Genworth

Coverage Change Request

from Genworth Life Insurance Company
and Genworth Life and Annuity Insurance Company

Genworth Life
Genworth Life & Annuity
P.O. Box 40005
Lynchburg, VA 24506

Policyholder information

Name of Policyholder (Insured 1)
First . Middle . Last .

Name of Policyholder (Insured 2) *Only if Shared Coverage*
First . Middle . Last .

Policy/Certificate number *If any* .

Refund of premiums

If the change you are requesting will result in a refund of premiums, you may select one of the following options.

◯ Please process the change as requested and cash refund any unearned premium. (Applies to non tax-qualified policies only).

◯ Please process the change as requested, but apply the unearned premium refund to reduce future premiums, so the change will not result in a cash refund of unearned premium. (This will automatically be done for tax-qualified policies).

◯ Please make the change effective as of the next premium due date, so the change will not result in any refund of unearned premium.

Not Applicable

◯ My policy was not intended to qualify under the IRS section 7702B.

SIGN HERE **X** . Date

Policyholder signature required (Insured 1)

SIGN HERE **X** . Date

Policyholder signature required (Insured 2)

Check request type

Check type of change to be made – then describe change (please print)

◯ **Premium Payment Mode** From . To .

◯ **Benefit Payment Maximum** From . To .

◯ **Benefit Increases Option** From . To . ◯ Delete Increases Option

◯ **Benefit Multiplier** From . To .

◯ **Elimination Period/Deductible Period** From . To .

◯ **Cancel Rider** ◯ **Add Rider** Name of Rider(s) .

◯ **Third Party Notification (TPN)** ◯ Add ◯ Change ◯ Delete

Protection against unintended lapse. You have the right to designate at least one person other than yourself to receive notice of lapse or termination of your long term care insurance policy for nonpayment of premium. That notice will not be given until 30 days after a premium is due and unpaid. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured.

◯ Waive - Protection against unintended 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 premium is due and unpaid. I elect NOT to designate a person to receive this notice.

Name .

Street Address . Phone number .

City . State . Zip code .

Note: For most products, there is an additional cost if you pay premium more often than annually.

Check request type *Continued*

◯ Non-Forfeiture Notifier (NFN) You have the right to designate at least one person other than yourself to receive annual notification related to the availability of your shortened benefit period including the dollar amount of the shortened benefit period.

◯ Add ◯ Change ◯ Delete
◯ Waive - I understand that I have the right to designate at least one person other than myself to receive annual notification related to the benefit retained under this long term care insurance policy. I elect NOT to designate any person other than myself to receive the notice.

Name

Street Address | Phone number

City | State | Zip code

◯ Cancel Coverage

◯ I applied for replacement coverage with Genworth. Please cancel my existing coverage on the effective date of the new coverage.
◯ The following other date

◯ Name change of

◯ Policyholder, Insured 1 ◯ Policyholder, Insured 2

From To

Attach legal documentation for name changes, except due to marriage or divorce.

◯ Address change of

◯ Policyholder, Insured 1 ◯ Policyholder, Insured 2 ◯ Bank Account Owner

Name

Street Address | Phone number

City | State | Zip code

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

Declaration and signature(s)

Your signature indicates you have read and understand all sections of this form. **If you are a Trustee, Attorney-In-Fact, Guardian, Conservator or other Fiduciary, you must sign in your capacity:** (e.g. Jane Smith, Trustee) and attach relevant legal documentation.

Signature of Joint Policyholder (if any) is required, unless otherwise stated in your contract.

The signature of the third party designee is required below for all policies issued in the state of New York, and/or all policies currently being held by New York residents.

SIGN HERE X

Policyholder's signature Date

Capacity: ◯ Trustee ◯ Guardian ◯ Attorney-in-fact POA
◯ Title/Office: ◯ Other:

SIGN HERE X

Joint Policyholder's signature(s) *if applicable* Date

Capacity: ◯ Trustee ◯ Guardian ◯ Attorney-in-fact POA
◯ Title/Office: ◯ Other:

SIGN HERE X

Third Party Designee's signature Date

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.