Genworth

Genworth Life and Annuity
Genworth Life
Genworth Life of New York
P. O. Box 40016
Lynchburg, Virginia 24506-4016
Tel: 888 GENWORTH (888 4369678)
Fax: 877 300.1280
genworth.com

Authorization to Receive Information

from Genworth Life and Annuity Insurance Company,
Genworth Life Insurance Company
and Genworth Life Insurance Company of New York†

- Use this form to designate any person or organization to receive information about your policy/certificate.
- **Please print clearly** using blue or black ink, **and initial any corrections** or we may not be able to accept your request.
- Please read this entire form and complete all required fields before signing.

Policy/certificate information

Policy/certificate number

Insured name

Designate person/organization

"Authorized party" is the party who has the rights stated in the policy/certificate. For life insurance, that party is the owner. For long term care insurance, it is the insured. In this form, "you" and "your" refer to the authorized party.

Select an option(s) and complete all information.
If more space is required please attach an additional sheet of paper to this form that states the requested changes and that lists the addresses and phone numbers. Please be sure to sign and date both the additional sheet of paper and this form.

Once you designate any person or organization to receive information about your policy/certificate, that authorization will remain in place as outlined in the declaration and signature(s) section.

○ **I no longer designate anyone to receive information about my policy/certificate.**

○ **I designate the following to receive all policy information as requested. I acknowledge that only those named on this form will be authorized to receive information.**

If you only want to add a person or organization, you must also restate those already authorized since this authorization replaces any previous version of this kind of authorization.

Name *Print* | Phone number | Birth date

Address *Complete address required*

City | State | Zip code

Name *Print* | Phone number | Birth date

Address *Complete address required*

City | State | Zip code

Declaration and signature(s)

Your signature indicates your understanding of the following:

- That you should keep a copy for reference, and a copy of it is as valid as the original.
- For policies that have long term care benefits, this authorization will be valid for two years from the date signed, unless a shorter duration is required under your state law or you revoke it in writing.
- For life insurance, this authorization will remain valid unless revoked in writing or by making a change in ownership.
- Revocation will take effect upon our receipt of your request although it will not pertain to any information that might have been used or disclosed prior to our receipt of your request.
- This authorization allows us to disclose health information to persons or organizations that may not be subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.
- Signing this authorization is not a condition for treatment, payment, enrollment, or eligibility for benefits.
- This authorization replaces any previous version of this kind of authorization.

All authorized parties must sign this form and indicate the capacity in which they are signing. For trustees, attorneys-in-fact, guardians, conservators and other fiduciaries, also attach all relevant legal documentation. We will not accept signatures of unauthorized parties.

SIGN HERE X

Signature of authorized party | **Capacity** | **Date Signed**

SIGN HERE X

Signature of other authorized party (e.g. Joint owner, joint/co-insured) | **Capacity** | **Date Signed**

†Only Genworth Life Insurance Company of New York is admitted in and conducts business in New York.