901 (TTY 866 346-3642 for hearing impaired); or use the website http://www.mib.com.

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

Contestability

If medical information is required in connection with a policy change, we strongly urge you to review the completed policy change form closely for accuracy. A claim may be denied or your coverage may be contested by a lawsuit if the policy change form is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy or benefit will be void and the coverage will be lost. Please be aware that fraudulent statements may involve penalties. Required fraud notices are printed on the following page.

Replacement of Existing Coverage

If you intend to replace existing coverage in connection with your policy change, tell the broker of your intention and answer "Yes" to the replacement question. State law may require that you be given information that will help you make an accurate comparison. If you are undecided about keeping existing coverage, anwer the replacement question "Yes." If you do replace existing coverage, the new benefit may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after sending your request to us **or** you borrow from an existing policy to pay premiums for the added benefit for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

FRAUD WARNINGS

ARKANSAS and LOUISIANA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE and TENNESSEE and WASHINGTON
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA
Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance 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 subjects such person to criminal and civil penalties.