



Genworth Life Insurance Company
 Long Term Care Insurance Division
 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948
 800 456.7766

Please print using black ink.

ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

Use this form to authorize use of electronic fund transfers (EFT) for either:
1. All Initial Premium modes as long as this form is submitted with the application.
2. Monthly renewal premium payments.

Instructions:

- **Monthly Payment Mode:** Initial & Renewal – Complete section A, B & C. For Renewal Only – complete sections A & C.
- **All other Payment Modes for initial only:** Complete sections A, B & C. Future premiums will be billed directly.
- Attach a copy of a Voided Check from your checking account.
- For Shared and Two Individual Policies, please provide signatures for both applicants.
- Complete and sign page 2 and provide to customer.

SECTION A

Print Name of Proposed Insured(s) below

Applicant A	Applicant B
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SECTION B (Initial Premium Only)

Initial Premium Amount (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required. Only one month is allowed in California and for New Hampshire applicants over 65.)

Applicant A	\$
Applicant B (to be used for 2 Individual policies only; do not enter an amount for Shared Plans.)	\$

TOTAL (The Total amount below is the amount we will deduct for the initial premium)

\$

SECTION C (Please complete the below required fields)

Account Holder's Name	Street Address	City	State	Zip Code
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Name of Financial Institution

ABA/Routing/Transit Number <i>9 digits</i>	Bank Account Number <i>12 digits</i>
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*Bank Account Holder(s) Signature <i>(If other than Applicant.)</i>	Date <i>mm/dd/yyyy</i>
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*Applicant A Signature	Date <i>mm/dd/yyyy</i>
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*Applicant B Signature	Date <i>mm/dd/yyyy</i>
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***By signing above, I am agreeing to the terms and conditions listed on page two (2) of this form**

Print Name of Agent	Agent Signature
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Office Use Only
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ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

CUSTOMER COPY

TERMS & CONDITIONS

I authorize Genworth Life Insurance Company (Company) to collect the Initial Premium and renewal for monthly mode, stated in this form from the Bank Account described in this form. I understand and agree that this Authorization is subject to the following conditions:

- This Authorization form must be completed in its entirety in order to be valid.
- Signing this Authorization does not mean that coverage is effective; coverage is effective only as stated in the application.
- Payment by EFT does not alter any contract issued by the Company.
- Any refund for coverage not taken or declinations will be made directly via check, not as a credit to the Bank Account. Otherwise, refunds will be applied in accordance with applicable laws.
- If the EFT charge request is not honored, no further attempt to use the EFT to collect premium will be made and Conditional Insurance Agreement (CIA) will not apply. A bill will be issued for the required premium. See CIA box of this form for additional information regarding CIA.
- Your Bank Account will be charged for the Initial Premium promptly after receiving authorization.
- Any refund of the premium will NOT include reimbursements for interest, fees or other obligations that the Financial Institution company may impose.
- If the appropriate premium split between applicants is not indicated, the Company will determine the split in the manner most appropriate. Please note that it may affect conditional insurance coverage.
- For questions regarding your EFT payment, please contact us at 800 309.0047.

CONDITIONAL INSURANCE AGREEMENT

If you requested an Effective Date that is later than your Date of Application, the following Agreement will not apply and our underwriting decision will consider any changes in your health status which occur after the Date of Application.

Agreement: This Agreement applies only if all of the following requirements have been satisfied:

1. The EFT authorization is approved for at least the full three (3) months of premium (one month in CA and for NH applicants over 65) set forth in the application for insurance; and
2. Applicant(s) did not request in writing, an Effective Date that is later than the Application Date; and
3. Applicant(s) accurately answered NO to all parts of the Insurability Profile in the application; and
4. The answers in the application accurately indicate that:
 - A. Within the past 5 years applicant(s) HAVE NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Epilepsy, Convulsions, Seizures, Fainting Spells, Blackouts, Mental Illness, or Paralysis; or been medically advised to have surgery that has not been performed; or received home health care; used an adult day care facility; been confined to a nursing home, assisted care facility, or other long term care facility.
 - B. For CA residents ONLY. The answers in the application accurately indicate that:
 - Within the past 5 years applicant(s) 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, Blackouts, Mental Illness, or Paralysis.
 - Within the past 3 years applicant(s) 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 be confined to a nursing home, assisted care facility, or other long term care facility.
5. NO material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, the applicant(s) and the Company agree that:

1. In underwriting the application Company may conduct a telephone or personal interview to determine your health status as of the Application Date. The Company will not disapprove your application based on any change in the applicant(s) health status that occurs after the Application Date.
2. If Company approves the application, Company will provide insurance under the policy for which application was made, and the Policy will be Effective as of the Application Date.

Paragraph three (3) of the following Agreement does not apply in the following states: CT, MD and TX.

3. If Company disapproves the application, Company will provide temporary insurance for loss which begins between the Application Date and the date the application was disapproved. The application shall be deemed disapproved if Company does not approve the application within 120 days of the Application Date. The temporary insurance will provide the same benefits and be subject to the same provision, 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 Company under the temporary insurance exceed the lesser of: (a) \$10,000; and (b) the actual expenses incurred.

Initial Premium Amount (Amount Should Match Full Modal Premium in Application. For CIA, 3 months minimum Required. Only one month is allowed in California and for New Hampshire applicants over 65.)

Applicant A

\$

Applicant B (to be used for 2 Individual policies only; do not enter an amount for Shared Plans.)

\$

Signature of Agent

Date Signed mm/dd/yyyy

Print Agent's Business Address

No applicant, agent, insurance producer, producer or representative has any power or authority to change any of the provisions of this Agreement.

Complete and submit this form with the application to:

Genworth Life Insurance Company Long Term Care Insurance Division, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948