

Coverage Change Request - Genworth Life Insurance Company of New York (Genworth Life of New York)

Name of Policyholder (Insured 1):

First Middle Last

Name of Policyholder (Insured 2) Only if Shared Coverage:

First Middle Last

Policy Number / Certificate Number (if any):

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

- Please process the change as requested and cash refund any unearned premium. I understand that requesting a cash refund of unearned premium will cause my policy not to qualify further for federal income tax advantages.* (**Changes to Tax-Qualified Policies issued after 1/1/97****: Under federal law, any unearned premium refunded in cash, other than on the death of the insured or on a complete surrender or cancellation of your policy, would disqualify your policy for further federal income tax advantages.)
- 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.
- 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.

* Policyholder signature required (Insured 1)

Insured Spouse Signature Required (Insured 2)

** Not applicable to changes requested within 60 days of policy's effective date and retroactive to effective date.

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

PLEASE NOTE: If this Coverage Change Request includes a "Within 60 Day Benefit Increase"** in your Policy, have you (or another Insured on your Policy, if applicable) received medical advice or treatment; been diagnosed; or consulted with a health professional for any of the following conditions, since the effective date of your policy:**

Policyholder

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

Insured Spouse

- Yes
- Yes
- Yes
- Yes
- Yes

- No Alzheimer's Disease or any other form of Dementia
- No Parkinson's Disease, Multiple Sclerosis
- No Stroke, Transient Ischemic Attack (TIA)
- No Any condition requiring the use of a Wheelchair; Walker; Oxygen Device; Respirator; Kidney Dialysis
- No Needing the assistance of or supervision by another person with Bathing; Dressing; Eating; Toileting; Bowel/Bladder Control; Moving in/out of bed or chair; Walking.

If you have answered "YES" to any of the above, you are NOT ELIGIBLE to increase your policy benefits. **** A "Within 60 Benefit Increase" is retroactive to the effective date of the contract and must occur within 60 days of policy issue.

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) _____

Are you requesting a "Within 60 Benefit Increase"****

- Yes No

Proposed Effective Date of Change:

From: _____ To: _____

- Match spouse Replacing other company

Name of company: _____

Cancel Coverage:

- I applied for replacement coverage with Genworth Life of New York. Please cancel my existing coverage on the effective date of the new coverage.
- The following other date: _____

Other/Notes: _____

Third Party Notification:

- Add Change Delete

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

Name Change of:

- Policyholder Insured Spouse

From: _____

To: _____

Address Change of:

- Policyholder Insured Spouse

Street: _____

City: _____

State: _____ Zip: _____

I hereby declare that I understand the nature of the changes requested above and that the information stated above is true and complete to the best of my knowledge and belief. I agree that any change will become effective on the date set by Genworth Life of New York following its receipt of this request.

Signature of Policyholder (Insured)

Date

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Signature of Policyholder (Insured Spouse)

Date

For Agent Use

Writing

Agent Name:

Payment

With Request:

Policy / Certificate

\$ Delivery Date:

Genworth Life Insurance Company of New York

Long Term Care Division, Administrative Office: P.O. Box 40005, Lynchburg, VA 24506

Received from: _____

Change of Coverage Receipt and Temporary Insurance Agreement

Make check payable to: **Genworth Life Insurance Company of New York**

the sum of: \$ _____

with Coverage Change Request dated: _____ for insurance under a policy issued by Genworth Life Insurance Company of New York. In return the company will provide Temporary Insurance during the period covered by this Agreement. The Temporary Insurance will have the same benefits and provisions and be subject to the same limitations and exclusions as the coverage change applied for; except no more than a total of \$10,000 in benefits will be paid under this Agreement. Temporary Insurance under this Agreement will begin on the later of: the date of this agreement; or the date the request is completed. Temporary Insurance ends on the earlier of: the effective date of the policy change; or the date the insured receives notice that the request has been declined. In the absence of earlier receipt, notice by mail will be considered to be received 5 days after it is mailed. All benefits for any loss incurred during the term of the Agreement cease as of the date this Agreement ends. If you have a claim for benefits under this Temporary Insurance Agreement, any payment received for this Agreement will be applied (on a pro-rated basis) to the period for which Temporary Insurance is provided. All other payments received for this Agreement will be applied to the first change premium if approved; and will be refunded to the Applicant when the change is declined. No agent is authorized to alter, amend, waive or in any other way change the terms of this Agreement.

Signature of Licensed Agent

Agent Address

Written Name of Licensed Agent

City, State and Zip Code

81223NY-RC 01/01/06