



GenworthSM
Financial

APPLICATION & OUTLINE OF COVERAGE

LONG TERM CARE INSURANCE

Underwritten by
Genworth Life Insurance Company

This Application can be used for:

- ♦ one applicant applying for one policy — (USE INDIVIDUAL BENEFIT COVERAGE SELECTION PAGE)
- ♦ a couple applying for separate policies — (USE INDIVIDUAL BENEFIT COVERAGE SELECTION PAGE)

You may want to complete section **B** before sections **I** and **A**. (Any applicant answering 'YES' to any part of Section **B** is uninsurable.)

Be sure all sections of the application are *fully* completed. Incomplete applications cause delays and may be returned.

APPLICATION INSTRUCTIONS

I COVERAGE SELECTION

Preferred Health Discount of 10% is given if applicant accurately answers NO to questions 1 through 10.

Couples Discount: Applicants who are married are eligible for a 25% discount. Also eligible are partners or family members who live together and share basic living expenses and who are not married to each other or anyone else and do not belong to different generations of the same family. "Requirements to Access Special (Spousal) Benefits" form must be submitted.

Applications must be submitted together or within 12 months of each other.

If eligible for both Couples and Preferred Health Discounts, take 35% off the total premium.

Submitted Premium: One month's premium (9% of the annual premium) must be submitted with application or both application and premium will be returned.

A APPLICANT INFORMATION

Print complete applicant's name as it should appear on the policy, and provide *all* other requested information.

B INSURABILITY PROFILE

Many applicants confuse Medicaid/Medi-Cal and Medicare. Ask if they have a Medicaid/Medi-Cal card. We cannot insure those covered by Medicaid/Medi-Cal.

C MEDICAL PROFILE

If you need more room to write, use section II "Additional Notes" on page **A-b** for *Individual Benefit*.

D PERSONAL PROFILE

To help us gain a perspective on the general health and activity level of the applicant, please provide as much information as possible.

F AUTHORIZATIONS

Please ensure applicant(s) read and understand these statements, check appropriate selections, and sign and date.

G AGENT'S REPORT

This information is needed to process the application. It is **not** part of the application that is included with the issued policy.

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UNDERWRITING REQUIREMENTS

Agent: Your assistance is needed in requesting these items.

AGE	Medical Records (MRR)	Telephone Interview	In-Person Health Interview	Physician's visit within last 2 years*
< 54 and eligible for health discount. Only the application is required.				
< 54	●			
55-64 and eligible for health discount.		●		
55-71	●			
72-79	●		●	
80-84	●		●	●*

* Do not take an application from individuals 80 to 84 years of age who have not had a physician's visit in the last two years.

Note: Additional requirements may be requested at the underwriter's discretion.

MEDICAL RECORDS REQUEST (MRR) FORM

- Complete a separate MRR for the applicant's primary physician (if seen in the last two years).
- **Do not** order MRRs for: specialists, dentists, optometrists, chiropractors, ophthalmologists, dermatologists, podiatrists, or allergists.
- Obtain required applicant signature.
- Make sure all information is complete and legible.
- Fax immediately to PMSI: **1-800-876-8329**. (☑ Check 'fax box' on MRR)
- Submit original with application.

TELEPHONE AND IN-PERSON INTERVIEWS

For applicants who require either interview, you will need to:

- Complete the *Family Caring Network* Interview Assessment Request
- Fax to: **1-800-233-3783**. (☑ Check 'fax box' on request form)
- Submit original with application.

Please advise applicants of the importance of these interviews, what is required, and who will be contacting them. Separate brochures explain both interviews in detail.

In-Person Health Interview:

- Interviews are paid for by Genworth Life.

Telephone Interview:

- This is a shortened version of the In-Person Interview.
- Includes a brief cognitive exercise.
- Takes approximately 15 minutes.

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SUBMIT TO HOME OFFICE

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Application — <i>fully completed</i> | <input type="checkbox"/> A Check for Submitted Premium | <input type="checkbox"/> Suitability form |
| <input type="checkbox"/> Medical Records Request (MRR) | <input type="checkbox"/> Replacement Notice (when required) | <input type="checkbox"/> State specific forms (when required) |
| <input type="checkbox"/> Requirements to Access Special (Spousal) Benefits form (for Individual Benefit Coverage) | | |

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INDIVIDUAL BENEFIT

① COVERAGE SELECTION

Applicant A _____ Age _____
 Printed name and age: _____

Applicant B _____ Age _____
 Printed name and age: _____

Daily Payment Maximum \$ _____		Benefit Multiplier <input type="checkbox"/> Unlimited <input type="checkbox"/> 2190 <input type="checkbox"/> 1460 <input type="checkbox"/> 1095 <input type="checkbox"/> 730	
Elimination Period <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	Nonforfeiture Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	Restoration of Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	

Daily Payment Maximum \$ _____		Benefit Multiplier <input type="checkbox"/> Unlimited <input type="checkbox"/> 2190 <input type="checkbox"/> 1460 <input type="checkbox"/> 1095 <input type="checkbox"/> 730	
Elimination Period <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	Nonforfeiture Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	Restoration of Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	

Inflation Protection / Benefit Increases
 5% Compound Increases 5% Equal Increases No Increases

Inflation Protection / Benefit Increases
 5% Compound Increases 5% Equal Increases No Increases

Eligible for Preferred Health Discount Must accurately answer NO to all of questions 1 through 10.
 Yes No
 If the medical history of the applicant is found to be inconsistent with the answers to the application questions referred to in this section, the company reserves the right to adjust the premium accordingly.

Eligible for Preferred Health Discount Must accurately answer NO to all of questions 1 through 10.
 Yes No
 If the medical history of the applicant is found to be inconsistent with the answers to the application questions referred to in this section, the company reserves the right to adjust the premium accordingly.

Eligible for Couples Discount Criteria must be met. See Instructions.
 Yes No
 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.

Eligible for Couples Discount Criteria must be met. See Instructions.
 Yes No
 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.

Name: _____

Social Security Number: _____ - _____ - _____

Existing Policy Number: _____

Name: _____

Social Security Number: _____ - _____ - _____

Existing Policy Number: _____

Premium Payment Mode
 Annual Semi-Annual Quarterly Monthly *
 * Automatic draft of checking account required. Must complete EFT section.

Premium Payment Mode
 Annual Semi-Annual Quarterly Monthly *
 * Automatic draft of checking account required. Must complete EFT section.

Submitted Premium \$ _____	Replacement Is this to replace an existing policy with us? <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------------------------	--

Submitted Premium \$ _____	Replacement Is this to replace an existing policy with us? <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------------------------	--

Agent Name: _____	Agent Producer Code (Required): _____	State in which application is signed: _____	For Internal Use Cell Code: _____
			LTCL-49215

Request for an Effective Date later than the Date of Application: I hereby request that, if my application is approved, no insurance will take effect until the date set by the Company following its approval of my application. I understand that the Company's underwriting decision will consider any changes in my health status that take place after the Date of Application and that the Initial Premium will be applied as of the Effective Date set by the Company.

Signature of Applicant A _____ Signature of Applicant B _____

ELECTRONIC FUNDS TRANSFER AUTHORIZATION (EFT) Enclose a blank voided check (not a deposit slip) for the account from which deductions will be made, and a valid check for one month's premium.

I AUTHORIZE Genworth Life Insurance Company to make deductions from my bank account for payment of premiums. I understand that: (1) Genworth Life Insurance Company shall not incur any liability on a draft returned by the bank; (2) amounts not clearing after their initial deposit shall constitute non-payment of premium and coverage under the contract shall lapse subject to its provisions; and (3) each monthly deduction will occur on or after the date which coincides with the policy effective date.

Applicant A / Bank Account Holder's Name _____	Applicant B / Bank Account Holder's Name _____
X Applicant A / Bank Account Holder's Signature _____	X Applicant B / Bank Account Holder's Signature _____
_____ Date	_____ Date

INDIVIDUAL BENEFIT

Use this page only if you need more room to provide information requested in the Medical Profile.

ADDITIONAL NOTES

Print Name of Applicant A _____ Print Name of Applicant B _____

Signature of Applicant A _____ Signature of Applicant B _____

Date: _____ Date: _____

DETAILS for YES answers. Provide name of medications and name, address and phone # of prescribing physician.

Details for Applicant A
Ques.#

Details for Applicant B
Ques.#

Horizontal lines for Applicant A details.

Horizontal lines for Applicant B details.

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** _____

14. Who is the primary care doctor 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.

Phone No.

D PERSONAL PROFILE

Applicant A			Applicant B	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	15A. Do you work 20 or more hours a week outside your home? If YES, list occupation.	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A: _____		Applicant B: _____		
<input type="checkbox"/>	<input type="checkbox"/>	B. Do you perform volunteer work? If YES, list type of work and if full-time or part-time.	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A: _____ <input type="checkbox"/> full <input type="checkbox"/> part		Applicant B: _____ <input type="checkbox"/> full <input type="checkbox"/> part		
<input type="checkbox"/>	<input type="checkbox"/>	C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? If YES, please describe.	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A: _____		Applicant B: _____		
<input type="checkbox"/>	<input type="checkbox"/>	16. Do you drive an automobile? If YES, provide approximate annual mileage:	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A: _____		Applicant B: _____		
<input type="checkbox"/>	<input type="checkbox"/>	17. Are you receiving disability income, workers compensation or any state or Social Security Disability Benefits?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, explain type and cause:				
Applicant A: _____		Applicant B: _____		
<input type="checkbox"/>	<input type="checkbox"/>	18. Do you live in some form of a residential retirement community?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, list the specific services that you receive (e.g., housekeeping, laundry, meals):				
Applicant A: _____		Applicant B: _____		

E OTHER COVERAGE AND REPLACEMENT

<input type="checkbox"/>	<input type="checkbox"/>	19A. Do you have any accident and sickness or long term care insurance policy or certificate (including health care service contract, health maintenance organization contract, or life insurance based long term care coverage) in force or applied for?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, give details below.				
Applicant A		Applicant B		
Company: _____		Company: _____		
Long Term Care? <input type="checkbox"/> No <input type="checkbox"/> Yes - Daily Benefit: \$ _____		Long Term Care? <input type="checkbox"/> No <input type="checkbox"/> Yes - Daily Benefit: \$ _____		
B. If you have long term care coverage with us, please list policy/certificate number(s):				
Applicant A		Applicant B		
Policy/certificate number(s): _____		Policy/certificate number(s): _____		
<input type="checkbox"/>	<input type="checkbox"/>	C. Did you have another long term care insurance policy/certificate in force during the last 12 months? If YES, with which company?	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A		Applicant B		
Company: _____		Company: _____		
If that insurance lapsed, when did it lapse?				
Applicant A: _____		Applicant B: _____		
<input type="checkbox"/>	<input type="checkbox"/>	D. Did you have another long term care application denied during the last 12 months? If YES, with which company?	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A: _____		Applicant B: _____		

Print Name of Applicant **A** _____ Print Name of Applicant **B** _____

Applicant A YES NO		Applicant B YES NO
<input type="checkbox"/> YES <input type="checkbox"/> NO	20. Do you intend to replace <i>any</i> of your long term care, medical, or health insurance coverage with this policy? If YES, name insurer being replaced: _____ Applicant A _____ Annual Premium:\$ _____ Applicant B _____ Annual Premium:\$ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

F AUTHORIZATIONS

PROTECTION AGAINST UNINTENTIONAL LAPSE: 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. **Check only one box. If selecting this option, we recommend designating someone other than a spouse or agent.**

Applicant A Use for Individual and Shared Applications

Applicant B Use for Individual Applications Only

I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:
 Mr. Mrs. Miss Ms. Other Title:
 Full Name _____ Relationship _____
 Home Address _____
 City, State, Zip _____ Phone: (____) _____
 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:
 Mr. Mrs. Miss Ms. Other Title:
 Full Name _____ Relationship _____
 Home Address _____
 City, State, Zip _____ Phone: (____) _____
 I elect NOT to designate any person to receive such notice.

REJECTION OF COMPOUND INFLATION PROTECTION: *Check box only if you have selected no, or equal, benefit increases.*

Applicant A

Applicant B

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans offering compound, equal and no increases, and I reject 5 percent annual compound inflation protection.

Signature of Applicant: _____

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans offering compound, equal and no increases, and I reject 5 percent annual compound inflation protection.

Signature of Applicant: _____

CHECKLIST: (Check the appropriate boxes below for items received at the time of application.)

- | | | |
|---|--|--|
| <input type="checkbox"/> The Privacy Notice which I have read.
<input type="checkbox"/> The notice entitled "Things You Should Know Before You Buy Long Term Care Insurance".
<input type="checkbox"/> A Long Term Care Insurance Personal Worksheet for completion and to return to the insurer.
<input type="checkbox"/> Information on the State of California Health Insurance Counseling and Advocacy Program (HICAP) and the name, address and telephone number of the local HICAP Program and the statewide HICAP number, 1-800-434-0222. | <input type="checkbox"/> The Outline of Coverage which includes a graphic comparison of the benefit levels of a policy that increases benefits at a compound annual rate of not less than 5 percent over the policy period with a policy that does not increase benefits. The benefit levels shown in that comparison were for a period of at least 20 years.
<input type="checkbox"/> Taking Care of Tomorrow - A Consumer's Guide to Long Term Care prepared by the California Department of Aging. | <input type="checkbox"/> A copy of the Notice to Applicant Regarding Replacement of Accident and Sickness or Long Term Care Insurance if Question 20 indicates that this is a replacement.
<input type="checkbox"/> A Shopper's Guide to Long Term Care Insurance |
|---|--|--|

Signature of Applicant A: _____ Signature of Applicant B: _____

Agent Certification: I delivered the documents checked above to the applicant(s): _____ Signature of Licensed and Appointed Agent **X** _____

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, its insurance support organizations (such as PMSI), 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 obtain 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 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 and agree that the

Company or its representatives may conduct a phone or in-person interview as part of the underwriting process. 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.

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 policy for which I am applying; and 3) no insurance will take effect under the policy for which I am applying: (a) until this application is approved by the Company; (b) unless the first premium is paid; (c) prior to the effective date which is established by the Company; and (d) if an answer given to any numbered question on this application changes materially after the date this application is signed but prior to the date this application is approved by the Company.

CAUTION: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.

Signature of Applicant A X	Signature of Applicant B X
Date Signed	Date Signed

Signature of Licensed and Appointed Agent **X** _____

G AGENT'S REPORT*To ensure against delays in processing please provide complete details.*

Applicant A			Applicant B	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	1. Did you personally interview the applicant face to face and witness his or her signature? If NO, give details:	<input type="checkbox"/>	<input type="checkbox"/>
		Applicant A: _____ Applicant B: _____		
<input type="checkbox"/>	<input type="checkbox"/>	2. Did you observe any physical or mental impairments with walking or talking, or any form of tremor? If YES, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
		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: _____		

AGENT INFORMATION

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

_____ Social Security No. or Tax ID of Licensed and Appointed Agent	_____ City, State, Zip
--	---------------------------

X _____ Signature of Licensed and Appointed Agent	() _____ Phone No.	() _____ Fax No.
--	---------------------------------	-------------------------------

Email Address of Licensed and Appointed Agent

1 PREMIUM RECEIPT AND CONDITIONAL INSURANCE AGREEMENT

Genworth Life Insurance Company

Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501
(Herein called "We", "Us", and "Our")

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

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

Print Name of Applicant A	Application Date	Print Name of Applicant B	Application Date
Initial Premium (Minimum 1 month premium)	\$ _____	Initial Premium (Minimum 1 month premium)	\$ _____
Printed Name of Agent	Agent's Business Address & Phone Number (please print)		
Signature of Agent	Date Signed		
X			

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 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. You accurately answered NO to all parts of questions #1 through #5 in the application; and
4. The answers in the application accurately 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, Convulsions, Seizures, Fainting Spells, Black Outs, Mental Illness, or Paralysis.
 - B. Within the past 3 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 facility, residential care facility, or any other facility.
5. 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 determine 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.
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.

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1 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, 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 61221

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
Administrative Office
3100 Albert Lankford Drive
Lynchburg, Virginia 24501

Genworth Life Insurance Company

Name of Applicant _____

A Genworth Financial company
Administrative Office: 3100 Albert Lankford Dr.
Lynchburg, Virginia 24501
Phone 1-800-456-7766

COMPREHENSIVE LONG TERM CARE INSURANCE

OUTLINE OF COVERAGE

For Policy Form Series 7035AX

Date of Application _____

Complete and Retain
for Your Records

This policy is an approved Long-Term Care Insurance Policy under California law and regulations. However, the benefits payable by this policy will not qualify for Medi-Cal Asset Protection under the California Partnership For Long-Term Care.

For information about policies and certificates qualifying under the California Partnership For Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number, 1 (800) 434-0222.

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits.

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.

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 are misstated or untrue, the company may have the right to deny benefits or rescind your coverage. 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, VA 24501.

1. THIS IS AN INDIVIDUAL POLICY OF INSURANCE.

2. PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies 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

If you are not satisfied with the policy, you have 30 days to return it to the company. All premiums paid will be returned within 30 days after return of the policy or denial of the application. The policy contains a provision for the return of unearned premium in the event of termination due to death. It also provides for return of unearned premium upon surrender or cancellation of the policy.

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 nor its agents represent Medicare, the federal government or any state government.

5. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community or in the home. This policy reimburses you for covered long term care expenses incurred by you. It is subject to limitations, elimination periods, coinsurance and other requirements.

6. BENEFITS PROVIDED BY THIS POLICY

COVERAGE SELECTION	
Daily Payment Maximum \$ _____	Inflation Protection/ Benefit Increases <input type="checkbox"/> Compound 5% <input type="checkbox"/> Equal 5% <input type="checkbox"/> None
Elimination Period <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 Days	Nonforfeiture Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Multiplier <input type="checkbox"/> Unlimited <input type="checkbox"/> 2190 <input type="checkbox"/> 1095 <input type="checkbox"/> 1460 <input type="checkbox"/> 730	
Restoration of Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	

BENEFIT ELIGIBILITY: For you to be eligible for Benefits provided by the policy, we must receive ongoing proof, including a current eligibility certification, which demonstrates, based on information from care providers, personal physicians and other Licensed Health Care Practitioners that the covered care is needed due to you continually being qualified for Benefits.

You will be qualified to receive the services covered by this policy if:

- You are a Chronically Ill Individual; and
- The services are prescribed for you in a written Plan of Care prepared by a Licensed Health Care Practitioner.

All services covered by the policy must be Qualified Long Term Care Services.

You will be considered a "Chronically Ill Individual" while you meet one (1) of the following criteria:

- You are unable to perform, without Standby Assistance or Hands-on Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity and this loss of functional capacity is expected to last at least 90 days; or
- You have a Severe Cognitive Impairment requiring Substantial Supervision to protect you from threats to health and safety.

The certification that you are a Chronically Ill Individual must be made by a Licensed Health Care Practitioner, independent of us, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid by this policy must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner.

An "Activity of Daily Living" is one of the following: Bathing; Dressing; Eating; Continence; Toileting; and Transferring.

"Standby Assistance" is the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the Activity of Daily Living.

“Hands-on Assistance” is the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

“Severe Cognitive Impairment” means 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: short-term or long-term memory; orientation as to people, places or time; and deductive or abstract reasoning.

“Substantial Supervision” means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a person who has Severe Cognitive Impairment from threats to his or her health or safety (as may result from wandering).

CONDITIONS: Benefits will be paid only for expenses you incur for Qualified Long Term Care Services that are covered by the policy, and are received pursuant to your Plan of Care and while your insurance is in force. Benefit payments are subject to: the Elimination Period requirements; the applicable Daily Payment Maximum and Lifetime Payment Maximum; and all other provisions of the policy.

A “Plan of Care” is a written description of your needs and a specification of the type, frequency (including duration), and providers of all formal and informal long term care services required by you, and the cost, if any. The Plan of Care will be developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical supervision based on an assessment of you. The final Plan of Care must be as prescribed by a Licensed Health Care Practitioner.

The Plan of Care must be updated as your needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 30 days. We will make copies of the current Plan of Care available to your personal physician. No more than one Plan of Care may be in effect at a time.

Your Right to Request Payment for Care Not Otherwise Covered: When you meet the Benefit Eligibility provisions and Conditions, you may request payment for care or services not otherwise covered by the policy. The care and services must be Qualified Long Term Care Services. We may, at our sole discretion, determine that providing benefits for those expenses is appropriate and payable under this policy. Payment of such benefits will be subject to the same Elimination Period requirements applicable to similar care and services otherwise covered by the policy, as determined by us; and will count against the Lifetime Payment Maximum.

Examples under which we may provide benefits include, but are not limited to the following: in-home safety devices; home delivered meals; stays in other types of facilities; and additional equipment benefits.

Remember: Any payment made under these circumstances must be included in your Plan of Care and be as agreed to by us.

CARE COORDINATION BENEFITS:

This is an Optional Benefit You MAY CHOOSE TO USE. Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for:

- Certifications by a Licensed Health Care Practitioner that you meet or continue to meet the definition of a Chronically Ill Individual;
- Preparation of a written Plan of Care by a Licensed Health Care Practitioner; and

- Privileged Care Coordination Services furnished by a Privileged Care Coordinator.

Payments Do Not Count Against the Lifetime Payment Maximum: Expenses paid under this Benefit will not count against the Lifetime Payment Maximum of this policy.

No Daily Payment Maximum or Elimination Period: The Daily Payment Maximum does not apply to payments made under this Benefit. Expenses covered by this Benefit are not subject to, and may not be used to satisfy, any Elimination Period.

A “Privileged Care Coordinator” is a Licensed Health Care Practitioner designated by us to provide Privileged Care Coordination Services. The Privileged Care Coordinator will not be an employee of ours and will not be compensated in any manner that is linked to the outcome of a certification of benefit eligibility.

Privileged Care Coordination Services include, but are not limited to:

- The performance of a comprehensive individualized face-to-face assessment conducted in your place of residence.
- Developing and prescribing a Plan of Care appropriate for your condition. The Plan of Care will be a written description of your needs and a specification of the type, frequency (including duration), and providers of all formal and informal long term care services required by you, and the cost, if any.
- Providing the initial and ongoing certifications required to satisfy the Current Eligibility Certification requirements.
- Suggesting 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 identified in your Plan of Care.
- Help with the completion of claims forms required to obtain payment under this policy.
- Assistance with implementing your Plan of Care by scheduling and coordinating the care and support service providers you have chosen from those suggested by the Privileged Care Coordinator.
- Ongoing monitoring of the care and support services you are receiving. This will include periodic re-assessments to determine revisions to the Plan of Care that are warranted by changes in your care and support service needs.

A “Privileged Care Coordinator” is a Licensed Health Care Practitioner who, either alone, or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

Privileged Care Coordinators are familiar with the care and service providers available in the 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 the client and his or her 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 care or service provider, you may request that the Privileged Care Coordinator identify other providers from which to choose.

HOME CARE BENEFIT: *This is an option you MAY CHOOSE TO USE.*

This Benefit provides payment for the below listed expenses you incur other than: (a) while you are confined in a Nursing Facility; or (b) on a day for which payment is made under the Respite Care Benefit; or (c) while you are in a Residential Care Facility, in which event, the Residential Care Facility Benefit provides coverage which includes, but is not limited to, the same services covered by this Benefit.

We will pay for the following care and services that are consistent with your Plan of Care:

- Home Health Care provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist or audiologist.
- Personal Care; Homemaker Services
- Adult Day Care; and Hospice Services.

We will pay this Benefit on a monthly basis. The total amount we will pay for all such expenses you incur during a calendar month will not exceed 31 times the Daily Payment Maximum. Benefit payments count against the Lifetime Payment Maximum and are subject to the Benefit Eligibility provisions and Conditions.

No Elimination Period/Credit Towards Your Elimination

Period: Payment under this Benefit is not subject to the Elimination Period requirement. In addition, when you use a Privileged Care Coordinator, each day you incur expenses for care and support services that are covered by this Benefit will count toward satisfying your Elimination Period for other benefits that are subject to an Elimination Period.

Eligible Care and Services Definitions and Eligible

Providers: “Adult Day Care” is medical or non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting and taking medications.

Eligible Providers in California include:

- Adult Day Care Facilities, and Adult Social Day Care Facilities, which are licensed by the Department of Social Services;
- Adult Day Health Care Facilities licensed by the Department of Health Services; and
- Alzheimer Day Care Resource Centers administered by the Department of Health Services.

“Home Health Care” is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Eligible Providers of Home Health Care are state licensed home health care agencies as well as licensed or certified professionals such as nurses and therapists who are acting within the scope of their licenses.

“Personal Care” is assistance with the Activities of Daily Living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction. “Instrumental activities of daily living” include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

Eligible Providers of Personal Care are individuals, such as home health aides or personal care attendants furnished by a home health care agency or similar organization, or other skilled or unskilled persons hired within the community.

“Homemaker Services” is assistance with activities necessary to or consistent with your ability to remain in your residence, that is provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction.

Eligible Providers of Homemaker Services are individuals furnished by a home health care agency or similar organization, or other skilled or unskilled persons hired within the community.

“Hospice Services” are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical,

emotional, social and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease (6 months or less to live). This includes supportive care provided to your family and primary caregiver; but not services for which any payment is made under Medicare. Hospice Services may be provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction. No benefits will be paid for any Hospice Service for which benefits are payable under Medicare.

Eligible Providers of Hospice Services are individuals furnished by a hospice organization or hospital, or other skilled or unskilled persons hired within the community.

CAREGIVER TRAINING BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for training an informal (unpaid) caregiver to care for you in your home. All of the following conditions apply to the payment of this Benefit.

- The person receiving the training can be a relative or someone else chosen by you; but in no event will we pay for training provided to someone who will be paid to care for you.
- The training cannot be received while you are confined in a hospital, Nursing Facility or Residential Care Facility, unless 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.

Eligible Providers of caregiver training include, but are not limited to state licensed home health care agencies as well as licensed or certified professionals such as nurses and therapists.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Caregiver Training Benefit is an amount equal to five (5) times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily Payment Maximum; but does count against the Lifetime Payment Maximum.

RESPIRE CARE BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for up to 21 days of Respite Care during a calendar year. Benefit payments are subject to the Daily Payment Maximum; and count against the Lifetime Payment Maximum.

“Respite Care” is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary informal (unpaid) caregiver in the home.

Eligible Providers of Respite Care include a Nursing Facility, a Residential Care Facility, a community-based program such as a provider of Adult Day Care, a person employed by a home health care agency or a person who is qualified by training and/or experience to provide care in accordance with the Plan of Care. It is not required that the provision of Respite Care be at a level of certification or licensure greater than that required by the eligible services, or that those services be provided by Medicare-certified agencies or providers.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

SUPPORTIVE EQUIPMENT BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for the purchase or rental of Supportive Equipment when all of the following conditions are satisfied.

- The equipment must be intended to assist you in living at home or in any other residential housing (which does not include a hospital, or

a Nursing Facility) by relieving your need for direct physical assistance.

- It must be reasonably expected (as stated in your Plan of Care) that the equipment will enable you to remain at home or in any other residential housing (which does not include a hospital, a Nursing Facility or a Residential Care Facility) for at least 90 days after the date of purchase or first rental.
- The equipment must be specified in, and consistent with, your Plan of Care.

“Supportive Equipment” means items, such as the following, which meet the above conditions: pumps and other devices for intravenous injection; ramps to permit movement from one level of the residence to another; grab bars to assist in toileting; and other mechanical aids to assist you in overcoming physical impairments. It does not include either: equipment that will, other than incidentally, increase the value of the residence in which it is installed; or artificial limbs, teeth, medical supplies, or equipment placed in your body, temporarily or permanently.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Supportive Equipment Benefit is an amount equal to 50 times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily Payment Maximum; but does count against the Lifetime Payment Maximum.

RESIDENTIAL CARE FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Qualified Long Term Care Services you receive while confined in a Residential Care Facility. This includes expenses you incur for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. Benefit payments are subject to the Daily Payment Maximum; and count against the Lifetime Payment Maximum.

Eligible Providers of this care include, but are not limited to the facility in which you reside as well as those persons and other entities which provide Qualified Long Term Care Services to you while you are confined in the facility. This also includes facilities and services provided by the Residential Care Facility, care and services covered under other benefits of the policy, and any other care and services that are needed to assist you with the disabling conditions that caused you to be a Chronically Ill Individual.

A “Residential Care Facility” is a facility that is licensed as a “residential care facility” or a “residential care facility for the elderly” as defined in the Health and Safety Code of the State of California.

Outside California a “Residential Care Facility” is a facility that meets the applicable licensing standards if any, and is engaged primarily in providing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impairment in cognitive ability. It must also:

- Provide such care and services on a twenty-four hour a day basis;
- Have a trained and ready to respond employee on duty in the facility at all times to provide care and services;
- Provide 3 meals a day and accommodate special dietary needs;
- Have agreements to ensure that residents receive the medical care services of a physician or Nurse in case of an emergency;
- Have the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

It should be noted that this definition would generally NOT be met by: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug

addiction or mental illness; a Nursing Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

NURSING FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for care and support services (including room and board and ancillary supplies and services) provided by a Nursing Facility. This includes expenses you incur for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. You must be confined there as a resident inpatient. Benefit payments are subject to the Daily Payment Maximum; and they count against the Lifetime Payment Maximum.

A “Nursing Facility” is an institution which is licensed by the appropriate licensing agency to engage primarily in providing nursing care to inpatients and meets all of the following criteria:

- It provides twenty-four hour a day nursing services under policies and procedures developed with the advice of, and periodically reviewed and executed by, a professional group of at least one duly licensed physician and one Nurse.
- It has a duly licensed physician available to furnish medical care in case of emergency.
- It has at least one Nurse who is employed there full time.
- It has a Nurse on duty or on call at all times.
- It maintains clinical records for all patients.
- It has appropriate methods and procedures for handling and administering drugs and biologicals.

A Nursing Facility is NOT: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; a Residential Care Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

BED RESERVATION BENEFIT: We will continue to pay benefits, or give Elimination Period credit, under the Nursing Facility Benefit and the Residential Care Facility Benefit for each day you:

- are temporarily absent during a stay in a Nursing Facility or a Residential Care Facility; and
- are charged to reserve your accommodations in that facility.

We will do this for a total of not more than the first 50 days (continuous or not) of such absence during a Policy Year. Benefit payments are subject to the Daily Payment Maximum; and they count against the Lifetime Payment Maximum.

SURVIVORSHIP BENEFIT: When your spouse dies after this policy has been in force for at least ten years, no further premium payments will be required for this policy if:

- Both you and such spouse continuously had long term care insurance coverage in force with us, other than under a Nonforfeiture Benefit, on the date of death of the spouse and for at least the prior ten year period; and
- Such spouse’s coverage included a similar Survivorship Benefit; and
- No long term care benefits were paid or payable by us for you or such spouse during the first ten years of such concurrent coverage.

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

Payment Maximum. The amount of the continued reduced coverage will be the greater of: 90 times your Daily Payment Maximum; or the total of all premiums paid for the policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

OPTIONAL RESTORATION OF BENEFITS RIDER: This is an optional rider for which an additional premium is charged. It will restore the policy's Lifetime Payment Maximum to the amount that would have applied if no benefits had been paid under the policy. This applies whenever a period of 180 consecutive days elapses during which the policy was in force and at no time during that period did you require, or receive, either:

- Substantial Supervision to protect yourself from threats to health or safety due to Severe Cognitive Impairment; or
- Substantial Assistance necessary to meet the policy's Benefit Eligibility requirements due to a loss of functional capacity.

GENERAL DEFINITIONS: The following definitions apply:

The "Daily Payment Maximum" is the greatest amount we will pay for all expenses combined that you incur on any one day under all of the following: the Respite Care Benefit; the Nursing Facility; and the Residential Care Facility Benefit. It is also used to determine other Benefit limits. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received. This amount increases over time in accordance with any Benefit Increases that apply.

The "Elimination Period" is the number of days for which you must incur expenses that qualify for payments under the Nursing Facility Benefit and the Residential Care Facility Benefit; but for which we will NOT pay benefits. It can be satisfied either by: days for which payment would otherwise be made under the Nursing Facility or Residential Care Facility Benefits (including Bed Reservation Benefit days); or days you receive services covered under the Home Care Benefit in accordance with a Privileged Care Coordinator's Plan of Care.

Days used to satisfy the Elimination Period do not need to be consecutive. Once you have satisfied this requirement, 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 described in section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

The "Lifetime Payment Maximum" is the combined total amount we will pay as benefits under the policy. This amount is determined by multiplying the Daily Payment Maximum by the applicable Benefit Multiplier. When Benefit Increases apply, this amount increases over time. The Lifetime Payment Maximum may be used interchangeably for any Qualified Long Term Care Services covered by the policy.

A "Nurse" is someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN); and is operating within the scope of that license.

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, 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 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 the protection from threats to health and safety due to Severe Cognitive Impairment.

7. LIMITATIONS AND EXCLUSIONS

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: If an institution has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a covered facility only if it meets the criteria in the definition of such a facility; is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and is engaged principally in providing not only room and board, but also care and services which meet all of those criteria.

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: Benefits are not payable for care, stays, or other items: (a) provided by a family member; (b) when no charge is normally made in the absence of insurance; (c) provided outside of the U.S.A. or its territories or possessions; (d) provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to you or your estate; (e) resulting from war or act of war; (f) resulting from an attempted suicide or an intentionally self-inflicted injury; or (g) for alcoholism and drug addiction; unless it has occurred as a result of the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

Note: Mental illness and Alzheimer's disease are covered, subject to the same exclusions, limitations and provisions applicable to other conditions.

Non-Duplication: Benefits will be paid only for covered expenses that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care plan or law (except Medicaid).

We will consider, for the purposes of satisfying an Elimination Period, days on which you incur expenses that would otherwise qualify as satisfying your Elimination Period, but are excluded from coverage because benefits are paid or payable under governmental health care plans or laws as stated above.

Actions in the Event of a Public Funded National or State Plan:

If a non-Medicaid/Medi-Cal national or state long term care program created through public funding substantially duplicates benefits provided by this policy, we will implement one of the following actions based on mutual agreement between us and the California Department of Insurance.

- We will reduce your future premium payments; or
- We will increase future benefits.

The amount of premium reductions and future benefit increases to be made by us will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and our claims experience. Our premium reduction and benefit increase plans will first be filed with and approved by the California Department of Insurance.

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. You may choose from two options at the time of application that will increase your benefits every year. *Equal*

Increases means the daily and lifetime limits will increase by 5% of their original amounts; and *Compound Increases* means the daily and lifetime limits will increase by 5% of the most recent amounts.

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 do not purchase such a Benefit Increase option, you will need to provide satisfactory evidence of insurability to later increase coverage. If you elect a Benefit Increase, premiums will be higher; but they will not increase due to a change in age or the automatic benefit increases. Below 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. A similar graphic comparison illustrates premiums for those types of policies.

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 as long as you pay your premiums on time. Genworth Life Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

The policy includes a Waiver of Premium for premiums that become due: while continuing benefits are payable under the Residential Care Facility, Nursing Facility or Bed Reservation Benefits; and when continued Home Care Benefits are payable in accordance with a Plan of Care from a Privileged Care Coordinator.

Premiums can be changed based on your premium class; but only if they are changed for all similar policies issued in your state on the same policy form.

10. ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND OTHER BRAIN DISORDERS

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.

11. PREMIUM

The table below shows the annual premium for the policy and any options you have chosen. It also shows your premium payment mode and the corresponding modal premium.

Eligible for Preferred Discount <input type="checkbox"/> Yes <input type="checkbox"/> No	Basic Policy: \$
	Nonforfeiture Benefit: \$
Eligible for Spousal Discount <input type="checkbox"/> Yes <input type="checkbox"/> No	Restoration of Benefits: \$
	Total of Above: \$
Premium Payment Mode (Adjustment Factor) <input type="checkbox"/> Annual (1.0) <input type="checkbox"/> Semi-Annual (.51) <input type="checkbox"/> Quarterly (.26) <input type="checkbox"/> Monthly (.09) - requires Electronic Funds Transfer	Total Discount: \$
	Total Annual Premium: \$
	Modal Premium: \$
	(Annual x mode factor)

12. ADDITIONAL FEATURES

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 85 years of age or older when applying.

Continuation for Lapse Due to Alzheimer's Disease, Organic Disorders 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 for any other reason. 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.

13. INFORMATION AND COUNSELING

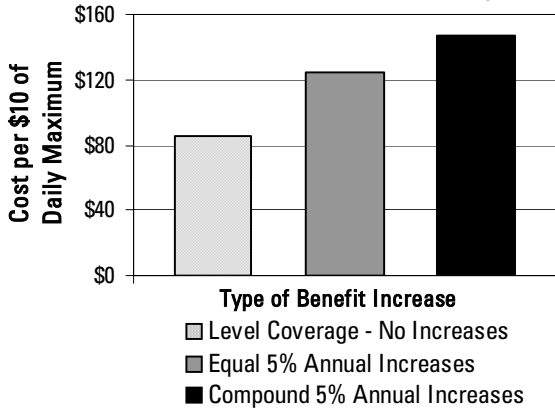
The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.

Local HICAP Office: _____
Agency Name

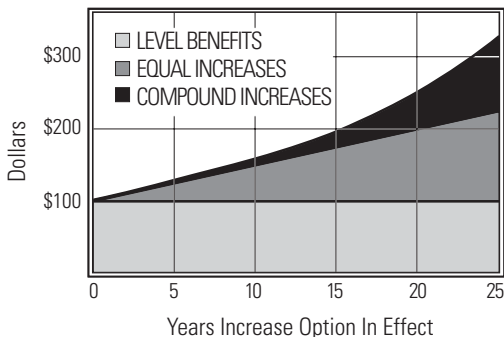
Agency Address

Agency Phone Number

Relative Premium Cost - Issue Age 65



Growth of Payment Maximums Over Time



Genworth Life Insurance Company

Name of Applicant _____

A Genworth Financial company
Administrative Office: 3100 Albert Lankford Dr.
Lynchburg, Virginia 24501
Phone 1-800-456-7766

COMPREHENSIVE LONG TERM CARE INSURANCE

OUTLINE OF COVERAGE

For Policy Form Series 7035AX

Date of Application _____

Complete and Retain
for Your Records

This policy is an approved Long-Term Care Insurance Policy under California law and regulations. However, the benefits payable by this policy will not qualify for Medi-Cal Asset Protection under the California Partnership For Long-Term Care.

For information about policies and certificates qualifying under the California Partnership For Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number, 1 (800) 434-0222.

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits.

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.

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 are misstated or untrue, the company may have the right to deny benefits or rescind your coverage. 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, VA 24501.

1. THIS IS AN INDIVIDUAL POLICY OF INSURANCE.

2. PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies 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

If you are not satisfied with the policy, you have 30 days to return it to the company. All premiums paid will be returned within 30 days after return of the policy or denial of the application. The policy contains a provision for the return of unearned premium in the event of termination due to death. It also provides for return of unearned premium upon surrender or cancellation of the policy.

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 nor its agents represent Medicare, the federal government or any state government.

5. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community or in the home. This policy reimburses you for covered long term care expenses incurred by you. It is subject to limitations, elimination periods, coinsurance and other requirements.

6. BENEFITS PROVIDED BY THIS POLICY

COVERAGE SELECTION	
Daily Payment Maximum \$ _____	Inflation Protection/ Benefit Increases <input type="checkbox"/> Compound 5% <input type="checkbox"/> Equal 5% <input type="checkbox"/> None
Elimination Period <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 Days	Nonforfeiture Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Multiplier <input type="checkbox"/> Unlimited <input type="checkbox"/> 2190 <input type="checkbox"/> 1095 <input type="checkbox"/> 1460 <input type="checkbox"/> 730	
Restoration of Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	

BENEFIT ELIGIBILITY: For you to be eligible for Benefits provided by the policy, we must receive ongoing proof, including a current eligibility certification, which demonstrates, based on information from care providers, personal physicians and other Licensed Health Care Practitioners that the covered care is needed due to you continually being qualified for Benefits.

You will be qualified to receive the services covered by this policy if:

- You are a Chronically Ill Individual; and
- The services are prescribed for you in a written Plan of Care prepared by a Licensed Health Care Practitioner.

All services covered by the policy must be Qualified Long Term Care Services.

You will be considered a "Chronically Ill Individual" while you meet one (1) of the following criteria:

- You are unable to perform, without Standby Assistance or Hands-on Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity and this loss of functional capacity is expected to last at least 90 days; or
- You have a Severe Cognitive Impairment requiring Substantial Supervision to protect you from threats to health and safety.

The certification that you are a Chronically Ill Individual must be made by a Licensed Health Care Practitioner, independent of us, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid by this policy must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner.

An "Activity of Daily Living" is one of the following: Bathing; Dressing; Eating; Continence; Toileting; and Transferring.

"Standby Assistance" is the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the Activity of Daily Living.

“Hands-on Assistance” is the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

“Severe Cognitive Impairment” means 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: short-term or long-term memory; orientation as to people, places or time; and deductive or abstract reasoning.

“Substantial Supervision” means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect a person who has Severe Cognitive Impairment from threats to his or her health or safety (as may result from wandering).

CONDITIONS: Benefits will be paid only for expenses you incur for Qualified Long Term Care Services that are covered by the policy, and are received pursuant to your Plan of Care and while your insurance is in force. Benefit payments are subject to: the Elimination Period requirements; the applicable Daily Payment Maximum and Lifetime Payment Maximum; and all other provisions of the policy.

A “Plan of Care” is a written description of your needs and a specification of the type, frequency (including duration), and providers of all formal and informal long term care services required by you, and the cost, if any. The Plan of Care will be developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical supervision based on an assessment of you. The final Plan of Care must be as prescribed by a Licensed Health Care Practitioner.

The Plan of Care must be updated as your needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 30 days. We will make copies of the current Plan of Care available to your personal physician. No more than one Plan of Care may be in effect at a time.

Your Right to Request Payment for Care Not Otherwise Covered: When you meet the Benefit Eligibility provisions and Conditions, you may request payment for care or services not otherwise covered by the policy. The care and services must be Qualified Long Term Care Services. We may, at our sole discretion, determine that providing benefits for those expenses is appropriate and payable under this policy. Payment of such benefits will be subject to the same Elimination Period requirements applicable to similar care and services otherwise covered by the policy, as determined by us; and will count against the Lifetime Payment Maximum.

Examples under which we may provide benefits include, but are not limited to the following: in-home safety devices; home delivered meals; stays in other types of facilities; and additional equipment benefits.

Remember: Any payment made under these circumstances must be included in your Plan of Care and be as agreed to by us.

CARE COORDINATION BENEFITS:

This is an Optional Benefit You MAY CHOOSE TO USE. Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for:

- Certifications by a Licensed Health Care Practitioner that you meet or continue to meet the definition of a Chronically Ill Individual;
- Preparation of a written Plan of Care by a Licensed Health Care Practitioner; and

- Privileged Care Coordination Services furnished by a Privileged Care Coordinator.

Payments Do Not Count Against the Lifetime Payment Maximum: Expenses paid under this Benefit will not count against the Lifetime Payment Maximum of this policy.

No Daily Payment Maximum or Elimination Period: The Daily Payment Maximum does not apply to payments made under this Benefit. Expenses covered by this Benefit are not subject to, and may not be used to satisfy, any Elimination Period.

A “Privileged Care Coordinator” is a Licensed Health Care Practitioner designated by us to provide Privileged Care Coordination Services. The Privileged Care Coordinator will not be an employee of ours and will not be compensated in any manner that is linked to the outcome of a certification of benefit eligibility.

Privileged Care Coordination Services include, but are not limited to:

- The performance of a comprehensive individualized face-to-face assessment conducted in your place of residence.
- Developing and prescribing a Plan of Care appropriate for your condition. The Plan of Care will be a written description of your needs and a specification of the type, frequency (including duration), and providers of all formal and informal long term care services required by you, and the cost, if any.
- Providing the initial and ongoing certifications required to satisfy the Current Eligibility Certification requirements.
- Suggesting 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 identified in your Plan of Care.
- Help with the completion of claims forms required to obtain payment under this policy.
- Assistance with implementing your Plan of Care by scheduling and coordinating the care and support service providers you have chosen from those suggested by the Privileged Care Coordinator.
- Ongoing monitoring of the care and support services you are receiving. This will include periodic re-assessments to determine revisions to the Plan of Care that are warranted by changes in your care and support service needs.

A “Privileged Care Coordinator” is a Licensed Health Care Practitioner who, either alone, or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

Privileged Care Coordinators are familiar with the care and service providers available in the 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 the client and his or her 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 care or service provider, you may request that the Privileged Care Coordinator identify other providers from which to choose.

HOME CARE BENEFIT: *This is an option you MAY CHOOSE TO USE.*

This Benefit provides payment for the below listed expenses you incur other than: (a) while you are confined in a Nursing Facility; or (b) on a day for which payment is made under the Respite Care Benefit; or (c) while you are in a Residential Care Facility, in which event, the Residential Care Facility Benefit provides coverage which includes, but is not limited to, the same services covered by this Benefit.

We will pay for the following care and services that are consistent with your Plan of Care:

- Home Health Care provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist or audiologist.
- Personal Care; Homemaker Services
- Adult Day Care; and Hospice Services.

We will pay this Benefit on a monthly basis. The total amount we will pay for all such expenses you incur during a calendar month will not exceed 31 times the Daily Payment Maximum. Benefit payments count against the Lifetime Payment Maximum and are subject to the Benefit Eligibility provisions and Conditions.

No Elimination Period/Credit Towards Your Elimination

Period: Payment under this Benefit is not subject to the Elimination Period requirement. In addition, when you use a Privileged Care Coordinator, each day you incur expenses for care and support services that are covered by this Benefit will count toward satisfying your Elimination Period for other benefits that are subject to an Elimination Period.

Eligible Care and Services Definitions and Eligible

Providers: “Adult Day Care” is medical or non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting and taking medications.

Eligible Providers in California include:

- Adult Day Care Facilities, and Adult Social Day Care Facilities, which are licensed by the Department of Social Services;
- Adult Day Health Care Facilities licensed by the Department of Health Services; and
- Alzheimer Day Care Resource Centers administered by the Department of Health Services.

“Home Health Care” is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Eligible Providers of Home Health Care are state licensed home health care agencies as well as licensed or certified professionals such as nurses and therapists who are acting within the scope of their licenses.

“Personal Care” is assistance with the Activities of Daily Living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction. “Instrumental activities of daily living” include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

Eligible Providers of Personal Care are individuals, such as home health aides or personal care attendants furnished by a home health care agency or similar organization, or other skilled or unskilled persons hired within the community.

“Homemaker Services” is assistance with activities necessary to or consistent with your ability to remain in your residence, that is provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction.

Eligible Providers of Homemaker Services are individuals furnished by a home health care agency or similar organization, or other skilled or unskilled persons hired within the community.

“Hospice Services” are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical,

emotional, social and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease (6 months or less to live). This includes supportive care provided to your family and primary caregiver; but not services for which any payment is made under Medicare. Hospice Services may be provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction. No benefits will be paid for any Hospice Service for which benefits are payable under Medicare.

Eligible Providers of Hospice Services are individuals furnished by a hospice organization or hospital, or other skilled or unskilled persons hired within the community.

CAREGIVER TRAINING BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for training an informal (unpaid) caregiver to care for you in your home. All of the following conditions apply to the payment of this Benefit.

- The person receiving the training can be a relative or someone else chosen by you; but in no event will we pay for training provided to someone who will be paid to care for you.
- The training cannot be received while you are confined in a hospital, Nursing Facility or Residential Care Facility, unless 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.

Eligible Providers of caregiver training include, but are not limited to state licensed home health care agencies as well as licensed or certified professionals such as nurses and therapists.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Caregiver Training Benefit is an amount equal to five (5) times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily Payment Maximum; but does count against the Lifetime Payment Maximum.

RESPIRE CARE BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for up to 21 days of Respite Care during a calendar year. Benefit payments are subject to the Daily Payment Maximum; and count against the Lifetime Payment Maximum.

“Respite Care” is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary informal (unpaid) caregiver in the home.

Eligible Providers of Respite Care include a Nursing Facility, a Residential Care Facility, a community-based program such as a provider of Adult Day Care, a person employed by a home health care agency or a person who is qualified by training and/or experience to provide care in accordance with the Plan of Care. It is not required that the provision of Respite Care be at a level of certification or licensure greater than that required by the eligible services, or that those services be provided by Medicare-certified agencies or providers.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

SUPPORTIVE EQUIPMENT BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for the purchase or rental of Supportive Equipment when all of the following conditions are satisfied.

- The equipment must be intended to assist you in living at home or in any other residential housing (which does not include a hospital, or

a Nursing Facility) by relieving your need for direct physical assistance.

- It must be reasonably expected (as stated in your Plan of Care) that the equipment will enable you to remain at home or in any other residential housing (which does not include a hospital, a Nursing Facility or a Residential Care Facility) for at least 90 days after the date of purchase or first rental.
- The equipment must be specified in, and consistent with, your Plan of Care.

“Supportive Equipment” means items, such as the following, which meet the above conditions: pumps and other devices for intravenous injection; ramps to permit movement from one level of the residence to another; grab bars to assist in toileting; and other mechanical aids to assist you in overcoming physical impairments. It does not include either: equipment that will, other than incidentally, increase the value of the residence in which it is installed; or artificial limbs, teeth, medical supplies, or equipment placed in your body, temporarily or permanently.

No Elimination Period: This Benefit is not subject to, and may not be used to satisfy, any Elimination Period.

Limitations on Benefit Payments: The lifetime maximum total amount we will pay under this Supportive Equipment Benefit is an amount equal to 50 times your Daily Payment Maximum. Payment under this Benefit will not count against any Daily Payment Maximum; but does count against the Lifetime Payment Maximum.

RESIDENTIAL CARE FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for Qualified Long Term Care Services you receive while confined in a Residential Care Facility. This includes expenses you incur for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. Benefit payments are subject to the Daily Payment Maximum; and count against the Lifetime Payment Maximum.

Eligible Providers of this care include, but are not limited to the facility in which you reside as well as those persons and other entities which provide Qualified Long Term Care Services to you while you are confined in the facility. This also includes facilities and services provided by the Residential Care Facility, care and services covered under other benefits of the policy, and any other care and services that are needed to assist you with the disabling conditions that caused you to be a Chronically Ill Individual.

A “Residential Care Facility” is a facility that is licensed as a “residential care facility” or a “residential care facility for the elderly” as defined in the Health and Safety Code of the State of California.

Outside California a “Residential Care Facility” is a facility that meets the applicable licensing standards if any, and is engaged primarily in providing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impairment in cognitive ability. It must also:

- Provide such care and services on a twenty-four hour a day basis;
- Have a trained and ready to respond employee on duty in the facility at all times to provide care and services;
- Provide 3 meals a day and accommodate special dietary needs;
- Have agreements to ensure that residents receive the medical care services of a physician or Nurse in case of an emergency;
- Have the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

It should be noted that this definition would generally NOT be met by: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug

addiction or mental illness; a Nursing Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

NURSING FACILITY BENEFIT: Subject to the Benefit Eligibility provisions and Conditions, we will pay the expenses you incur for care and support services (including room and board and ancillary supplies and services) provided by a Nursing Facility. This includes expenses you incur for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. You must be confined there as a resident inpatient. Benefit payments are subject to the Daily Payment Maximum; and they count against the Lifetime Payment Maximum.

A “Nursing Facility” is an institution which is licensed by the appropriate licensing agency to engage primarily in providing nursing care to inpatients and meets all of the following criteria:

- It provides twenty-four hour a day nursing services under policies and procedures developed with the advice of, and periodically reviewed and executed by, a professional group of at least one duly licensed physician and one Nurse.
- It has a duly licensed physician available to furnish medical care in case of emergency.
- It has at least one Nurse who is employed there full time.
- It has a Nurse on duty or on call at all times.
- It maintains clinical records for all patients.
- It has appropriate methods and procedures for handling and administering drugs and biologicals.

A Nursing Facility is NOT: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; a Residential Care Facility; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

BED RESERVATION BENEFIT: We will continue to pay benefits, or give Elimination Period credit, under the Nursing Facility Benefit and the Residential Care Facility Benefit for each day you:

- are temporarily absent during a stay in a Nursing Facility or a Residential Care Facility; and
- are charged to reserve your accommodations in that facility.

We will do this for a total of not more than the first 50 days (continuous or not) of such absence during a Policy Year. Benefit payments are subject to the Daily Payment Maximum; and they count against the Lifetime Payment Maximum.

SURVIVORSHIP BENEFIT: When your spouse dies after this policy has been in force for at least ten years, no further premium payments will be required for this policy if:

- Both you and such spouse continuously had long term care insurance coverage in force with us, other than under a Nonforfeiture Benefit, on the date of death of the spouse and for at least the prior ten year period; and
- Such spouse’s coverage included a similar Survivorship Benefit; and
- No long term care benefits were paid or payable by us for you or such spouse during the first ten years of such concurrent coverage.

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

Payment Maximum. The amount of the continued reduced coverage will be the greater of: 90 times your Daily Payment Maximum; or the total of all premiums paid for the policy and any attached riders. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

OPTIONAL RESTORATION OF BENEFITS RIDER: This is an optional rider for which an additional premium is charged. It will restore the policy's Lifetime Payment Maximum to the amount that would have applied if no benefits had been paid under the policy. This applies whenever a period of 180 consecutive days elapses during which the policy was in force and at no time during that period did you require, or receive, either:

- Substantial Supervision to protect yourself from threats to health or safety due to Severe Cognitive Impairment; or
- Substantial Assistance necessary to meet the policy's Benefit Eligibility requirements due to a loss of functional capacity.

GENERAL DEFINITIONS: The following definitions apply:

The "Daily Payment Maximum" is the greatest amount we will pay for all expenses combined that you incur on any one day under all of the following: the Respite Care Benefit; the Nursing Facility; and the Residential Care Facility Benefit. It is also used to determine other Benefit limits. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received. This amount increases over time in accordance with any Benefit Increases that apply.

The "Elimination Period" is the number of days for which you must incur expenses that qualify for payments under the Nursing Facility Benefit and the Residential Care Facility Benefit; but for which we will NOT pay benefits. It can be satisfied either by: days for which payment would otherwise be made under the Nursing Facility or Residential Care Facility Benefits (including Bed Reservation Benefit days); or days you receive services covered under the Home Care Benefit in accordance with a Privileged Care Coordinator's Plan of Care.

Days used to satisfy the Elimination Period do not need to be consecutive. Once you have satisfied this requirement, 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 described in section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

The "Lifetime Payment Maximum" is the combined total amount we will pay as benefits under the policy. This amount is determined by multiplying the Daily Payment Maximum by the applicable Benefit Multiplier. When Benefit Increases apply, this amount increases over time. The Lifetime Payment Maximum may be used interchangeably for any Qualified Long Term Care Services covered by the policy.

A "Nurse" is someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN); and is operating within the scope of that license.

"Qualified Long Term Care Services" are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, 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 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 the protection from threats to health and safety due to Severe Cognitive Impairment.

7. LIMITATIONS AND EXCLUSIONS

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: If an institution has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a covered facility only if it meets the criteria in the definition of such a facility; is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and is engaged principally in providing not only room and board, but also care and services which meet all of those criteria.

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: Benefits are not payable for care, stays, or other items: (a) provided by a family member; (b) when no charge is normally made in the absence of insurance; (c) provided outside of the U.S.A. or its territories or possessions; (d) provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to you or your estate; (e) resulting from war or act of war; (f) resulting from an attempted suicide or an intentionally self-inflicted injury; or (g) for alcoholism and drug addiction; unless it has occurred as a result of the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.

Note: Mental illness and Alzheimer's disease are covered, subject to the same exclusions, limitations and provisions applicable to other conditions.

Non-Duplication: Benefits will be paid only for covered expenses that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care plan or law (except Medicaid).

We will consider, for the purposes of satisfying an Elimination Period, days on which you incur expenses that would otherwise qualify as satisfying your Elimination Period, but are excluded from coverage because benefits are paid or payable under governmental health care plans or laws as stated above.

Actions in the Event of a Public Funded National or State Plan:

If a non-Medicaid/Medi-Cal national or state long term care program created through public funding substantially duplicates benefits provided by this policy, we will implement one of the following actions based on mutual agreement between us and the California Department of Insurance.

- We will reduce your future premium payments; or
- We will increase future benefits.

The amount of premium reductions and future benefit increases to be made by us will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and our claims experience. Our premium reduction and benefit increase plans will first be filed with and approved by the California Department of Insurance.

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. You may choose from two options at the time of application that will increase your benefits every year. *Equal*

Increases means the daily and lifetime limits will increase by 5% of their original amounts; and *Compound Increases* means the daily and lifetime limits will increase by 5% of the most recent amounts.

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 do not purchase such a Benefit Increase option, you will need to provide satisfactory evidence of insurability to later increase coverage. If you elect a Benefit Increase, premiums will be higher; but they will not increase due to a change in age or the automatic benefit increases. Below 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. A similar graphic comparison illustrates premiums for those types of policies.

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 as long as you pay your premiums on time. Genworth Life Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

The policy includes a Waiver of Premium for premiums that become due: while continuing benefits are payable under the Residential Care Facility, Nursing Facility or Bed Reservation Benefits; and when continued Home Care Benefits are payable in accordance with a Plan of Care from a Privileged Care Coordinator.

Premiums can be changed based on your premium class; but only if they are changed for all similar policies issued in your state on the same policy form.

10. ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND OTHER BRAIN DISORDERS

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.

11. PREMIUM

The table below shows the annual premium for the policy and any options you have chosen. It also shows your premium payment mode and the corresponding modal premium.

Eligible for Preferred Discount <input type="checkbox"/> Yes <input type="checkbox"/> No	Basic Policy: \$
	Nonforfeiture Benefit: \$
Eligible for Spousal Discount <input type="checkbox"/> Yes <input type="checkbox"/> No	Restoration of Benefits: \$
	Total of Above: \$
Premium Payment Mode (Adjustment Factor) <input type="checkbox"/> Annual (1.0) <input type="checkbox"/> Semi-Annual (.51) <input type="checkbox"/> Quarterly (.26) <input type="checkbox"/> Monthly (.09) - requires Electronic Funds Transfer	Total Discount: \$
	Total Annual Premium: \$
	Modal Premium: \$
	(Annual x mode factor)

12. ADDITIONAL FEATURES

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 85 years of age or older when applying.

Continuation for Lapse Due to Alzheimer's Disease, Organic Disorders 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 for any other reason. 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.

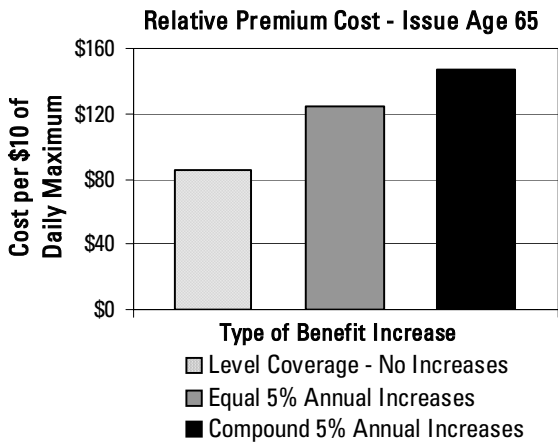
13. INFORMATION AND COUNSELING

The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.

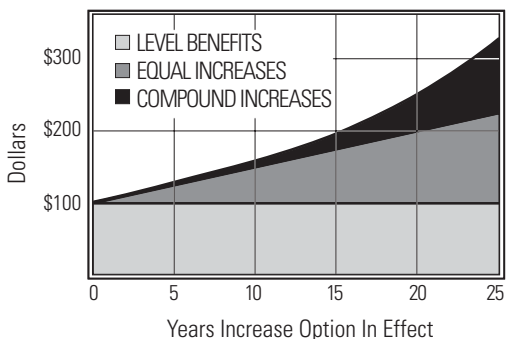
Local HICAP Office: _____
Agency Name

Agency Address

Agency Phone Number



Growth of Payment Maximums Over Time



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