

Genworth Life Insurance Company of New York

(Hereinafter referred to as "the Company")

A Stock Company

State of Domicile: New York

Home Office: 666 Third Street, 9th Floor, New York, NY 10017

Service Center Address: 3100 Albert Lankford Drive, Lynchburg, VA 24501

P. O. Box 461, Lynchburg, Virginia 24505-0461

Service Center Phone: (888) 325-5433

The Company will pay the Death Benefit Payable to the Beneficiary subject to the provisions of this Policy. Payment will not be made until all of the following have been received at the Service Center:

- this Policy;
- due proof that the Insured died while this Policy was in force; and
- a written claim for the death proceeds completed on a form supplied by the Company.

CONSIDERATION. This Policy is issued in consideration of the Application for this Policy and the payment of the Initial Premium.

RIGHT TO EXAMINE POLICY. The Owner may return this Policy for any reason within 30 days after its delivery by taking it or mailing it to the Service Center or to any life insurance agent appointed by the Company. Immediately upon delivery or mailing to the Company, this Policy will be deemed void from the beginning. Any premium paid, including any policy fees or other charges, will be returned.

This Policy is a legal contract between the Owner and the Company.

READ THIS POLICY CAREFULLY.

This Policy was signed on the Date of Issue.



President



Secretary

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE POLICY
Adjustable Death Benefit
Flexible Premium Payable on the Policy Date
Benefits Vary with Current Risk Rates and Current Interest Rates
Nonparticipating – No Dividends

ULPLTCIPGLI NY (11/05)

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SPECIMEN

SUMMARY OF POLICY FEATURES

For purposes of this Summary, "You" and "Your" refer to the Owner. "We," "Our" and "Us" refer to the Company.

This Summary is an overview of the important features and operations of Your policy. It is meant to give You a basic understanding of Your policy. **Policy provisions provide specific details not fully described in this Summary. Please read the entire policy carefully.**

THE POLICY. The policy combines life insurance and an accelerated benefit for long term care services. The life insurance portion is flexible-premium, adjustable life insurance.

"Flexible-premium" means that You can pay premiums in addition to the initial premium subject to limitations stated in the policy. **The policy is NOT a single premium policy. It is NOT guaranteed to remain in effect at the original benefit levels after payment of only one premium. You might have to pay more premiums to keep Your original benefit levels. Under certain circumstances, the Guaranteed Minimum Benefit Rider included in the policy provides that You will never have to pay more premiums, if You elect to reduce benefits to the Guaranteed Minimum Benefit Values.**

"Adjustable life insurance" means that the death benefit can be changed subject to limitations stated in the policy.

The long term care services portion is provided in the form of a rider that "accelerates" the Specified Amount shown in the policy's schedule to reimburse covered long term care expenses incurred by the Insured. These accelerated expense reimbursements reduce the amount payable to the beneficiary at the Insured's death, as well as the Policy Value. If You have chosen an additional rider extending benefits for long term care services, the policy provides coverage for these services once accelerated benefit rider payments have been exhausted.

POLICY VALUE. We subtract an expense charge from each premium You pay and credit the rest to the Policy Value. Each policy month We deduct charges for insurance and a monthly administrative fee from the Policy Value. We also credit interest to the Policy Value. Premiums paid and interest credited increase the Policy Value, and the monthly deduction for charges and fees decreases it. In simple terms, if amounts credited exceed amounts deducted, the Policy Value grows; if amounts deducted exceed amounts credited, the Policy Value shrinks. If the Policy Value becomes so small that We cannot deduct a full monthly deduction, then the policy will likely terminate unless: (1) You pay more premiums; (2) policy benefits are reduced to Guaranteed Minimum Benefit Values; or (3) Your monthly deduction is being waived as described in the policy. Partial Withdrawals reduce the Policy Value.

CONDITIONAL GUARANTEES PROVIDED BY RIDER

These guarantees are effective under certain conditions:

- **the rider providing the guarantee must be in effect; and**
- **You must not have taken certain actions, namely taken a policy loan or a partial withdrawal.**

Return of Premium: The Return of Premium Benefit Rider provides that if You surrender the policy in the first fifteen policy years, You will receive the greater of the following: (1) the Cash Surrender Value (Policy Value minus any surrender charge); and (2) a return of Your initial premium less any amounts paid for long term care expenses. **Any premium You pay after the initial premium will not be returned.** Taking a policy loan or partial withdrawal terminates this rider and no benefit is payable.

Guaranteed Minimum Benefits: The Guaranteed Minimum Benefit Rider provides a guarantee if the following circumstances exist as of a policy anniversary:

- Either the credited interest rate is equal to the Guaranteed Credited Interest Rate shown in the policy or any of the rates for insurance provided by the base policy and attached riders have increased above the corresponding rates of insurance in effect on the Policy Date; and
- We project the Policy Value to be insufficient to maintain the policy to the Insured's Attained Age 100.

We shall then give You notice that We will reduce the policy's benefits to the Guaranteed Minimum Benefit Values described in the rider unless You elect not to reduce benefits. If benefits are reduced, You will never have to pay more premiums as long as You do not subsequently take a policy loan or partial withdrawal.

If You elect not to reduce benefits, You can pay additional premium as defined in the rider to maintain the protection provided by this rider as long as You do not subsequently take a policy loan or partial withdrawal.

If You elect not to reduce benefits and do not pay additional premium, the Guaranteed Minimum Benefit Rider and Return of Premium Benefit Rider terminate.

As long as We have not already given You the notice described above, You may voluntarily reduce benefits as of the next policy anniversary to the Guaranteed Minimum Benefit levels.

Taking a policy loan or partial withdrawal at any time, even after benefits are reduced, voids this guarantee and any return of premium guarantee. And, You may have to pay more premiums to keep the policy in force.

EFFECT OF POLICY PROVISIONS ON POLICY PERFORMANCE. Policy performance is affected by a number of variables. The variables that have the biggest effects are Your premium payments, credited interest rates, and the insurance rates We charge. You should monitor these variables closely.

Credited Interest Rates: The credited interest rate is the rate of interest We apply to Your Policy Value each month. It is the variable most likely to change. You should not presume that these rates will remain constant for any extended period. We can adjust the credited interest rate at any time based on factors identified in the policy, but We cannot reduce the rate below the Guaranteed Credited Interest Rate shown in the policy's schedule.

Insurance Rates:

Life Insurance and Accelerated Benefits: The insurance rates are based on the likelihood that a person with characteristics similar to that of the Insured will die or incur long term care expenses in a policy month. These rates will generally increase each year as the insured gets older. The size of the Policy Value can offset the effect of these increasing rates, but generally You should expect the cost of the life insurance and accelerated benefits for long term care services to increase each year. We can change the scheduled rates based on factors identified in the policy, but We will not raise them above the maximum rates shown in the policy's schedule. For the first five policy years, We guarantee not to change the scheduled rates for accelerated benefits for long term care services.

Optional Extension of Benefits and Optional Inflation Protection Benefit: Rates for these benefits may remain unchanged for the life of the policy, BUT We can contractually increase them after the first five policy years. We cannot increase them above the maximum rates shown in the policy's schedule. We can only increase them on a class basis, meaning that We must increase them on an entire group of insureds with similar characteristics and not on

individual insureds because of changes in age or individual health. We guarantee not to increase rates for these benefits for the first five policy years.

Premium Payments: Payment of the Initial Premium does not guarantee that the policy will perform as expected or even continue in effect. The Policy Value of Your Policy may be impacted due to the effects of credited interest rates, insurance rates, policy loans, long term care claim payments, and partial withdrawals. This impact may be positive or negative. If it is negative You may have to pay more premiums to keep the policy in effect.

Monitoring Your Policy's Performance: We will send You an annual report to help You monitor Your policy's performance and compare it to Your objectives when You purchased Your policy. Begin by verifying that Your premium payment will still accomplish Your objective. Then be diligent in comparing actual policy values and benefits to the illustration You received when You purchased Your policy. Ask Your insurance agent to explain anything that You do not understand. You might need to pay more premium to achieve Your insurance objectives. You may request an illustration of future death benefits and policy values from Us at any time. There is no charge for the first illustration You request in a policy year.

IMPORTANT REMINDER: The purpose of this summary is to help You understand the features and operations of Your policy. Some of the optional benefits and features described in this summary may not be a part of the coverage You have chosen for Your policy. This is only a summary. Please read Your policy carefully.

SPECIMEN

SCHEDULE

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

Insured Information

Insured: John Doe
Issue Age: 49
Sex: Male
Premium Class: Standard No Nicotine

Owner and Beneficiary Information

Owner: As designated in the Application or as subsequently changed by the Owner John Doe
Beneficiary: As designated in the Application or as subsequently changed by the Owner Jane Doe

Life Insurance Benefit Information

Initial Specified Amount \$256,260.74

Policy Information

Policy Number: 123456*
Policy Date: January 1, 2007
Date of Issue: January 1, 2007
Policy Delivery State: New York

Rider Information

Guaranteed Minimum Benefit Rider**
Accelerated Benefit Rider for Long Term Care Services
Accelerated Benefit Rider for Terminal Illness
Extension of Benefits Rider for Nursing Home and Home Care Services
Return of Premium Benefit Rider***

Premium Information

Initial Premium: \$75,000

Fees and Charges

Monthly Administrative Fee: \$9.30
Premium Expense Charge: 9% of each premium received
Administrative Fee for Partial Withdrawal: \$25.00
Administrative Fee for Accelerated Death Benefit for Terminal Illness Payment: 250.00

Interest Rates

Guaranteed Credited Interest Rate: 3.5% compounded annually****
Guaranteed Policy Loan Interest Rate: 5.5% compounded annually
Credited Interest Rate on Loans: 3.5% compounded annually
Paid Up Insurance Interest Rate 4.0% compounded annually

***Note:** This Policy provides life insurance coverage until the death of the Insured if sufficient premiums are paid to keep this Policy in force. The duration and amount of coverage will depend on the amount, timing and frequency of premium payments, the interest credited, any Policy Loans or Partial Withdrawals, Monthly Deductions, any applicable benefit payments, and premium expense charges. This Policy may terminate if the premiums paid plus credited interest are insufficient to continue it in force.
Additional premium may be needed to keep this Policy in force.

**No additional premium or charges are required for this Rider.

***The Return of Premium Benefit Rider is issued in consideration of the Initial Premium shown above. No additional charges are associated with the Return of Premium Benefit Rider.

****Additional interest amounts are not guaranteed, and We have the right to change the amount of interest credited to the Policy, and the amount of the cost of insurance and other expense charges deducted under the Policy, which may require more premium to be paid than was illustrated, or the cash values may be less than those illustrated.

SCHEDULE
(continued)

ADDITIONAL BENEFITS PROVIDED BY RIDER

Accelerated Benefit Rider for Long Term Care Services

Rider Rate Classification: Standard

Coverage

| | |
|------------------------------------|--------------|
| Accelerated Lifetime Maximum | \$256,260.74 |
| Accelerated Monthly Maximum..... | \$10,677.53 |

Benefits and Services Provided

Coverage Maximum

| | |
|---|---|
| Privileged Care Coordination Services | 100% covered by the Company |
| Home Care Benefit | 100% of Covered Care expenses incurred in a calendar month, subject to the Accelerated Monthly Maximum |
| <i>Home Care Benefit includes coverage for: Adult Day Care Services, Nurse and Therapist Services, Home Health Aide and Personal Care Services, Homemaker Services, Chore Services, and Hospice Care.</i> | |
| Nursing Facility Benefit | 100% of Covered Care expenses incurred in a calendar month, subject to the Accelerated Monthly Maximum |
| Assisted Living Facility Benefit | 100% of Covered Care expenses incurred in a calendar month, subject to the Accelerated Monthly Maximum |
| Bed Reservation Benefit..... | Covered up to 60 days per Policy Year |
| Respite Care Benefit..... | Covered up to 30 days per Policy Year |
| Caregiver Training Benefit..... | 100% of Covered Care expenses up to a Lifetime maximum benefit equal to 20% of the Accelerated Monthly Maximum |
| Supportive Equipment Benefit..... | 100% of Covered Care expenses up to a Lifetime maximum benefit equal to two times the Accelerated Monthly Maximum |

SCHEDULE
(continued)

ADDITIONAL BENEFITS PROVIDED BY RIDER

Accelerated Benefit Rider for Long Term Care Services (continued)

Benefits and Services Provided

COVERAGE MAXIMUM

Alternative Care Benefit Benefit payment subject to mutual agreement

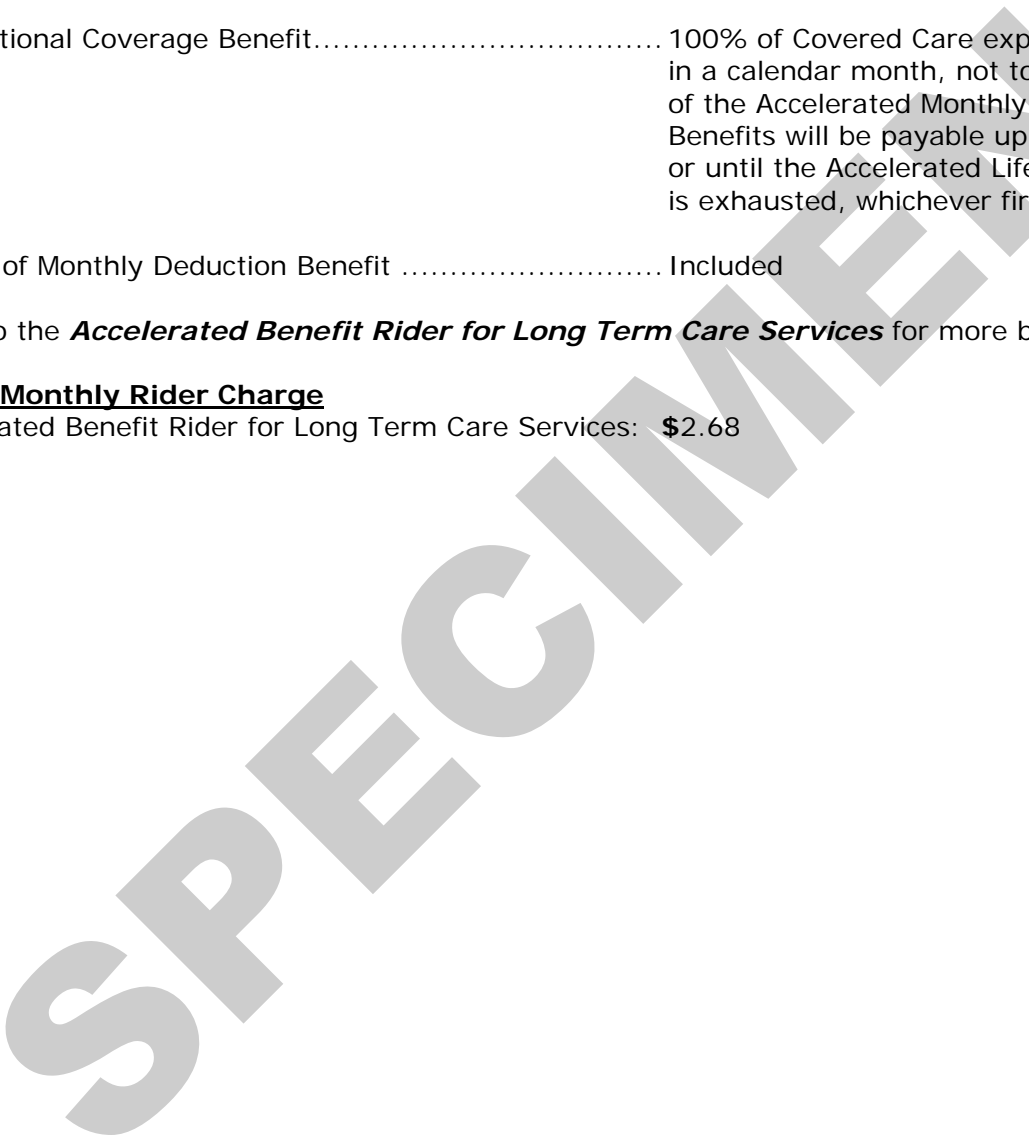
International Coverage Benefit..... 100% of Covered Care expenses incurred in a calendar month, not to exceed 75% of the Accelerated Monthly Maximum. Benefits will be payable up to 48 months or until the Accelerated Lifetime Maximum is exhausted, whichever first occurs.

Waiver of Monthly Deduction Benefit Included

Refer to the *Accelerated Benefit Rider for Long Term Care Services* for more benefit details.

Initial Monthly Rider Charge

Accelerated Benefit Rider for Long Term Care Services: \$2.68



SCHEDULE
(continued)

ADDITIONAL BENEFITS PROVIDED BY RIDER

Extension of Benefits Rider for Nursing Home and Home Care Services

Benefits provided under the Rider begin when benefits provided under the Accelerated Benefit Rider for Long Term Care Services have been exhausted.

Rider Rate Classification: Standard

Coverage

| | |
|--|--------------|
| Extension Lifetime Maximum | \$256,260.74 |
| Extension Monthly Maximum | \$10,677.53 |
| Optional Nonforfeiture Benefit..... | Included |
| Optional Contingent Nonforfeiture Benefit..... | Included |
| Optional Inflation Protection Benefit..... | Not Included |
| Simple Benefit Increase Option | 3% 5% |
| Compound Benefit Increase Option | 3% 5% |

Benefits and Services Provided

Coverage Maximum

| | |
|---|---|
| Privileged Care Coordination Services | 100% covered by the Company |
| Home Care Benefit | 100% of Covered Care expenses incurred in a calendar month subject to the Extension Monthly Maximum |
| <i>Home Care Benefit includes coverage for: Adult Day Care Services, Nurse and Therapist Services, Home Health Aide and Personal Care Services, Homemaker Services, Chore Services, and Hospice Care.</i> | |
| Nursing Facility Benefit | 100% of Covered Care expenses incurred in a calendar month subject to the Extension Monthly Maximum |
| Assisted Living Facility Benefit | 100% of Covered Care expenses incurred in a calendar month subject to the Extension Monthly Maximum |
| Bed Reservation Benefit..... | Covered up to 60 days per Policy Year |
| Respite Care Benefit..... | Covered up to 30 days per Policy Year |

SCHEDULE
(continued)

ADDITIONAL BENEFITS PROVIDED BY RIDER

Extension of Benefits Rider for Nursing Home and Home Care Services (continued)

| <u>Benefits and Services Provided</u> | <u>Coverage Maximum</u> |
|---------------------------------------|---|
| Caregiver Training Benefit..... | 100% of Covered Care expenses up to a Lifetime maximum benefit equal to 20% of the Extension Monthly Maximum* |
| Supportive Equipment Benefit..... | 100% of Covered Care expenses up to a lifetime maximum benefit equal to two (2) times the Extension Monthly Maximum* |
| Alternative Care Benefit | Benefit payment subject to mutual agreement |
| International Coverage Benefit..... | 100% of Covered Care expenses incurred in a calendar month, not to exceed 75% of the Extension Monthly Maximum. Benefits will be payable up to 48 months or until the Extension Lifetime Maximum is exhausted, whichever first occurs.* |

*The Coverage Maximum for this Benefit will be reduced by the amount paid for this Benefit under the **Accelerated Benefit Rider for Long Term Care Services**.

Refer to the **Extension of Benefits Rider for Nursing Home and Home Care Services** for more benefit details.

Initial Monthly Rider Charge

Extension of Benefits Rider for Nursing Home and Home Care Services: \$23.87
Additional charge for the Optional Inflation Protection Benefit for this Rider: \$39.44

SCHEDULE

TABLE OF SURRENDER CHARGES*

*Maximum Surrender Charges will be capped based on the maximum unused expense allowances prescribed by life insurance nonforfeiture requirements in the Owner's state. The surrender cap will be based on the current Specified Amount in effect.

| <u>POLICY YEAR</u> | <u>MAXIMUM SURRENDER CHARGE *</u> |
|--------------------|-----------------------------------|
| 1 | \$3,904.75 |
| 2 | \$3,773.69 |
| 3 | \$3,637.46 |
| 4 | \$3,495.80 |
| 5 | \$3,348.60 |
| 6 | \$3,195.56 |
| 7 | \$3,036.46 |
| 8 | \$2,871.10 |
| 9 | \$2,699.25 |
| 10 | \$2,520.65 |
| 11 | \$2,335.03 |
| 12 | \$2,142.06 |
| 13 | \$1,941.34 |
| 14 | \$1,732.47 |
| 15 and later | \$0.00 |

*The Maximum Surrender Charge will be the lesser of the amount shown in the table above or the percentage of the Policy Value as shown in the table below.

| <u>POLICY YEAR</u> | <u>PERCENT OF POLICY VALUE</u> |
|--------------------|--------------------------------|
| 1 | 10.0% |
| 2 | 10.0% |
| 3 | 10.0% |
| 4 | 10.0% |
| 5 | 10.0% |
| 6 | 10.0% |
| 7 | 10.0% |
| 8 | 10.0% |
| 9 | 10.0% |
| 10 | 10.0% |
| 11 | 8.0% |
| 12 | 6.0% |
| 13 | 4.0% |
| 14 | 2.0% |
| 15 and later | 0.0% |

SCHEDULE
(continued)

**TABLE OF MONTHLY RISK RATES FOR BASE POLICY
PER \$1,000 OF NET AMOUNT AT RISK**

This Table shows the current and maximum Monthly Risk Rates per \$1,000 of Net Amount at Risk for the Base Policy. The rates shown are for the Insured's Attained Age, sex, and Premium Class for the Base Policy as shown on page 3. The Guaranteed Maximum Monthly Risk Rates shown below will never change. The Current Monthly Risk Rates are applicable on the Policy Date and may change based on the Company's expectations as to future investment earnings, mortality, morbidity, persistency, expenses, and taxes. In no event will the Current Monthly Risk Rates exceed the Guaranteed Maximum Monthly Risk Rates. If this Policy includes an extra risk rating, then the Monthly Risk Rates shown below have been adjusted to include an additional amount for that rating.

| <u>Attained Age</u> | <u>Guaranteed Maximum Monthly Risk Rate</u> | <u>Current Monthly Risk Rate</u> | <u>Attained Age</u> | <u>Guaranteed Maximum Monthly Risk Rate</u> | <u>Current Monthly Risk Rate</u> |
|---------------------|---|----------------------------------|---------------------|---|----------------------------------|
| 35 | 0.04 | 0.04 | 68 | 1.68 | 1.23 |
| 36 | 0.05 | 0.05 | 69 | 1.83 | 1.35 |
| 37 | 0.06 | 0.06 | 70 | 2.00 | 1.51 |
| 38 | 0.07 | 0.07 | 71 | 2.20 | 1.67 |
| 39 | 0.08 | 0.08 | 72 | 2.46 | 1.84 |
| 40 | 0.09 | 0.09 | 73 | 2.73 | 2.01 |
| 41 | 0.10 | 0.10 | 74 | 3.02 | 2.20 |
| 42 | 0.11 | 0.11 | 75 | 3.33 | 2.43 |
| 43 | 0.12 | 0.12 | 76 | 3.67 | 2.67 |
| 44 | 0.14 | 0.14 | 77 | 4.07 | 2.90 |
| 45 | 0.15 | 0.15 | 78 | 4.53 | 3.19 |
| 46 | 0.18 | 0.18 | 79 | 5.07 | 3.50 |
| 47 | 0.20 | 0.20 | 80 | 5.65 | 3.86 |
| 48 | 0.22 | 0.22 | 81 | 6.32 | 4.25 |
| 49 | 0.25 | 0.25 | 82 | 7.01 | 4.62 |
| 50 | 0.27 | 0.27 | 83 | 7.75 | 5.06 |
| 51 | 0.29 | 0.29 | 84 | 8.58 | 5.52 |
| 52 | 0.32 | 0.32 | 85 | 9.50 | 6.01 |
| 53 | 0.35 | 0.32 | 86 | 10.52 | 6.49 |
| 54 | 0.39 | 0.32 | 87 | 11.64 | 6.99 |
| 55 | 0.43 | 0.36 | 88 | 12.84 | 7.51 |
| 56 | 0.48 | 0.42 | 89 | 14.10 | 8.06 |
| 57 | 0.53 | 0.46 | 90 | 15.42 | 8.61 |
| 58 | 0.59 | 0.51 | 91 | 16.66 | 9.22 |
| 59 | 0.64 | 0.57 | 92 | 17.95 | 9.86 |
| 60 | 0.74 | 0.62 | 93 | 19.31 | 10.54 |
| 61 | 0.82 | 0.68 | 94 | 20.75 | 11.29 |
| 62 | 0.92 | 0.74 | 95 | 22.26 | 12.10 |
| 63 | 1.04 | 0.81 | 96 | 23.64 | 13.00 |
| 64 | 1.16 | 0.89 | 97 | 25.12 | 14.01 |
| 65 | 1.28 | 0.97 | 98 | 26.69 | 15.13 |
| 66 | 1.41 | 1.05 | 99 | 28.37 | 16.38 |
| 67 | 1.54 | 1.13 | 100 and older | 00.00 | 00.00 |

Monthly Risk Rates are not applicable beginning at Attained Age 100 and thereafter.

Refer to the **Cost of Insurance** provision in Section 9 of this Policy for more details. The Guaranteed Maximum Monthly Risk Rates shown in the Table above are based on the 2001 Commissioner's Standard Ordinary Select and Ultimate, Smoker or Non-Smoker Mortality Table, Sex Distinct, Age Nearest Birthday.



SCHEDULE
(continued)

TABLE OF END-OF-POLICY-YEAR DEATH BENEFIT FACTORS
FOR THE INITIAL SPECIFIED AMOUNT

This Table shows the Death Benefit Factor applicable to this Policy during the last Policy Month of each Policy Year. The figures shown are based on the Insured's Attained Age, sex, and the Premium Class shown on page 3. Factors for other months are calculated actuarially, adjusted using monthly interest and monthly mortality as appropriate. These factors are available upon request.

| <u>End of Policy Year</u> | <u>Death Benefit Factor</u> | <u>End of Policy Year</u> | <u>Death Benefit Factor</u> |
|---------------------------|-----------------------------|---------------------------|-----------------------------|
| 1 | 4.8645582 | 44 | 1.3630753 |
| 2 | 4.6878681 | 45 | 1.3385564 |
| 3 | 4.5190858 | 46 | 1.3155665 |
| 4 | 4.3576645 | 47 | 1.2941710 |
| 5 | 4.2031099 | 48 | 1.2741256 |
| 6 | 4.0549741 | 49 | 1.2552842 |
| 7 | 3.9128508 | 50 | 1.2376444 |
| 8 | 3.7763700 | 51 | 1.2211895 |
| 9 | 3.6451949 | 52 | 1.2059119 |
| 10 | 3.5200159 | 53 | 1.1917895 |
| 11 | 3.3995306 | 54 | 1.1787381 |
| 12 | 3.2850855 | 55 | 1.1666173 |
| 13 | 3.1755053 | 56 | 1.1552783 |
| 14 | 3.0703580 | 57 | 1.1442658 |
| 15 | 2.9699873 | 58 | 1.1333104 |
| 16 | 2.8734378 | 59 | 1.1221266 |
| 17 | 2.7803959 | 60 | 1.1103302 |
| 18 | 2.6911492 | 61 | 1.0973427 |
| 19 | 2.6054426 | 62 | 1.0820580 |
| 20 | 2.5234343 | 63 | 1.0632069 |
| 21 | 2.4448352 | 64 | 1.0389190 |
| 22 | 2.3697150 | 65 | 1.0064646 |
| 23 | 2.2977740 | 66 and later | 1.0000000 |
| 24 | 2.2290227 | | |
| 25 | 2.1628809 | | |
| 26 | 2.1003949 | | |
| 27 | 2.0407589 | | |
| 28 | 1.9840543 | | |
| 29 | 1.9303773 | | |
| 30 | 1.8793813 | | |
| 31 | 1.8307240 | | |
| 32 | 1.7842623 | | |
| 33 | 1.7397153 | | |
| 34 | 1.6969531 | | |
| 35 | 1.6558533 | | |
| 36 | 1.6164018 | | |
| 37 | 1.5786691 | | |
| 38 | 1.5429736 | | |
| 39 | 1.5091090 | | |
| 40 | 1.4769173 | | |
| 41 | 1.4462433 | | |
| 42 | 1.4169952 | | |
| 43 | 1.3892571 | | |

For an explanation of these factors, refer to the *Death Benefit* provision in Section 7.

SCHEDULE
(continued)

ACCELERATED BENEFIT RIDER FOR LONG TERM CARE SERVICES
TABLE OF MONTHLY RISK RATES
PER \$1,000 OF RIDER NET AMOUNT AT RISK

This Table shows the current and maximum Monthly Risk Rates per \$1,000 of Rider Net Amount at Risk for the Accelerated Benefit Rider for Long Term Care Services. The rates shown are for the Insured's Attained Age and Rate Classification shown in the Schedule for the Accelerated Benefit Rider for Long Term Care Services. The Guaranteed Maximum Monthly Risk Rates shown below will never change. The Current Monthly Risk Rates are applicable on the Policy Date and may be changed as described in the Rider. In no event will the Current Monthly Risk Rates exceed the Guaranteed Maximum Monthly Risk Rates. If this Policy includes an extra risk rating, then the Monthly Risk Rates shown below have been adjusted to include an additional amount for that rating.

| <u>Attained Age</u> | <u>Guaranteed Maximum Monthly Risk Rate</u> | <u>Current Monthly Risk Rate</u> | <u>Attained Age</u> | <u>Guaranteed Maximum Monthly Risk Rate</u> | <u>Current Monthly Risk Rate</u> |
|---------------------|---|----------------------------------|---------------------|---|----------------------------------|
| 35 | 0.0143 | 0.0143 | 68 | 0.3046 | 0.2031 |
| 36 | 0.0200 | 0.0200 | 69 | 0.3348 | 0.2232 |
| 37 | 0.0229 | 0.0229 | 70 | 0.3777 | 0.2518 |
| 38 | 0.0258 | 0.0258 | 71 | 0.4162 | 0.2775 |
| 39 | 0.0286 | 0.0286 | 72 | 0.4549 | 0.3033 |
| 40 | 0.0393 | 0.0315 | 73 | 0.4978 | 0.3319 |
| 41 | 0.0472 | 0.0315 | 74 | 0.5493 | 0.3662 |
| 42 | 0.0514 | 0.0343 | 75 | 0.6009 | 0.4006 |
| 43 | 0.0601 | 0.0401 | 76 | 0.6609 | 0.4406 |
| 44 | 0.0643 | 0.0429 | 77 | 0.7210 | 0.4807 |
| 45 | 0.0729 | 0.0486 | 78 | 0.7939 | 0.5293 |
| 46 | 0.0772 | 0.0515 | 79 | 0.8668 | 0.5779 |
| 47 | 0.0816 | 0.0544 | 80 | 0.9570 | 0.6380 |
| 48 | 0.0816 | 0.0544 | 81 | 1.0557 | 0.7038 |
| 49 | 0.0816 | 0.0544 | 82 | 1.1458 | 0.7639 |
| 50 | 0.0816 | 0.0544 | 83 | 1.2574 | 0.8383 |
| 51 | 0.0816 | 0.0544 | 84 | 1.3690 | 0.9127 |
| 52 | 0.0816 | 0.0544 | 85 | 1.4892 | 0.9928 |
| 53 | 0.0816 | 0.0544 | 86 | 1.6093 | 1.0729 |
| 54 | 0.0816 | 0.0544 | 87 | 1.7338 | 1.1559 |
| 55 | 0.0943 | 0.0629 | 88 | 1.8625 | 1.2417 |
| 56 | 0.1030 | 0.0687 | 89 | 1.9956 | 1.3304 |
| 57 | 0.1159 | 0.0773 | 90 | 2.1372 | 1.4248 |
| 58 | 0.1287 | 0.0858 | 91 | 2.2831 | 1.5221 |
| 59 | 0.1416 | 0.0944 | 92 | 2.4420 | 1.6280 |
| 60 | 0.1588 | 0.1059 | 93 | 2.6136 | 1.7424 |
| 61 | 0.1716 | 0.1144 | 94 | 2.7982 | 1.8655 |
| 62 | 0.1888 | 0.1259 | 95 | 2.9998 | 1.9999 |
| 63 | 0.2017 | 0.1345 | 96 | 3.2230 | 2.1487 |
| 64 | 0.2232 | 0.1488 | 97 | 3.4719 | 2.3146 |
| 65 | 0.2446 | 0.1631 | 98 | 3.7509 | 2.5006 |
| 66 | 0.2617 | 0.1745 | 99 | 4.0557 | 2.7038 |
| 67 | 0.2832 | 0.1888 | 100 and older | 0.0000 | 0.0000 |

Monthly Risk Rates are not applicable beginning at Attained Age 100 and thereafter.

Refer to the **Rider Charges** provision in the **Accelerated Benefit Rider for Long Term Care Services** for more details.

SCHEDULE
(continued)

EXTENSION OF BENEFITS RIDER FOR NURSING HOME AND HOME CARE SERVICES
TABLE OF MONTHLY RATES
PER \$1,000 OF EXTENSION MONTHLY MAXIMUM

This Table shows the current and maximum Monthly Rates per \$1,000 of the Extension Monthly Maximum for the Extension of Benefits Rider for Nursing Home and Home Care Services. The rates shown are for the Insured's Attained Age and Rate Classification shown in the Schedule for the Extension of Benefits Rider for Nursing Home and Home Care Services. The Guaranteed Maximum Monthly Rates shown below will never change. The Current Monthly Rates are applicable on the Policy Date and may be changed as described in the Rider. In no event will the Current Monthly Rates exceed the Guaranteed Maximum Monthly Rates. If this Policy includes an extra risk rating, then the Monthly Rates shown below have been adjusted to include an additional amount for that rating.

| <u>Attained Age</u> | <u>Guaranteed Maximum Monthly Rate</u> | <u>Current Monthly Rate</u> |
|---------------------|--|-----------------------------|
| 49 through 53 | 4.0222 | 4.0222 |
| 54 | 5.0277 | 4.0222 |
| 55 through 99 | 6.0333 | 4.0222 |
| 100 and older | 0.0000 | 0.0000 |

Monthly Rates are not applicable beginning at Attained Age 100 and thereafter.

Refer to the *Rider Charges* provision in the *Extension of Benefits Rider for Nursing Home and Home Care Services* for additional information.

SCHEDULE
(continued)

**OPTIONAL INFLATION PROTECTION BENEFIT FOR
EXTENSION OF BENEFITS RIDER FOR NURSING HOME AND HOME CARE SERVICES
TABLE OF MONTHLY RATES
PER \$1,000 OF EXTENSION MONTHLY MAXIMUM**

This Table shows the current and maximum Monthly Rates per \$1,000 of the original Extension Monthly Maximum in effect on the Policy Date for the Optional Inflation Protection Benefit provided under the Extension of Benefits Rider for Nursing Home and Home Care Services. The rates shown are for the Insured's Attained Age and Rate Classification shown in the Schedule for the Extension of Benefits Rider for Nursing Home and Home Care Services. The Guaranteed Maximum Monthly Rates shown below will never change. The Current Monthly Rates are applicable on the Policy Date and may be changed as described in the Rider. In no event will the Current Monthly Rates exceed the Guaranteed Maximum Monthly Rates. If this Policy includes an extra risk rating, then the Monthly Rates shown below have been adjusted to include an additional amount for that rating.

| Attained Age | Guaranteed Maximum Monthly Rate | Current Monthly Rate |
|---------------------|--|-----------------------------|
| 49 through 53 | 3.6942 | 3.6942 |
| 54 | 4.6177 | 3.6942 |
| 55 through 99 | 5.5413 | 3.6942 |
| 100 and older | 0.0000 | 0.0000 |

Monthly Rates are not applicable beginning at Attained Age 100 and thereafter.

Refer to the *Optional Inflation Protection Benefit* provision in the *Extension of Benefits Rider for Nursing Home and Home Care Services* for benefit information.

SCHEDULE
(continued)

Guaranteed Minimum Benefit Values

The following are the Guaranteed Minimum Benefit Values for this Policy on the Policy Date.

| <u>Benefit</u> | <u>Guaranteed Minimum Benefit Value*</u> |
|---|--|
| Specified Amount | \$109,122.40 |
| Accelerated Benefit Rider for Long Term Care Services | |
| Accelerated Lifetime Maximum | \$109,122.40 |
| Accelerated Monthly Maximum | \$ 4,546.77 |
| Extension of Benefits Rider for Nursing Home and Home Care Services | |
| Extension Lifetime Maximum | \$ 109,122.40 |
| Extension Monthly Maximum | \$ 4,546.77 |

***Guaranteed Minimum Benefit Values** will change over time in the same manner as their corresponding non-guaranteed values change. If benefit values have been reduced under the Guaranteed Minimum Benefit Rider, the Guaranteed Minimum Benefit Values applicable on the date of reduction will apply in place of the non-guaranteed values, even after the Rider terminates, subject to future changes provided in the Policy and attached Riders.

SECTION 1: GENERAL DEFINITIONS

The following are key words used in this Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within the Schedule or the provisions in which they appear in this Policy.

Accelerated Benefit means the amount of the Specified Amount that has been approved by the Company to be accelerated to pay benefits under either of the accelerated benefit riders for terminal illness or long term care services attached to this Policy.

Application means the Application(s) for this Policy, and any Riders if included, attached to and made a part of this Policy. Application includes: (a) any subsequent Applications submitted to the Company to request a change in benefits or to reinstate this Policy; and (b) any amendments to the Application.

Attained Age means the Issue Age shown in the Schedule plus the number of whole years elapsed from the Policy Date.

Base Policy means this Policy without any additional benefits provided by Riders.

Beneficiary means the person(s) or entity(ies) named in the Application or in the most recent change on record with the Company to receive the Death Benefit Payable upon the death of the Insured.

Cash Surrender Value is, on any day, equal to the Policy Value on that day less the Surrender Charge.

Contingent Beneficiary means the person(s) or entity(ies) named in the Application or in the most recent change on record with the Company to receive the Death Benefit Payable if the Beneficiary is not alive at the Insured's death.

Contingent Owner means the person or entity named in the Application or in the most recent change on record with the Company who will become the Owner of this Policy if the Owner dies before the Insured.

Date of Issue is the date on which this Policy is considered to have been produced. The Date of Issue is shown in the Schedule.

Evidence means evidence of the insurability of the Insured acceptable to the Company.

Initial Premium is the premium received as part of the consideration for this Policy. The Initial Premium is shown in the Schedule.

Initial Specified Amount means the Specified Amount effective on the Policy Date as shown in the Schedule.

Issue Age means the Insured's age on his or her birthday nearest the Policy Date. The Issue Age is shown in the Schedule.

Net Cash Surrender Value means the Cash Surrender Value less the Loan Balance on the date of surrender.

Notice means a written notice received at the Service Center in a form acceptable to the Company. It must include the Owner's signature, the date the notice was signed, and the Policy Number of this Policy.

Payee means the person to whom the Company will make benefit payments as provided in Section 11 of this Policy.

Owner means the person or entity who may exercise the rights set forth in this Policy. On the Policy Date, the Owner and any Contingent Owner are as designated in the Application.

Policy Anniversary means the same day and month as the Policy Date for each succeeding year this Policy remains in force.

Policy Date means the date this Policy becomes effective. It is the date from which Policy Anniversaries, Policy Years and Policy Months are measured. The Policy Date is shown in the Schedule.

Policy Month(s) and **Policy Year(s)** mean the months and years during which this Policy is in force. Policy Months and Policy Years are measured from the Policy Date.

Policy Value means a policy value as described in Section 9 of this Policy.

Premium Class means the mortality classifications assigned under this Policy. The Premium Class of the Insured is shown in the Schedule.

Request means a written request received at the Service Center in a form acceptable to the Company. It must include: (a) the Owner's signature; (b) the date the request was signed; and (c) the Policy Number of this Policy which is shown in the Schedule. A Request may be subject to approval by the Company, if applicable.

Rider means a form attached to this Policy that provides additional benefits under this Policy. Any Rider attached to this Policy is shown in the Schedule.

Schedule means the Schedule issued with this Policy on the Policy Date, as well as any subsequent modifications to the Schedule for changes made after the Policy Date.

Service Center means the office of the Company designated for the servicing of this Policy. All correspondence regarding this Policy should be sent to the Service Center. The Service Center address and telephone number are indicated on the face page of this Policy.

Specified Amount means the Specified Amount in effect under this Policy at any given time while this Policy is in force. The Specified Amount may change as described in this Policy and Riders, as applicable.

Surrender Charge means the charge made against the Policy Value in the event of surrender of this Policy. The Surrender Charge is described in the Table of Surrender Charges in the Schedule.

SECTION 2: GENERAL PROVISIONS

THE CONTRACT

The entire contract consists of the following:

- this Policy, including any applicable endorsements, Riders and amendments; and
- the Application.

The Application is evidenced by the copy that was attached to this Policy at issue or delivery. Any subsequent Application will be evidenced by the copy sent to the Owner for attachment to this Policy following Company approval. For purposes of this provision, any Applications sent to the Owner will become part of the entire contract between the parties.

An Application includes all sections and forms the Company has specifically designated as parts of that Application. All statements made by or by the authority of the applicant in an Application are deemed representations and not warranties. No statement will void this Policy or be used in defense of a claim unless it is deemed a material misrepresentation and is contained in an Application attached to, or made a part of this Policy when issued or delivered.

The Owner may amend this Policy during the Insured's lifetime with the Company's consent.

POLICY DATE

The first Policy Year begins on the Policy Date. Subsequent Policy Years begin on the same date each year thereafter. A Policy Anniversary occurs at the beginning of each Policy Year after the first Policy Year. The first Policy Month begins on the Policy Date. Each subsequent Policy Month begins on the same day of the month as the Policy Date unless the month does not contain that day. In such a case, the Policy Month will begin on the first day of the next Policy Month.

Policy Dating When the Initial Premium is Received Before the Date of Issue

When the Initial Premium is received before the Date of Issue, the Policy Date of this Policy will be as shown in the Schedule.

Policy Dating When the Initial Premium is Received On or After the Date of Issue

When the Initial Premium is received on or after the Date of Issue, coverage under this Policy will begin on the date of delivery. The Policy Date will be the same as the date of delivery, unless on the date of delivery the Insured's age for insurance purposes would be different from the age shown in the Schedule. In such a case, the Policy Date will be the last day that the age shown in the Schedule is applicable.

The date of delivery is the date on which this Policy is delivered to the Owner and the first premium is paid while all persons proposed for insurance are living and insurable as described in the Application.

INCONTESTABILITY

The Company will not contest this Policy based on statements made in the Application after this Policy has been in force during the Insured's lifetime for two (2) years from the Date of Issue. The Company can contest this Policy for nonpayment of premium at any time.

Any reinstatement or addition of benefits provided by Rider will be incontestable, except for non-payment of premium, only after such reinstatement or addition of benefits provided by Rider has been in force during the lifetime of the Insured for two (2) years from the effective date of such change.

Requested increases in coverage and addition of benefits provided by Rider may be contested only on the basis of material misrepresentations made in the Application for such change. Reinstatements may be contested only on the basis of material misrepresentations made in the reinstatement Application.

This provision does not apply to any Rider providing additional benefits under this Policy, unless otherwise specified in the Rider.

ASSIGNMENT

No assignment will bind the Company until it has been recorded at the Service Center. The assignment must be submitted to the Company in writing. The Company is not responsible for the validity or effect of any assignment of this Policy by the Owner.

An irrevocable Beneficiary must consent to any assignment in writing. If the Owner lives in a community property state, the Company may require the Owner's spouse to give consent.

MISSTATEMENT

If an insured person's age or sex is misstated, the Company will adjust the benefits to the amount that the Initial Premium paid would have purchased on the Policy Date based on the insured person's correct Issue Age and sex.

SUICIDE

If the Insured dies by suicide within two (2) years beginning with the Date of Issue, the Death Benefit Payable, if any, will be equal to:

- the premiums paid; less
- the Loan Balance on the date of death; less
- any reductions in Policy Value for Partial Withdrawals from this Policy; less
- any benefits paid under any Rider attached to this Policy.

Any premiums paid after the date of the Insured's death will be refunded to the Owner or the Owner's estate, without interest, in addition to the Death Benefit Payable, if any, which will be paid to the Beneficiary.

If this Policy is reinstated, the two (2) year time period provided under this Suicide provision will not start anew.

NONPARTICIPATING

This Policy does not share in any distribution of surplus. No dividends are payable.

TERMINATION

This Policy will terminate on the earliest of:

- the date this Policy terminates in accordance with the **Grace Period** provision in Section 4;
- the date of death of the Insured; or
- the date this Policy is surrendered in accordance with the **Surrender and Net Cash Surrender Value** provision in Section 9.

Any premium received after the date of termination will not cause this Policy to continue in force. Any such premium will be refunded without interest.

SECTION 3: OWNERSHIP AND BENEFICIARY

OWNER AND BENEFICIARY

The designations of Owner, Contingent Owner, Primary Beneficiary and Contingent Beneficiary are as shown in the Application or as subsequently elected by the Owner in a Notice. If the Insured becomes the Owner, any designation of Contingent Owner is automatically revoked.

The Owner has all rights stated in this Policy. If the Owner is other than the Insured and the Owner dies or ceases to exist during the Insured's lifetime, all rights of the Owner vest in the surviving Contingent Owner and the Contingent Owner becomes the Owner. If there is no surviving Contingent Owner, all ownership rights vest in the Owner's estate (if the Owner is an individual) or the Owner's successor in interest (if the Owner is not a natural person).

The interest of a Beneficiary terminates if that Beneficiary dies or ceases to exist before the Insured dies. Upon the Insured's death, the Company will pay the proceeds to any surviving Primary Beneficiaries. If there are no surviving Primary Beneficiaries, the Company will pay the proceeds to any surviving Contingent Beneficiaries. If there are no surviving beneficiaries, the Company will pay the proceeds to the surviving Owner. If there is no surviving Owner, the Company will pay the Owner's estate (if the Owner is an individual) or the Owner's successor in interest (if the Owner is not a natural person).

CHANGE OF OWNER AND BENEFICIARY

The Owner may change the designations of Owner, Contingent Owner, and Primary and Contingent Beneficiary during the Insured's lifetime by providing a Notice to the Company. The new designation will take effect as of the date the Owner signed the Notice. Such a change does not affect any payment made or other action taken by the Company before the Notice is received. If the designation of Owner is changed, any existing revocable Beneficiary designations and any Contingent Owner designation are automatically revoked. The terms of an irrevocable Beneficiary designation cannot be changed or revoked without the consent of that Beneficiary.

SECTION 4: PREMIUM PROVISIONS

PREMIUM PAYMENTS

Any premium paid after the first premium payment should be sent to the Service Center or to the address designated by the Company for receipt of premium payments. Payment may be made to a life insurance agent of the Company, but only in exchange for a receipt signed by an authorized officer of the Company and countersigned by the agent.

The Company reserves the right to limit the amount or frequency of any such additional premium payment if the premium payment would result in an increase in the Death Benefit Payable. We may require evidence of insurability for such an increase.

Unless the Owner requests otherwise, any payment made to the Company for this Policy will be deemed a premium and not: (a) a repayment of a loan; or (b) a payment for loan interest.

Any payment made to the Company, once credited to this Policy, is non-refundable except as otherwise specified in this Policy. No benefits are provided under this Policy on the basis of any premium until that premium is actually paid.

The Company will not accept any premium payment after the Policy Anniversary on or after the Insured reaches Attained Age 100, except for a payment to remove this Policy from the Grace Period.

More premium after the Initial Premium payment will have to be paid to keep this Policy in force in the following circumstances:

- the Net Cash Surrender Value at the beginning of a Policy Month is less than the Monthly Deduction for that month; or
- The Loan Balance exceeds the Cash Surrender Value.

TIMING OF PAYMENTS

This Policy provides life insurance coverage until the death of the Insured if sufficient premiums to keep this Policy in force are paid. It is important for the Owner to make the necessary premium payments to keep this Policy in force. The duration of coverage under this Policy will depend on: (a) the amount, timing and frequency of premium payments; (b) the interest credited; (c) Policy Loans; (d) Partial Withdrawals; (e) Monthly Deductions; (f) applicable benefit payments; and (g) premium expense charges.

PREMIUM LIMITS

This Policy is intended to qualify as a life insurance contract under the Internal Revenue Code of 1986, as amended. The provisions of this Policy are to be interpreted accordingly, despite any other provision to the contrary. The Company reserves the right to limit the amount and frequency of additional premium payments if such payments increase the Death Benefit Payable. The Company will provide written notice of any limitations within 30 days of receipt of such additional premium payment and, any the payment will be refunded by the Company. The Company will not refund a premium payment that is necessary to continue coverage.

GRACE PERIOD

After the first Policy Month, a Grace Period of 62 days is provided under this Policy for payment of the amount required to keep this Policy from terminating. This Policy and all in force Riders will stay in force during the Grace Period. This Policy will enter a Grace Period at the beginning of a Policy Month if:

- the Net Cash Surrender Value is less than the Monthly Deduction for that month; or
- The Loan Balance exceeds the Cash Surrender Value.

At least 30 days prior to the end of the Grace Period, the Company will give written notice advising that the Policy Value is insufficient to keep this Policy in effect. Such notice will be given to:

- the Owner;
- any assignee of record at their last known address; and
- the person designated by the Owner as the Owner's Representative at the Representative's last known address.

If an amount sufficient to remove this Policy from the Grace Period is not paid, this Policy and all Riders will terminate without value as of the later of the following:

- the 31st day after the Company mails the notice for the Grace Period; and
- the 62nd day of the Grace Period.

Death During the Grace Period

If the Insured dies while this Policy is in the Grace Period, the premium required to remove this Policy from the Grace Period as of the date of death will be deducted from the Death Benefit Payable. The amount of this premium will equal the amount of premium required to give this Policy a Net Cash Surrender Value of zero as of the Insured's date of death.

REINSTATEMENT

If this Policy terminates according to the **Grace Period** provision in this Section, the Owner may request reinstatement of this Policy. The following must be received at the Service Center within three (3) years beginning with the date of termination:

- Evidence;
- payment or reinstatement of the Loan Balance, where the Loan Balance is equal to the Loan Balance that existed at the end of the Grace Period; and
- payment of the premium for reinstatement.

If the Company approves the Application for reinstatement, this Policy, including any applicable Surrender Charges, will be reinstated on the day the above conditions are satisfied, which is the date of reinstatement.

The Premium for Reinstatement will equal:

- the amount of premium required to give this Policy a Net Cash Surrender Value of zero as of the date of reinstatement; plus
- two Monthly Deductions.

At the time of Reinstatement, the Policy Value will equal the sum of:

- the Policy Value that yields a Cash Surrender Value of zero; and
- two Monthly Deductions.

At the time of Reinstatement, the Surrender Charges will be the same as if the Policy had never terminated.

SECTION 5: CONTINUATION OF INSURANCE BEYOND ATTAINED AGE 100

If this Policy is in force on the day preceding the Policy Anniversary when the Insured is Attained Age 100, this Policy may be continued in force if the Cash Surrender Value on that day is greater than zero. However, if this Policy is in the Grace Period, sufficient premium must be paid prior to the end of the Grace Period in order to continue this Policy in force.

The following will apply to such continuation of coverage:

- no additional premium may be paid;
- Policy Loan repayments will be allowed in accordance with the **Loan Interest and Repayment** provision in Section 10;
- reinstatement of this Policy will be allowed in accordance with the **Reinstatement** provision in Section 4;
- no additional Monthly Deductions will be taken;
- any Riders attached to this Policy which are then in force will be continued;
- Policy Loan interest will continue to accrue;
- New Policy Loans will be allowed if there is sufficient Policy Value; and
- New Partial Withdrawals will be allowed if there is sufficient Policy Value.

This Policy will enter the Grace Period after the Insured reaches Attained Age 100 if the Loan Balance exceeds the Policy Value. Refer to the **Grace Period** provision in Section 4 for more information.

Except as addressed in this Section, no other changes will be made to this Policy as a result of the Insured reaching Attained Age 100.

Under federal tax law, this policy may not qualify as life insurance on and after Attained Age 100. It may be subject to adverse tax consequences; you should consult a tax advisor.

SECTION 6: ANNUAL REPORT

ANNUAL REPORT

An annual report will be sent to the Owner. It will show the following for the period covered by the report:

- the actual Policy Values;
- Policy activity, including credits and deductions; and
- any other information required by state law and regulation.

If asked, the Company will provide a new illustration of future values. The first illustration in each Policy Year will be provided free of charge.

SECTION 7: DEATH BENEFIT PAYABLE

The Death Benefit Payable under this Policy will be the greater of the following:

- the Death Benefit as described in the **Death Benefit** provision in this Section; and
- the Residual Death Benefit as described in the **Residual Death Benefit** provision in this Section.

Upon the death of the Insured, the Death Benefit Payable under this Policy will be either the Death Benefit or the Residual Death Benefit, but not both.

The Death Benefit Payable will be paid if all of the following have been received at the Service Center:

- this Policy;
- due proof that the Insured died while this Policy was in force; and
- a written claim for the death proceeds completed on a form supplied by the Company.

The Death Benefit Payable will be subject to:

- this Policy's **Misstatement of Age, Incontestability, Suicide, Grace Period, and Partial Withdrawal** provisions, as applicable;
- Section 10, **Policy Loans**; and
- the provisions of any accelerated benefit rider for long term care services attached to this Policy.

Any premiums paid after the date of the Insured's death will be refunded to the Owner or the Owner's estate, without interest, in addition to the Death Benefit Payable, if any, which will be paid to the Beneficiary.

DEATH BENEFIT

The Death Benefit is the greater of the following amounts:

- the Specified Amount in effect on the date of the Insured's death, less any Loan Balance; and
- the Policy Value on the date of the Insured's death times the Death Benefit Factor for the Specified Amount for the Policy Month of death, less any Loan Balance.

The Schedule contains a Table of End-of-Policy-Year Death Benefit Factors for the Specified Amount. Factors for other months are calculated actuarially, adjusted using monthly interest and monthly mortality as appropriate. These factors are available upon request.

RESIDUAL DEATH BENEFIT

The Residual Death Benefit will be equal to the lesser of:

- \$25,000 less 10% of the sum of the Loan Balance and Partial Withdrawals; and
- 10% of the Initial Specified Amount less 10% of the sum of the Loan Balance and Partial Withdrawals.

The Residual Death Benefit may not be accelerated under the terms of any Rider.

SECTION 8: PROCEEDS PAYABLE

PAYMENT OF PROCEEDS PAYABLE

Proceeds Payable means:

- the Death Benefit Payable to be paid upon the Insured's death as provided in Section 7; or
- the amount that becomes payable upon surrender of this Policy.

The Proceeds Payable will be paid from the Service Center. This Policy must be returned to the Company. Unless paid in accordance with a Settlement Option as described in Section 11, the Proceeds Payable will be paid in one sum.

SECTION 9: NONFORFEITURE PROVISIONS

POLICY VALUE

The Policy Value on the Policy Date is equal to:

- any Net Premium credited on the Policy Date; less
- the Monthly Deduction for the first Policy Month.

The Net Premium is the premium paid less the Premium Expense Charge shown in the Schedule.

The Policy Value at the beginning of the Policy Month other than the first Policy Month equals:

- the Policy Value at the beginning of the preceding Policy Month accumulated with interest to the beginning of the current Policy Month; plus
- the Net Premiums credited to this Policy since the beginning of the preceding Policy Month, including any interest on such premiums; less
- the reduction in Policy Value for each Partial Withdrawal made since the beginning of the preceding Policy Month including any interest; less
- any reduction in the Policy Value due to acceleration of the Specified Amount as provided in any accelerated benefit rider attached to this Policy, including any interest; less.
- The Monthly Deduction for the current Policy Month.

The Policy Value on any other day equals:

- the Policy Value at the beginning of the Policy Month accumulated with interest to the day on which the Policy Value is being determined; plus
- the Net Premiums credited to this Policy after the beginning of the Policy Month, including any interest on such premiums; less
- the reduction in Policy Value for each Partial Withdrawal made since the beginning of the Policy Month, including any interest; less
- any reduction in the Policy Value due to acceleration of the Specified Amount as provided in any accelerated benefit rider attached to this Policy, including any interest.

MONTHLY DEDUCTION

The Monthly Deduction for a Policy Month includes:

- the monthly Cost of Insurance for the Base Policy; plus
- any monthly Rider Charge for additional benefits provided by any Rider attached to this Policy, plus
- the Monthly Administrative Fee shown in the Schedule.

Monthly Deductions will cease on the Policy Anniversary coinciding with the Insured's Attained Age 100.

COST OF INSURANCE FOR THE BASE POLICY

The Cost of Insurance is determined each Policy Month.

The Cost of Insurance for the Death Benefit for a Policy Month equals:

- the Monthly Cost of Insurance Rate per \$1,000; times
- the number of thousands of Net Amount at Risk for that Policy Month.

The Monthly Cost of Insurance Rate per \$1,000 equals:

- the Monthly Risk Rate per thousand; divided by
- one (1) plus the monthly decimal equivalent of the interest rate used to calculate this Cost of Insurance Rate.

The Net Amount at Risk for a Policy Month equals:

- the Death Benefit; less
- the Projected Policy Value at the end of the Policy Month.

The Projected Policy Value at the end of a Policy Month is the Policy Value at the beginning of the Policy Month accumulated with interest to the end of the Policy Month at the interest rate(s) assumed to be credited for that Policy Month.

The Cost of Insurance for the Base Policy does not include charges for the portion of the Net Amount at Risk equal to the difference between the Residual Death Benefit, if in effect, and the remaining Death Benefit.

MONTHLY RISK RATES

The Table of Monthly Risk Rates for the Base Policy is shown in the Schedule.

INTEREST RATE

The Credited Interest Rate used to calculate the Policy Value will never be less than the Guaranteed Credited Interest Rate shown in the Schedule.

CHANGES IN RATES, CHARGES AND FEES

At its sole discretion, the Company may change the Monthly Risk Rates and the Credited Interest Rates for the Base Policy. The Credited Interest Rate on Policy Loans will not be less than the Guaranteed Credited Interest Rate. The Credited Interest Rate on Policy Loans and the Guaranteed Credited Interest Rate are shown in the Schedule. The Monthly Risk Rates for the Base Policy will not exceed the Guaranteed Maximum Monthly Risk Rates shown in the Table of Monthly Risk Rates for Base Policy in the Schedule.

The Company will base any change on its expectations as to future investment earnings, mortality, morbidity, persistency, expenses and taxes. The Company will not make any change in order to recoup prior losses.

Any change in the Monthly Risk Rates for the Base Policy will apply to all insureds with the same combination of the following: (a) Attained Age; (b) number of years of insurance in force; (c) Premium Class; (d) sex; and (e) Net Amount at Risk.

CASH SURRENDER VALUE

The Cash Surrender Value on any day is equal to the Policy Value on that day less the Surrender Charge.

SURRENDER CHARGE

A Surrender Charge will be taken upon surrender of this Policy. The Surrender Charge is shown in the Schedule.

SURRENDER AND NET CASH SURRENDER VALUE

The Owner may surrender this Policy for its Net Cash Surrender Value by filing Notice with the Company. Surrender occurs on the date of surrender provided the Insured is living on the date the Notice is signed. This Policy will terminate as of the date of surrender. The Grace Period does not apply to termination due to surrender.

The date of surrender will be one of the following:

- the date the Notice was signed if the Notice is received at the Service Center within 30 days after the date it was signed;
- the date the Company receives the Notice if the Notice is received at the Service Center more than 30 days after the date it was signed.

The Net Cash Surrender Value is the amount payable on surrender. It equals:

- the Cash Surrender Value on the date of surrender; less
- any Loan Balance on the date of surrender.

The Company may defer payment up to six (6) months after Notice is received. Interest at the current Credited Interest Rate payable by the Company will be payable after the date the Company receives the Notice at the Service Center on the amount of the Net Cash Surrender Value if not paid within 10 working days or as required by law.

If the date of surrender is within 30 days after a Policy Anniversary, the Net Cash Surrender Value will not be less than:

- the Net Cash Surrender Value on the Policy Anniversary; less
- each Policy Loan made since the Policy Anniversary and the accrued interest on each loan; less
- the reduction in Policy Value for each Partial Withdrawal made since the Policy Anniversary and the interest on each reduction.

PARTIAL WITHDRAWAL

The Owner may make a Partial Withdrawal by filing Notice with the Company. A Partial Withdrawal will be made on the date of Partial Withdrawal provided the Insured is then living and this Policy is not then being continued as paid-up insurance in accordance with any paid-up insurance provision provided under this Policy or by Rider.

The date of Partial Withdrawal will be one of the following:

- the date of the Notice if the Notice is received at the Service Center within 30 days after that date; or
- the date the Company receives the Notice if the Notice is received at the Service Center more than 30 days after the date of the Notice.

The maximum amount that may be paid to the Owner as a Partial Withdrawal will be an amount equal to:

- the Net Cash Surrender Value on the date of Partial Withdrawal less \$275.00; less
- loan interest to the end of the Policy Year.

Payment to the Owner may be deferred up to six (6) months after Notice is received. However, a Partial Withdrawal to pay premiums to the Company will not be deferred. Interest at the current Credited Interest Rate payable by the Company will be payable after the date the Company receives the Notice at the Service Center on the amount of the Partial Withdrawal if not paid within 10 working days or as required by law.

The Policy Value is reduced on the date of Partial Withdrawal by an amount referred to as the reduction in Policy Value. The amount of this reduction is equal to:

- the amount paid to the Owner; plus
- the Administrative Fee for Partial Withdrawal shown in the Schedule.

The Specified Amount will be decreased on the date of Partial Withdrawal by an amount equal to the Partial Withdrawal.

PAID-UP INSURANCE

If this Policy has a positive Net Cash Surrender Value, the Owner may elect to continue this Policy as a level amount of paid-up insurance by providing the Company with a Notice. The effective date of the paid-up insurance will be the beginning of the Policy Month on or immediately following receipt of the Notice provided the Insured is then living.

The amount of this paid-up insurance will be that which the Cash Surrender Value on the effective date of the paid-up insurance will provide when applied as a net single premium. Coverage for any Riders, other than an Accelerated Death Benefit Rider for Terminal Illness, will cease, except to the extent that nonforfeiture benefits are defined within such Riders.

This paid-up insurance may be surrendered at any time. The amount payable on surrender is the Net Cash Surrender Value. The Net Cash Surrender Value is the Cash Surrender Value less the Loan Balance. The Cash Surrender Value is the net single premium for the benefits remaining under the paid-up insurance.

If the date of surrender is within 30 days after a Policy Anniversary, the Net Cash Surrender Value will not be less than:

- the Net Cash Surrender Value on the Policy Anniversary; less
- each Policy Loan made since the Policy Anniversary and the accrued interest on each loan.

BASIS OF COMPUTATIONS

The mortality tables and rates of interest used in calculating minimum Policy Values and paid up insurance net single premiums are shown in the Schedule. Policy Values are at least equal to those required by statute in the state in which this Policy was delivered. A detailed statement of the method used to compute these values has been filed with the insurance department of that state.

SECTION 10: POLICY LOANS

POLICY LOAN

The Company will make a Policy Loan upon the sole security and assignment of this Policy. The Owner may obtain the Policy Loan while this Policy is in force by providing a Notice to the Company. The amount advanced as a Policy Loan will not exceed:

- the Loan Value; less
- the Loan Balance on the date the Policy Loan is to be made; less
- the projected Policy Loan interest to the end of the Policy Year.

The Loan Value is equal to:

- the Cash Surrender Value on the date the Loan Value is being determined; less
- the projected Monthly Deductions for the remainder of the current Policy Year.

The Loan Balance at any time is equal to:

- the sum of all Policy Loans made; less
- the sum of all Policy Loan repayments; plus
- accrued Policy Loan interest.

DEFERRAL

The Company may defer making a Policy Loan up to six (6) months after it receives Notice; however, a loan for payment of premiums to the Company will not be deferred. Interest at the current Credited Interest Rate payable by the Company will be payable after the date the Company receives the Notice at the Service Center on the amount of the Policy Loan if not paid within 10 working days or as required by law.

DETERMINING THE LOAN INTEREST RATES CHARGED

We will determine the loan interest rates for this product on January 1 of each calendar year using the following 3-step process.

Step 1. Comparison

We determine the greater of (a) and (b) where:

- (a) is the Published Monthly Average for October of the preceding calendar year.
- (b) is the interest rate we credited to unloaned Policy Value under this life insurance product as of October 31 of the preceding calendar year plus 1%.

Published Monthly Average means:

- Moody's Corporate Bond Yield Average – Monthly Average Corporates as published by Moody's Investors Services, Inc. or its successor(s); or
- A substantially similar average set by regulation issued by the department of insurance of the state in which this policy was delivered if Moody's Corporate Bond Yield Average – Monthly Average Corporates is no longer published.

Step 2. Maximum Loan Interest Rate

If the outcome of Step 1 exceeds or falls short of the Maximum Loan Interest Rate for the preceding calendar year by no more than $\frac{1}{2}\%$, we will set the Maximum Loan Interest Rate equal to the Maximum Loan Interest Rate for the preceding calendar year. Otherwise, we will set the Maximum Loan Interest Rate at the greater of (a) and (b) in Step 1.

The interest rate we charge will not exceed the Maximum Loan Interest Rate determined in Step 2.

These rates will become effective for this policy as of the Policy Anniversary on or immediately following January 1 and will remain in effect until the next Policy Anniversary. They will apply to both new and existing loans.

SECTION 11: SETTLEMENT OPTIONS

PAYMENT OF THE DEATH BENEFIT PAYABLE UPON THE DEATH OF INSURED

When this Policy becomes payable by the death of the Insured, settlement will be made within two (2)

months after receipt of due proof of death in a form satisfactory to the Company. The Proceeds Payable may be paid in a single sum or left with the Company for payment under a mutually agreeable

settlement option. The amount applied under an option must be at least \$2,000. The amount of each payment under an option must be at least \$50.

The Owner may elect or revoke a settlement option at any time before the Proceeds Payable is paid. If no settlement option election is in effect at the time the Proceeds Payable is to be paid, the Payee may make an election. Notice must be filed at the Service Center. Election or revocation will take effect as of the date of the Notice. An election does not affect any payment made or other action taken by the Company before the Notice is received. A Payee that is not a natural person may elect a settlement option only with the Company's approval. An assignee cannot elect a settlement option. Change of Owner or Beneficiary automatically revokes any election in effect.

CLAIMS OF CREDITORS

Unless otherwise provided at the time an alternative is selected, the Payee may neither commute, anticipate, assign, alienate nor otherwise encumber any payment under an alternative. Payments under any alternative are exempt from the claims of creditors and from legal process to the extent the law permits.

DEATH OF PAYEE

Unless otherwise specified, at the death of the last Payee a final payment will be made to the Payee's estate.

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE POLICY
Adjustable Death Benefit
Flexible Premium Payable on the Policy Date
Benefits Vary with Current Risk Rates and Current Interest Rates
Nonparticipating – No Dividends

Genworth Life Insurance Company of New York

(Herein referred to as "the Company")

A Stock Company

Home Office: 666 Third Street, 9th Floor, New York, NY 10017

Service Center Address: 3100 Albert Lankford Drive, Lynchburg, VA 24501

P. O. Box 461, Lynchburg, VA 24505-0461

Service Center Phone: 888-325-5433

ACCELERATED BENEFIT RIDER FOR LONG TERM CARE SERVICES NURSING HOME AND HOME CARE INSURANCE

This Rider, also referred to as "Accelerated Benefit Rider", is made a part of the Policy to which it is attached. This Rider accelerates the Policy's Specified Amount to reimburse the Owner for expenses the Insured incurs for Qualified Long Term Care Services that are covered under this Rider. It is subject to all of the terms, conditions and definitions of the Policy unless stated otherwise in this Rider. READ THIS RIDER CAREFULLY.

TAXATION: This Rider is intended to be federally tax-qualified long term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191 (herein referred to as the "Code"). **This is not a health insurance rider and is not subject to the minimum requirements of New York Law pertaining to Long Term Care Insurance and does not qualify for the New York State Long Term Care Partnership Program, and is not a Medicare Supplement Policy. This Rider is intended to be a qualified long term care insurance rider for federal tax law only**

CONFORMITY WITH INTERNAL REVENUE CODE: If it is determined that this Rider does not comply with the requirements of the above-cited section of the Code, the Company will, upon approval of the appropriate state regulatory agency, inform the Owner in writing of any such required change in the provisions of this Rider. The Owner will be given the choice of accepting the change or retaining this Rider without the change.

THE OWNER HAS AN UNCONDITIONAL RIGHT TO RETURN THIS RIDER IN THE FIRST 30 DAYS. The Owner may return this Rider for any reason within 30 days after its delivery by taking it or mailing it to the Service Center or to any life insurance agent appointed by the Company. Immediately upon delivery or mailing to the Company, the Policy and this Rider will be deemed void from the beginning. Any premium paid will be returned.

NOTICE TO OWNER: This Rider may not cover all of the costs associated with long term care which may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all limitations in the Policy and this Rider.

CAUTION: *The issuance of this Rider is based upon the responses to the questions on the Application for the Policy and this Rider. A copy of the Application is enclosed. If any answers fail to include all material information requested, the Company has the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any answers are incorrect, contact the Service Center at the above address.*

RENEWABILITY: This Rider is guaranteed renewable. This means that the Company may not, on its own, cancel or reduce coverage provided by this Rider. Subject to the Rider Termination provisions, this Rider will remain in force for as long as the Policy remains in force and the required charges for this Rider are paid.

CONSIDERATION: This Rider is issued in consideration of the Application for this Rider and payment of the Initial Premium.

- **RIDER CHARGES:** The monthly charge for this Rider will be included in the Monthly Deduction for the Policy.

The Initial Monthly Charge for this Rider is shown in the Schedule.

The monthly charge for this Rider is equal to:

- the applicable Monthly Risk Rate per \$1,000 of Rider Net Amount at Risk, divided by 1,000; multiplied by
- the Rider Net Amount at Risk (which is equal to the Specified Amount reduced by the Policy Value);
- as those amounts apply on the date the charge is made.

Subject to rate requirements applicable in the State of New York, the Company may change the Current Monthly Risk Rates or Current Monthly Rates shown in the Schedule for this Rider on any Policy Anniversary. Any rate change will be made only when the Company changes the rates on a class basis for all riders on the same form as this Rider that are delivered in the same state as this Rider. However, the rate change will never exceed the Guaranteed Maximum Monthly Risk Rates and Guaranteed Maximum Monthly Rates shown in the Schedule. The Company will give the Owner at least 60 days prior written notice before the effective date of any rate change.

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SECTION 1: THE RIDER TAKING EFFECT AND REMAINING IN FORCE

EFFECTIVE DATE

This Rider is issued with the Policy. Its effective date is the Policy Date shown in the Policy Schedule, and its Date of Issue is the Date of Issue of the Policy as shown in the Schedule. This Rider will not become effective unless the Policy becomes effective.

RIDER TERMINATION

This Rider will terminate on the earliest of:

- the date the Policy terminates as described in the Policy;
- the date the Owner exercises an Accelerated Benefit Rider for Terminal Illness, if attached to the Policy;
- the date the Accelerated Lifetime Maximum is exhausted; or
- the date of death of the Insured.

Except as specified above, this Rider may not be terminated unless the Policy is also terminated.

Upon termination of this Rider, no further benefits will be paid under this Rider except as provided under the ***Extended Benefits When Policy and Rider Terminate*** provision in this Rider.

EXTENDED BENEFITS WHEN POLICY AND RIDER TERMINATE

Termination of the Policy and this Rider will not affect any benefits payable if eligibility for such benefits or total disability began while the Policy and this Rider were in force and continues without interruption from the date of termination. For the purposes of this provision, total disability means that the Insured is a Chronically Ill Individual. This extension of benefits beyond the date of termination will continue only until the earliest of the following:

- for benefits payable under the Nursing Facility Benefit, the Assisted Living Facility Benefit, the Bed Reservation Benefit, the International Coverage Benefit and the Alternative Care Benefit, the date a period of 180 days elapses during which the Insured has not incurred expenses covered by any of those Benefits;
- the date the Accelerated Lifetime Maximum is exhausted;
- the date the Insured ceases to meet the requirements of the Eligibility for Payment of Benefits provision in this Rider.

Except as stated above, this provision is subject to the:

- the Benefits' Coverage Maximums as shown in the Schedule;
- and all other applicable provisions of this Rider and the Policy.

IF THE INSURED'S BENEFITS ARE CONTINUED UNDER THIS PROVISION, THE DEATH BENEFIT PAYABLE UNDER THE POLICY WILL NOT BE PAID.

SECTION 2: DEFINITIONS

The following are key words used in this Rider. When they are used, they are capitalized. Also, some terms are capitalized and defined within the Policy or the provisions in which they appear in this Rider.

Accelerated Lifetime Maximum means the amount shown in the Schedule as of the Policy Date and as changed over time. The amount of the Accelerated Lifetime Maximum will:

- decrease due to Partial Withdrawals;
- decrease due to benefit payments made under this Rider; and
- decrease due to payment of the Death Benefit Payable under the Policy.

Accelerated Monthly Maximum means the total monthly amount the Company will pay for Covered Care expenses incurred under all of the following Benefits combined:

- the Home Care Benefit;
- the Nursing Facility Benefit;
- the Assisted Living Facility Benefit;
- the Bed Reservation Benefit;
- the Respite Care Benefit; and
- the International Coverage Benefit.

The Accelerated Monthly Maximum is also used to determine the maximum amounts payable for benefits in this Rider, as set forth in the Schedule. The Accelerated Monthly Maximum applicable on the Policy Date is shown in the Schedule. As described in this Rider, the amount of the Accelerated Monthly Maximum will decrease due to Partial Withdrawals.

Activities of Daily Living (ADLs) means the following functions:

- **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring:** Moving into or out of a bed, chair or wheelchair.
- **Continence:** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.

Adult Day Care Services means a program for six (6) or more individuals of social and health related services provided during the day in a community setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside of the Home.

Assisted Living Facility means a facility (including a facility for people with Alzheimer's disease) that is not excluded below and is engaged primarily in providing continual (24 hours a day, every day) assistance and supervision to residents who are unable to perform Activities of Daily Living or have Severe Cognitive Impairment. It must provide those services under the terms of a license, certification or similar permit and oversight by the federal government or the state in which it is located. If such licensing, certification or similar permit and oversight by the federal government or the state in which it is located is not required the facility must provide such services in accordance with all applicable laws and regulations and continuously satisfy all of the following.

- It has accommodations for at least ten (10) residents;
- It maintains records for all care and services provided to each resident inpatient;
- It has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment;
- It has an awake employee who is aware of the whereabouts of the resident inpatients;
- It provides Substantial Assistance with Activities of Daily Living;
- It provides three (3) meals a day and accommodates special dietary needs;
- It has written formal procedures, including an agreement with a physician or Nurse, for the furnishing of medical care and services in case of an emergency; and
- It has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Living Facility is NOT any of the following:

- A facility that does not satisfy the above definition.
- A clinic or hospital.
- A subacute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- A Nursing Facility.
- The Covered Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- An adult residence establishment or environment which is substantially similar to the above.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Living Facility only if it is engaged primarily in providing care that satisfies the above definition.

Chore Services means assistance with the following light work activities: (a) minor household repairs related to the Insured's safety at Home (such as to handrails and safety rails, stairs, or floors); (b) taking out the garbage; and (c) simple cleaning tasks to remove unsafe debris or dirt in the Insured's Home.

Chore Services do not include any type of: (a) residential upkeep; (b) construction; (c) renovation or routine home preservation (such as painting); (d) lawn or yard care; (e) snow removal; (f) vehicle or equipment maintenance; or (g) similar tasks.

Chronically Ill Individual means a person who has been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

Covered Care means only those Qualified Long Term Care Services for which this Rider pays benefits.

Current Eligibility Certification is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that the Insured meets the above requirements for being a Chronically Ill Individual.

Domestic Partner means a person who lives with the Insured in a domestic partner relationship; provided that the Insured has completed and returned a declaration of domestic partnership in a form and manner acceptable to the Company.

Family Member means: (a) the Insured's spouse or Domestic Partner; and (b) the following relatives of the Insured or the Insured's spouse or Domestic Partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Home means the Insured's primary place of residence in the area the Insured uses principally for independent residential living. This could be: (a) a house; (b) a condominium; (c) an apartment; (d) a unit in a congregate care community; or (e) similar residential environment. The Insured's Home does not include: (a) a hospital; (b) Nursing Facility; or (c) Assisted Living Facility.

Home Health Aide and Personal Care Services means assistance the Insured receives with: (a) simple health care tasks; (b) personal hygiene; (c) managing medications; (d) help in performing Activities of Daily Living; and (e) supervision the Insured needs when he or she has Severe Cognitive Impairment.

Homemaker Services means assistance with one or more of the following tasks: (a) meal planning and preparation; (b) doing laundry; and (c) light house cleaning, such as: (1) vacuuming; (2) dry mopping; (3) dishwashing; (4) cleaning the kitchen or bath; and (5) changing soiled bedding.

Hospice Care means services that are designed to:

- provide palliative care to the Insured; or
- alleviate the Insured's physical, emotional and spiritual discomforts because the Insured is experiencing the last phases of life due to a terminal disease (diagnosed with six (6) months or less to live).

Hospice Care can be provided in:

- the Insured's Home; or
- a separate facility that is licensed or certified to provide Hospice Care by the state in which it is located. Room and board expenses provided in such a facility will be a Covered Care expense under this Rider.

Hospice Care does not include coverage for prescription drugs.

Insured means the person named as the Insured in the Schedule. Insured does not include any other persons who may be covered by an added benefit Rider.

Licensed Health Care Practitioner means any of the following who is not a Family Member:

- a physician as defined in Section 1861(r)(1) of the Social Security Act;
- a registered professional Nurse;
- a licensed social worker; or
- any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Medicaid means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Nurse means 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.

Nurse and Therapist Services means services provided in the Insured's Home by:

- a Nurse; or
- a licensed physical, occupational, respiratory, or speech therapist.

Nursing Facility means a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse. The facility must employ at least one full-time (at least 30 hours per week) Nurse. A Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Facility does NOT include any of the following:

- A clinic or hospital.
- A subacute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- An Assisted Living Facility.
- The Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- An adult residence establishment or environment which is similar to the above.

Out-of-Country Nursing Facility is an institution, not excluded below, that:

- is located outside the United States, its territories and possessions; and
- is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients; and
- satisfies all of the following Conditions.

Conditions: To satisfy this Out-of-Country Nursing Facility definition, such facility, or a separate portion, ward, wing or unit thereof, must at all times:

- provide such nursing care in accordance with the authority granted by a license or similar accreditation acceptable to the Company that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which benefits would be payable under the Nursing Facility Benefit of this Rider;
- employ at least one full-time (employed at least 30 hours per week) Graduate Nurse;
- have a Graduate Nurse on duty or on call in the facility at all times
- have an awake employee on duty in the facility who is:
 - trained and ready to provide its residents with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
 - aware of the whereabouts of the residents;
 - provide three meals a day and accommodate special dietary needs;

- have arrangements with a duly licensed physician or Graduate Nurse to furnish medical care and services in case of an emergency;
- have the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications; and
- have accommodations for at least ten resident inpatients in that location.

For the purposes of this definition, a Graduate Nurse is a person who has:

- completed an extensive post-secondary nursing care training program; and
- a current license to provide skilled nursing care to sick or infirm individuals under the direction of a licensed physician.

Excluded Places: The definition of an Out-of-Country Nursing Facility does NOT include any of the following:

- A clinic or hospital.
- A subacute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- The Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- An adult residence establishment or environment which is substantially similar to the above.

Plan of Care means a written, individualized plan for care and support services for the Insured that:

- has been developed as a result of an assessment and incorporates any information provided by the Insured's personal physician;
- has been prescribed by a Licensed Health Care Practitioner;
- fairly, accurately and appropriately addresses the Insured's long term care and support service needs; and
- specifies the following:
 - the type, frequency and duration of all services required to meet those needs;
 - the providers appropriate to furnish those services; and
 - an estimate of the appropriate cost of such services.

The Company retains the right to discuss the Plan of Care with the Licensed Health Care Practitioner. The Company may also verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual. The Plan of Care must be updated as the Insured's needs change. The Company must receive a copy of the Plan of Care upon its completion and each time it is updated. The Company retains the right to request periodic updates not more frequently than once every 30 days. The Company will make a copy of the current Plan of Care available to the Insured's personal physician, when requested. No more than one Plan of Care may be in effect at a time.

Qualified Long Term Care Services means the necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which are:

- required if the Insured becomes a Chronically Ill Individual; and
- provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Important Note: To be eligible for payment under this Rider, it is not sufficient for services to be only Qualified Long Term Care Services. Such services must also:

- be care or support services for which this Rider pays benefits; and
- satisfy all requirements for Benefit eligibility and payment.

"Maintenance or Personal Care Services" as used above and elsewhere in this Rider 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 Insured is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that is:

- comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- 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;
 - deductive or abstract reasoning;
 - judgment as it relates to safety awareness.

Substantial Assistance is either:

- **Hands-on Assistance**, which is the physical assistance (minimal, moderate or maximal) of another person without which the Insured would be unable to perform the Activity of Daily Living; or
- **Standby Assistance**, which is the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he or she is performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include verbal cueing, prompting, gestures, or other demonstrations) by another nearby person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

SECTION 3: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

For benefits to be payable under this Rider:

- the Insured must be a Chronically Ill Individual;
- the Company must receive a Current Eligibility Certification for the Insured; and
- the Company must receive ongoing proof which demonstrates that the Covered Care the Insured receives is needed due to his or her continually being a Chronically Ill Individual. The proof can be based on information from:
 - care providers;
 - personal physicians; and
 - other Licensed Health Care Practitioners.

CONDITIONS FOR PAYMENT

Benefits will be paid as reimbursement for incurred Covered Care expenses that meet all of the following conditions:

- the Owner must elect to accelerate the Specified Amount by submitting a claim for benefits under this Rider;
- the payment of any benefit amount must be approved by any irrevocable Beneficiary;
- the Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- the Insured has not exhausted any limits applicable to the specific benefits claimed;
- the Insured meets all additional requirements for the specific benefits claimed; and,
- except as stated in the **Extended Benefits** provision, the Policy and this Rider must be in force on the date the expense, fee, or charge for an item of Covered Care is incurred. An expense, fee or charge will be considered to be incurred on the day on which the Covered Care is received.

Once the Company determines that the Insured is eligible for benefits, the Insured's eligibility for benefits will continue for as long as the Insured continues to be a Chronically Ill Individual, and has not exhausted the Accelerated Lifetime Maximum. The Company reserves the right to perform periodic reassessments of the Insured's eligibility, but no more frequently than every 90 days.

SECTION 3A: PRIVILEGED CARE® COORDINATION SERVICES

These services are intended to help identify care needs and community resources available to deliver care when the Insured is a Chronically Ill Individual. These services are furnished by a team of Privileged Care Coordinators provided by the Company at its own expense. The Company will pay for these services when the Insured receives them while this Rider is in force. These payments will NOT count against any payment maximum.

ABOUT THE PRIVILEGED CARE COORDINATION SERVICES

Privileged Care Coordination Services will provide the Insured with a team of Privileged Care Coordinators who will review the Insured's specific situation and develop a Plan of Care to meet the Insured's needs. Privileged Care Coordinators will:

- assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis;
- work with the Insured to identify the specific services and care providers the Insured requires;
- develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs;
- provide the initial and ongoing Current Eligibility Certifications; and
- monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care.

The Company should be contacted immediately when the services of a Privileged Care Coordinator are desired. The Company will then make arrangements for a Privileged Care Coordinator to contact the Insured and begin providing the Insured with these services.

A **Privileged Care Coordinator** is a Nurse or licensed social worker who is:

- qualified by training and experience to assess and coordinate the overall care needs of a Chronically Ill Individual; and
- meets standards satisfactory to the Company that pertain to quality assurance, reporting and record maintenance requirements.

PRIVILEGED CARE COORDINATION SERVICES ARE VOLUNTARY

The Insured is not required to use Privileged Care Coordination Services. However, the Company will not cover the expense of any of the following from by a Licensed Health Care Practitioner who is not a Privileged Care Coordinator:

- creation of a Plan of Care;
- providing a Current Eligibility Certification; or
- assistance in coordinating services.

Payment for these services is NOT subject to:

- the Accelerated Lifetime Maximum;
- the Accelerated Monthly Maximum; or
- any other payment limits.

Payment for these services does not qualify for the Waiver of Monthly Deduction Benefit.

Payment Limitations: Privileged Care Coordination Services will not be provided in connection with the International Coverage Benefit.

SECTION 3B: HOME CARE BENEFIT

The Company will pay for expenses the Insured incurs for the following Covered Care:

- Adult Day Care Services;
- Nurse and Therapist Services;
- Home Health Aide and Personal Care Services;
- Homemaker Services;
- Chore Services; and
- Hospice Care.

These services must be:

- received in the Insured's Home, unless they are Adult Day Care Services or Hospice Care;
- necessary to enable the Insured to continue to stay safely at Home, unless the services are in a facility providing Hospice Care;
- necessary because the Insured alone is not able to perform them due to the Insured being a Chronically Ill Individual; and
- consistent with the needs addressed in the Insured's Plan of Care.

Providers of these services do not need to be affiliated with a home health care agency.

Payment Limitations: Payment of this Benefit is subject to the Accelerated Lifetime Maximum and the Accelerated Monthly Maximum.

SECTION 3C: NURSING FACILITY BENEFIT

The Company will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by a Nursing Facility while the Insured is confined there as a resident inpatient.

This includes expenses for:

- private duty nursing care provided by a Nurse who is not employed by the facility; and
- all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility.

The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Payment Limitations: Payment of this Benefit is subject to the Accelerated Monthly Maximum, and the Accelerated Lifetime Maximum.

SECTION 3D: ASSISTED LIVING FACILITY BENEFIT

The Company will pay the expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Assisted Living Facility while the Insured is confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Payment Limitations: Payment of this Benefit is subject to the Accelerated Monthly Maximum, and the Accelerated Lifetime Maximum.

SECTION 3E: BED RESERVATION BENEFIT

The Company will continue to pay benefits under the *Nursing Facility Benefit* and the *Assisted Living Facility Benefit* while the Insured:

- is temporarily absent during a stay in a Nursing Facility or Assisted Living Facility; and
- is charged to reserve the Insured's accommodations in that facility.

The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay or when the Insured spends holidays or other time with his or her family.

Payment Limitations: Payment of this Benefit is subject to the Accelerated Monthly Maximum, and the Accelerated Lifetime Maximum. Payment will not exceed the number of days (continuous or not) shown in the Schedule for this Benefit.

SECTION 3F: RESPITE CARE BENEFIT

When the Insured receives Respite Care, the Company will pay the following Benefits:

- the Nursing Facility Benefit;
- the Assisted Living Facility Benefit;
- the Bed Reservation Benefit; and
- the Home Care Benefit.

Respite Care means short-term care that is provided to the Insured in order to relieve the person who normally provides the Insured with unpaid informal care in the Insured's Home. The Insured's Plan of Care must state:

- the name of the unpaid caregiver for whom respite is being provided;
- the period of respite; and
- the Covered Care the Insured will require to replace that care normally provided by the unpaid caregiver.

Respite Care can be received in the Insured's Home, or during a temporary stay in a Nursing Facility or Assisted Living Facility.

Payment Limitations: Payment of this Benefit is subject to the Accelerated Lifetime Maximum and the Accelerated Monthly Maximum. This Benefit will not be payable at the same time as any other Benefit except when the Company pays for Privileged Care Coordination Services or Caregiver Training. Payment of benefits will not exceed the number of days shown in the Policy Schedule for this benefit.

SECTION 3G: CAREGIVER TRAINING BENEFIT

The Company will pay for expenses the Insured incurs for training an unpaid informal caregiver to care for the Insured in the Insured's Home. All the following conditions apply to this Benefit:

- The Company will not pay to train someone who will be paid to care for the Insured.
- The training can be received while the Insured is confined in a hospital, Nursing Facility, or Assisted Living Facility only if it is reasonably expected that the training will make it possible for the Insured to go Home where the Insured can be cared for by the person receiving the training.

Payment Limitations: This Benefit is not subject to the Accelerated Monthly Maximum. This Benefit is subject to the Accelerated Lifetime Maximum and the Coverage Maximum shown in the Schedule.

SECTION 3H: SUPPORTIVE EQUIPMENT BENEFIT

Benefits will be payable for Supportive Equipment if it is specified and provided in accordance with the Insured's Plan of Care. The Company will pay for expenses, including installation fees, labor and related costs, the Insured incurs for the purchase or rental of Supportive Equipment, if such equipment is:

- intended to assist the Insured in living at Home by relieving the Insured's need for direct physical assistance; and
- specified and provided in accordance with the Insured's Plan of Care stating that the equipment is expected to enable the Insured to remain at Home for at least 90 days after the date of purchase or first rental.

Supportive Equipment includes items such as the following:

- pumps and other devices for intravenous injection;
- ramps to permit movement from one level of a residence to another;
- grab bars to assist in toileting, bathing or showering; and
- stair lifts for going between levels of the Insured's Home.

Supportive Equipment 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 the Insured's body, temporarily or permanently.

Payment Limitations: This Benefit is subject to the Accelerated Lifetime Maximum shown in the Schedule and the Coverage Maximum shown in the Schedule.

SECTION 3I: ALTERNATIVE CARE BENEFIT

For expenses not otherwise covered. Prior approval by the Company is required.

The Company will pay for expenses the Insured incurs for care, treatment, services, supplies or other items not specifically covered by another Benefit under this Rider when all of the following conditions are met:

- They are clearly specified in the Insured's Plan of Care and in a separate written mutual agreement between the Company, the Owner, any irrevocable Beneficiary, and if appropriate, the Insured or the Insured's physician.
- They are cost-effective alternatives to Benefits specifically available under this Rider.
- They are for Qualified Long Term Care Services.
- They are incurred while such mutual agreement is in effect.
- They are incurred while the Insured's insurance is in force under the Policy and this Rider.
- The expenses are not otherwise covered under another Benefit in this Rider.
- Prior approval from the Company is received for such items.

Examples include, but are not limited to:

- in-home safety devices;
- community-based services that provide meals in the Home for disabled individuals (such as Meals on Wheels);
- equipment in the Insured's Home that is not covered under the **Supportive Equipment Benefit**;
- rental or lease of emergency medical response devices; and
- other care, treatment, services, supplies, or other items designed to help the Insured remain at Home.

Any such agreement will not waive any of the rights the Owner or the Company has under this Rider. The agreement may be discontinued at any time without affecting the right to the Benefits otherwise available under this Rider.

Payment Limitations: The agreement will state any time period and payment maximums. Payment of this Benefit is also subject to the Accelerated Lifetime Maximum and all other provisions and conditions of this Rider.

SECTION 3J: INTERNATIONAL COVERAGE BENEFIT

The Company will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Out-of-Country Nursing Facility while the Insured is confined there as a resident inpatient.

This includes expenses for all levels of care (whether skilled, intermediate or custodial) provided by the Out-of-Country Nursing Facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in the Out-of-Country Nursing Facility.

Payment of this Benefit is subject to the following conditions:

- Payment will be in lieu of all other Benefits and reimbursement otherwise provided by this Rider for expenses incurred during the period for which payment is made under this Benefit.
- Privileged Care Coordination Services will not be provided in connection with this Benefit.
- The Waiver of Monthly Deduction Benefit will not apply to any period for which payment is made under this Benefit.
- Payment will only be made in the lawful money of the United States of America. Any foreign exchange rate will be determined by the Company.
- This Benefit will not be payable if it is prohibited by United States Government sanctions as specified by the United States Department of the Treasury's Office of Foreign Asset Control (or its successor organization).
- The Company must receive proof, satisfactory to it, that the Insured has met all of the requirements stated in the Limitations or Conditions on Eligibility for Benefits section. The Company must be furnished, at no expense to the Company, with complete documentation in English. Such documentation shall include, but is not limited to:
 - A Current Eligibility Certification.
 - A satisfactory Plan of Care prescribing the need for care due to the Insured's being a Chronically Ill Individual.
 - Properly completed claims forms, billing statements, and supporting medical and care documentation.
 - A copy of the Insured's passport, airline ticket or other proof acceptable to the Company that the Insured is outside the United States of America, its territories and possessions.
 - The Company may require that it be provided all of the above information at reasonable intervals. The Company will not require this more frequently than monthly.
- **Payment Limitations:** Payment of this Benefit is subject to the Accelerated Lifetime Maximum, and the Coverage Maximum shown in the Schedule for this Benefit. This Benefit will not be payable at the same time as any other Benefit; nor will it qualify for the Waiver of Monthly Deduction Benefit.

SECTION 3K: WAIVER OF MONTHLY DEDUCTION BENEFIT

The Company will waive all Monthly Deductions for the Policy and all Riders when benefits are payable under:

- the Home Care Benefit
- the Nursing Facility Benefit;
- the Assisted Living Facility Benefit; or
- the Bed Reservation Benefit.

This waiver will begin with the first Monthly Deduction to be made following the date such benefits are first paid by the Company. This waiver will stop when the Insured is no longer receiving Covered Care for which benefits are payable under any of the above listed Benefits. When this waiver stops, Monthly Deductions will resume as otherwise scheduled. Any Monthly Deductions required to keep the Policy in force that are not paid or waived through the Owner's exercise of a waiver benefit will be added as a lien to the Policy. In lieu of the addition any Monthly Deduction amounts to a lien, the Owner may directly pay to Company such Monthly Deduction amounts within the Grace Period as defined in the Policy.

SECTION 4: EFFECT OF BENEFIT PAYMENTS

EFFECT OF RIDER BENEFIT PAYMENTS

When a benefit payment is made under this Rider, it will:

- reduce the remaining Accelerated Lifetime Maximum by the amount of the benefit payment; and
- reduce the Policy's Specified Amount by an amount equal to:
 - the benefit payment amount; multiplied by
 - the Specified Amount in effect prior to the benefit payment; divided by
 - the remaining Accelerated Lifetime Maximum in effect prior to the benefit payment; and
- reduce the Policy Value by an amount equal to:
 - the benefit payment amount; multiplied by

- the Policy Value in effect prior to the benefit payment; divided by
- the remaining Accelerated Lifetime Maximum in effect prior to the benefit payment.

In no event will the reduction in the Policy Value exceed the amount of reduction to the Specified Amount.

Reductions to the Specified Amount resulting directly from benefit payments made under this Rider will **NOT** cause a reduction in the Accelerated Monthly Maximum.

EFFECT OF PARTIAL WITHDRAWALS

When a Partial Withdrawal is made under the Policy, it will:

- reduce the remaining Accelerated Lifetime Maximum by the amount of the Partial Withdrawal;
- reduce the Accelerated Monthly Maximum by an amount equal to:
 - the amount of the Partial Withdrawal; multiplied by
 - the Accelerated Monthly Maximum in effect prior to the Partial Withdrawal; divided by
 - the Accelerated Lifetime Maximum in effect prior to the Partial Withdrawal; and
- reduce the Specified Amount and Policy Value by the amount of the Partial Withdrawal as stated in the Policy.

Any reduction in the Accelerated Monthly Maximum will apply only to expenses incurred on or following the date of the Partial Withdrawal.

EFFECT ON POLICY LOANS

When a Policy Loan is outstanding at the time of a benefit payment under this Rider, a portion of the benefit payment will be allocated to reduce the outstanding Policy Loan. The amount allocated for Policy Loan repayment will equal:

- the benefit payment; multiplied by
- the Loan Balance in effect prior to the Policy Loan repayment; divided by
- the remaining Accelerated Lifetime Maximum in effect prior to the benefit payment.

The remaining portion will be paid in accordance with the terms of this Rider.

EFFECT OF DEATH BENEFIT PAYMENTS

When the Death Benefit Payable is paid under the Policy:

- The Specified Amount and Policy Value will be reduced to zero; and
- The Accelerated Lifetime Maximum will be reduced to zero and no further benefits will be paid under this Rider.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- provided by a Family Member, unless:
 - the Family Member is a regular employee of the organization that is providing the services; and
 - such organization receives payment for the services; and
 - the Family Member receives no compensation other than the normal compensation for employees in her or his job category.
- for which no charge is normally made in the absence of insurance.
- provided outside of the United States of America, its territories and possessions; except as provided in the International Coverage Benefit.
- provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to the Insured or the Insured's estate, or unless otherwise required by law.
- provided for alcoholism and drug addiction or narcotics, but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.
- resulting, directly or indirectly, from:
 - war or act of war, whether declared or not; or
 - attempted suicide or an intentionally self-inflicted injury.

Note: The Company will pay benefits for Alzheimer's disease or demonstrable organic brain disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

NON-DUPLICATION

Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid or payable under Medicare (including amounts that would be reimbursed but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid).

SECTION 6: CLAIMS PROVISIONS

NOTE: No benefits will be paid under this Rider after the Death Benefit Payable has been paid. Refer to the *Effect of Death Benefit Payments* provision in Section 4 of this Rider.

STARTING THE CLAIMS PROCESS

Contacting the Company as soon as it appears the Insured may be a Chronically Ill Individual will facilitate a timely claim review. This can help the Company greatly in the claims process and at the same time lead to early planning of the Insured's Covered Care.

If the services of a Privileged Care Coordinator are requested, the Company will make arrangements for such a coordinator to contact the Insured immediately and begin providing the Insured with Privileged Care Coordination Services.

ASSISTANCE IN COMPLETING CLAIM FORMS

The Owner may call the Company if he or she needs any type of assistance during any phase of the claim process. When services of a Privileged Care Coordinator are used, the Company will work with that coordinator to ensure that the Company understands the Insured's condition, the prescribed Plan of Care, and any care and support services received.

TELLING THE COMPANY ABOUT A CLAIM

Notice of Claim

The Company must be notified when there is a claim. The notice can be given to the Company at its Service Center or to the Company's agent. It must be received within 60 days of the date the covered loss starts, or as soon as reasonably possible. The notice should include at least:

- the Owner's name;
- the Insured's name;
- the Policy Number (as shown in the Schedule); and
- an address to which the claim forms should be sent.

Claim Forms

When the Company gets a notice of claim, it will send out the necessary forms to be used to file proof of loss.

The forms to be completed and signed by the Owner, any irrevocable Beneficiary, and the Insured, if required, will explain how to complete them and where to send them. They should be read carefully. All required information must be provided. This proof of loss must be in the form of written documentation acceptable to the Company that:

- describes and confirms that the Insured is a Chronically Ill Individual;
- includes a Current Eligibility Certification from a Licensed Health Care Practitioner;
- describes and confirms the Insured's confinement in a covered facility (if applicable);
- describes and confirms any other Covered Care the Insured is receiving;
- includes copies of itemized bills, paid invoices or cancelled checks for charges the Insured incurred for Covered Care.

The Company must be provided with the authorization necessary for it to request copies of the Insured's medical records or a care provider's daily notes of care. The Company may choose to consult by telephone with the Licensed Health Care Practitioner who prescribed the Insured's Plan of Care, or any care provider the Insured used.

This information will assist the Company in the evaluation of the claim so that it can determine the benefits for which the Insured is eligible.

If the Company does not provide the necessary claim forms within 15 days, proof of loss can be filed without them by sending the Company a letter, signed by the Owner, which describes the occurrence, the character and the extent of the loss for which claim is made. That letter must be sent to the Company at its Service Center within the time period stated in the next paragraph.

Proofs of Loss

When this Rider provides for payment for continuing loss, written proof of the loss must be given to the Company within 90 days after the end of each monthly period for which benefits may be payable. For any other Covered Care expense loss covered by this Rider, written proof must be given to the Company within 90 days after such loss. If it was not reasonably possible to give the Company written proof in the time required, the Company shall not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless the Owner is not legally capable, the required proof must always be given to the Company no later than one (1) year from the time specified.

THE COMPANY'S EVALUATION CRITERIA; AND THE CLAIMS PAYMENT PROCESS

How the Company Evaluates Claims

The Company will obtain information about the Insured by working with the Insured, the Owner, and the Insured's personal physician, as appropriate. The Company will also consult with any Licensed Health Care Practitioners, agencies and other care providers the Insured used. The Company will then review that information to determine eligibility for benefits. The Company reserves the right, as part of the review and at the Company's expense, to do an assessment or a physical examination of the Insured. Similar reviews may be required, at reasonable intervals, to determine eligibility for continued benefits. The Company may use outside services to assist in evaluating the Insured's condition.

On an ongoing basis, the Company must receive updates to the Insured's Plan of Care and Current Eligibility Certifications. The Company will also need a copy of the Insured's Medicare Explanation(s) of Benefits (or similar form for other plans and programs subject to the Non-Duplication provision) to determine which expenses (if any) are excluded from coverage.

Physical Examinations

At the Company's expense, the Company has the right to require a medical examination of the Insured when a claim is made and at reasonable intervals while continued benefits are being claimed, but no more than frequently then every 90 days.

Time of Payment of Claim

After the Company receives the proper written proof of loss, the Company will pay any benefits then due immediately. When the loss is expected to result in on-going benefits, the Company will pay any benefits at the end of each monthly period after the first payment date.

Payment of Claims

Benefits will be paid to the Owner. Any benefits unpaid at the Owner's death will be paid to the Owner's estate.

The Company may pay all or a portion of any benefits for care or services the Insured receives to the provider of the care or services, unless the Owner directs the Company to do otherwise in writing by the time proofs of loss are filed. The Company does not require that a particular provider provide the care or services.

APPEALING A CLAIM DECISION

The Company will inform the Owner in writing if a claim, or any part of a claim, is denied.

Appeal Process

If it is believed that the Company's decision on a claim is in error, the Owner may appeal, and the Company will reconsider the claim. To make an appeal, the Owner must send the Company a brief note (no special form needed) that tells the Company why it is felt that the Company should change its decision. The Owner may authorize someone else to act for him or her in this appeal process.

The written appeal should include the names, addresses and phone numbers of any providers the Company should contact to learn more about the health and the care received by the Insured. This would include those physicians, health care professionals and other care providers who treated the Insured, and the facilities from which the Insured received care, treatment, services, equipment or other items.

The Company will provide the Owner with a written explanation of the reasons for any claim denial and make available all information directly related to that denial within 40 days of the date of any written claims appeal. The Company will immediately pay any benefits due as a result of the Company's reconsideration.

SPECIMEN

SECTION 7: GENERAL PROVISIONS

REINSTATEMENT

If the Policy to which this Rider is attached is reinstated, this Rider will also be reinstated, subject to the same terms and conditions of the Reinstatement provision in the Policy, unless the Accelerated Lifetime Maximum has been exhausted. The reinstatement shall be subject to Evidence. Upon reinstatement, this Rider will:

- only provide benefits for Covered Care received after the date of reinstatement;
- be subject to all terms and conditions of the Policy and this Rider.

If, however, the Insured was a Chronically Ill Individual when the Policy and this Rider lapsed and, if the reinstatement is requested within five (5) months after the date of the lapse, then in lieu of submitting Evidence, the Policy and this Rider may be reinstated by submitting to the Company satisfactory proof that the Insured is a Chronically Ill Individual. Upon reinstatement, this Rider will:

- provide benefits for Covered Care received after the date of the lapse as if coverage had remained in force; and
- be subject to all terms and conditions of the Policy and this Rider.

REPRESENTATIONS

In the absence of fraud, any statement made by the Owner or the Insured will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed Application.

INCONTESTABILITY PERIOD

A material misstatement by an Owner or the Insured in any Application for the Policy or this Rider may be used to rescind (void) or cancel this Rider or deny an otherwise valid claim during the Insured's lifetime for two (2) years from the Date of Issue. After the first six (6) months from the Date of Issue, but before the end of two (2) years, We may take such action only if the misstatement was material to both the issuance of this Rider and pertains to the condition for which benefits are being sought. The Company can contest the Policy or this Rider for nonpayment of premium at any time.

No benefits will be paid under this Rider if it is rescinded or canceled. In such an event, the Policy will also be rescinded or canceled; but, We will not attempt to recover any prior benefits paid.

Requested increases in coverage and addition of benefits provided by the Rider may be contested only on the basis of material misrepresentations made in the Application for the amount of such change during the Insured's lifetime for two (2) years from the date of such increase and addition of benefits. After the first six (6) months from the date of such increase, but before the end of two (2) years, We may take such action only if the misstatement was material to both the issuance of the increase and pertains to the condition for which benefits are being sought.

PRE-EXISTING CONDITIONS NOT EXCLUDED

The Company will not reduce or deny any claim under this Rider because of a sickness or a physical or medical condition that existed before the Policy Date.

Signed for Genworth Life Insurance Company of New York.



President

ULRABRIPGLI NY (07/09)

Secretary

Genworth Life Insurance Company of New York

(Herein referred to as "the Company")

A Stock Company

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P. O. Box 461, Lynchburg, VA 24505-0461

Service Center Phone: 888-325-5433

EXTENSION OF BENEFITS RIDER FOR NURSING HOME AND HOME CARE INSURANCE

(Extending Benefits provided under the Accelerated Benefit Rider for Long Term Care Services)

This Rider, also referred to as "Extension of Benefits Rider," is made a part of the Policy to which it is attached. This Rider extends benefits provided under the Accelerated Benefit Rider for Long Term Care Services, herein referred to as the "Accelerated Benefit Rider." It reimburses the Owner for expenses the Insured incurs for nursing home and home care services covered under this Rider after benefit payments have exhausted the Accelerated Lifetime Maximum provided under the Accelerated Benefit Rider. This Rider is subject to all of the terms, conditions and definitions of the Policy and the Accelerated Benefit Rider unless stated otherwise in this Rider. **READ THIS RIDER CAREFULLY.**

TAXATION: This Rider is intended to be federally tax-qualified long term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191 (herein referred to as the "Code").

CONFORMITY WITH INTERNAL REVENUE CODE: If it is determined that this Rider does not comply with the requirements of the above-cited section of the Code, the Company will, upon approval of the appropriate state regulatory agency, inform the Owner in writing of any such required change in the provisions of this Rider. The Owner will be given the choice of accepting the change or retaining this Rider without the change.

RECEIPT OF BENEFITS UNDER THIS RIDER MAY BE TAXABLE. NEITHER WE NOR OUR AGENTS CAN PROVIDE TAX ADVICE. THE OWNER SHOULD SEEK ASSISTANCE FROM THE OWNER'S PERSONAL TAX ADVISOR TO ASSESS THE TAX CONSEQUENCES OF THIS RIDER.

THE OWNER HAS AN UNCONDITIONAL RIGHT TO RETURN THIS RIDER IN THE FIRST 30 DAYS.

The Owner may return this Rider for any reason within 30 days after its delivery by taking it or mailing it to the Service Center or to any life insurance agent appointed by the Company. Immediately upon delivery or mailing to the Company, any charges applicable to this Rider will be reversed and this Rider will be deemed void from the beginning.

NOTICE TO OWNER: This Rider may not cover all of the costs associated with nursing home and home care which may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all limitations in the Policy and this Rider.

THIS RIDER IS NOT MEDICARE SUPPLEMENT COVERAGE. If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

CAUTION: *The issuance of this nursing home and home care insurance Rider is based upon the responses to the questions on the Application for the Policy and this Rider. A copy of the Application is enclosed. If any answers fail to include all material information requested, the Company has the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the answers are incorrect, contact the Service Center at the above address.*

RENEWABILITY: This Rider is guaranteed renewable. This means that the Insured has the right to continue the nursing home and home care insurance in force by the timely payment of premiums and the Company has no unilateral right to make any change in any provision of this Rider while the insurance is in force except, however, the premium rates may be revised by the insurer on a class basis.

CONSIDERATION: This Rider is issued in consideration of the Application for this Rider and payment of the Initial Premium.

RIDER CHARGES: The monthly charge for this Rider will be included in the Monthly Deduction for the Policy. The Initial Monthly Rider Charge for this Rider is shown in the Schedule.

The monthly charge for this Rider is equal to:

- the Extension Monthly Maximum divided by 1,000; multiplied by
- the sum of: (1) the applicable Monthly Rate per \$1,000 of Extension Monthly Maximum for this Rider; plus (2) any applicable Monthly Rate per \$1,000 for the Optional Inflation Protection Benefit, if included.

Subject to rate requirements applicable in the State of New York, and approval by the New York Insurance Department, the Company may change the Current Monthly Rates shown in the Schedule on any Policy Anniversary. Any rate change will be made only when the Company changes the rates on a class basis for all riders on the same form as this Rider that are delivered in the same state as this Rider. However, such rate change will never exceed the Guaranteed Maximum Monthly Rates shown in the Schedule. The Company will give the Owner at least 60 days prior written notice before any rate change.

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NEW YORK MINIMUM STANDARDS AND THE USE OF ADDITIONAL BENEFITS

New York Minimum Standards: The coverage provided by this Rider meets the minimum standards for Nursing Home and Home Care Insurance as established by Section 52.13(a) of New York State Insurance Department Regulation 62. This Rider provides benefits that are in addition to the Nursing Home and Home Care coverage required by Section 52.13(a). The additional coverages are: Privileged Care Coordination Services; care in an Assisted Living Facility; Respite Care; Caregiver Training; Adult Day Care; Hospice Care; Supportive Equipment; and Alternative Care.

Managing the Use of Benefits: The Rider Coverage Maximum applies to all benefits provided by this Rider, not just those required for Nursing Home and Home Care. If the Owner chooses to use any of those additional coverages (and the Owner may decide not to do so), they may count against the Rider Coverage Maximum and, in some instances, other payment limits. As a result, such payments could reduce the number of days for which the Owner is eligible to claim benefits that would fall within the New York defined minimum benefit package for Nursing Home and Home Care.

SECTION 1: THE RIDER TAKING EFFECT AND REMAINING IN FORCE

EFFECTIVE DATE

This Rider is issued with the Policy. Its effective date is the Policy Date shown in the Schedule, and its Date of Issue is the Date of Issue of the Policy as shown in the Schedule. This Rider will not become effective unless the Policy becomes effective.

RIDER TERMINATION

This Rider will terminate on the earliest of:

- the date the Policy terminates, as described in the Policy;
- the date the Extension Lifetime Maximum is exhausted;
- the date of death of the Insured; or
- the later of: (a) the date the Company received Notice from the Owner requesting termination of this Rider; or (b) the termination date stated in the Notice

EXTENDED BENEFITS WHEN THE RIDER TERMINATES

Termination of this Rider will not affect any benefits payable if eligibility for such benefits or total disability began while this Rider is in force, and continues without interruption from the date of termination of this Rider. For the purposes of this provision, total disability means that the Insured is a Chronically Ill Individual. This extension of benefits beyond the date of termination will continue only until the earlier of the following:

- for benefits payable under the Nursing Facility Benefit, the Assisted Living Facility Benefit, the Bed Reservation Benefit, the International Coverage Benefit and the Alternative Care Benefit, the date a period of 180 days elapses during which the Insured has not incurred expenses covered by any of those Benefits;
- with respect to the Home Care Benefit, the date a period of 12 months elapses from such termination date; or,
- the date the Extension Lifetime Maximum is exhausted.

Except as stated above, this provision is subject to the:

- the Benefits' Coverage Maximums as shown in the Schedule;
- and all other applicable provisions of this Rider.

OPTION TO PURCHASE A CONVERSION POLICY

The Owner may purchase a conversion policy, to be issued to the same Owner and Insured as issued under this Policy and Rider, without evidence of insurability, if this Rider terminates while this Option is in force.

This option will terminate and cease to be in force on the date this Rider becomes reduced paid-up coverage in accordance with the optional **Nonforfeiture Benefit** described in Section 3L of this Rider, if the **Nonforfeiture Benefit** provides a benefit greater than the minimum as would be provided under a conversion policy as described below.

The coverage provided by the conversion policy will be the greater of:

- the amount of coverage the annual charges for this Extension of Benefits Rider will purchase as an annual premium; or
- the minimum standards for Nursing Home and Home Care Insurance as established by Section 52.13(a) of New York State Insurance Department Regulation 62, compounded at 5% annually for each year the Rider has been in force.

The Owner may elect to include the Optional Inflation Protection Benefit in the conversion policy. Premiums for the conversion policy will be based on the Insured's attained age on the effective date of the conversion policy.

In order to qualify for the conversion policy, the Insured:

- must not be a Chronically Ill Individual within 90 days of the date conversion is requested;
- within 90 days of requesting conversion, must not have taken (and not fully repaid) Partial Withdrawals and Policy Loans that in total exceed the minimums of a conversion policy as described above; and
- a written request for the conversion policy must be received by Us within 45 days after the date the Rider terminates.

NOTICE: Partial Withdrawals and Policy Loans taken less than 90 days before conversion is requested that in total exceed the minimums for Nursing Home and Home Care required by Section 52.13(a) of New York State Insurance Department Regulation 62, compounded by 5% annually for each year the Rider has been in force, will result in loss of the right to a long term care conversion policy. If the Owner believes such an action will occur in the future, the purchase of a standalone long term care insurance policy might be a more appropriate purchase.

SECTION 2: DEFINITIONS

The following are key words used in this Rider. When they are used, they are capitalized. Also, some terms are capitalized and defined within the Policy, or the provisions in which they appear in this Rider or in the Accelerated Benefit Rider.

Activities of Daily Living (ADLs) means the following functions:

- **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring:** Moving into or out of a bed, chair or wheelchair.
- **Continence:** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.

Adult Day Care Services means a program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home. The program must be operating either under appropriate licensure or certification, if required, or for six (6) or more individuals.

Assisted Living Facility means a facility (including a facility for people with Alzheimer's disease) that is not excluded below and is engaged primarily in providing continual (24 hours a day, every day) assistance and supervision to residents who are unable to perform Activities of Daily Living or have Severe Cognitive Impairment. It must provide those services under the terms of a license, certification or similar permit and oversight by the federal government or the state in which it is located. If such licensing, certification or similar permit and oversight by the federal government or the state in which it is located is not required the facility must provide such services in accordance with all applicable laws and regulations and continuously satisfy all of the following.

- It has accommodations for at least ten (10) residents;
- It maintains records for all care and services provided to each resident inpatient;
- It has an awake employee on duty in the facility who is trained and ready to provide its resident inpatients with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment;

- It has an awake employee who is aware of the whereabouts of the resident inpatients;
- It provides Substantial Assistance with Activities of Daily Living;
- It provides three (3) meals a day and accommodates special dietary needs;
- It has written formal procedures, including an agreement with a physician or Nurse, for the furnishing of medical care and services in case of an emergency; and
- It has the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications.

Excluded Places: An Assisted Living Facility is NOT any of the following:

- A facility that does not satisfy the above definition.
- A clinic or hospital.
- A subacute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- A Nursing Facility.
- The Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- An adult residence establishment or environment which is substantially similar to the above.

If a facility has multiple licenses, certifications, purposes, or locations, a separate portion, ward, wing, unit or location thereof can qualify as an Assisted Living Facility only if it is engaged primarily in providing care that satisfies the above definition.

Chore Services means assistance with the following light work activities: (a) minor household repairs related to the Insured's safety at Home (such as to handrails and safety rails, stairs, or floors); (b) taking out the garbage; and (c) simple cleaning tasks to remove unsafe debris or dirt in the Insured's Home.

Chore Services do not include any type of: (a) residential upkeep; (b) construction; (c) renovation or routine home preservation (such as painting); (d) lawn or yard care; (e) snow removal; (f) vehicle or equipment maintenance; or (g) similar tasks.

Chronically Ill Individual means a person who has been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

Covered Care means only those Qualified Long Term Care Services for which this Rider pays benefits or would pay Benefits in the absence of an Elimination Period.

Current Eligibility Certification is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that the Insured meets the above requirements for being a Chronically Ill Individual.

Domestic Partner means a person who lives with the Insured in a domestic partner relationship; provided that the Insured has completed and returned a declaration of domestic partnership in a form and manner acceptable to the Company.

Extension Lifetime Maximum means the amount shown for this Rider in the Schedule as of the Policy Date and as changed over time. As described in this Rider, this amount is reduced by benefit payments made under this Rider and will increase due to any Optional Inflation Protection Benefit increases, if the Optional Inflation Protection Benefit is included.

Extension Monthly Maximum means the total monthly amount the Company will pay for Covered Care expenses incurred under all of the following Benefits combined:

- the Home Care Benefit;
- the Nursing Facility Benefit;
- the Assisted Living Facility Benefit;
- the Bed Reservation Benefit;
- the Respite Care Benefit; and
- the International Coverage Benefit.

The Extension Monthly Maximum is also used to determine the maximum amounts payable for Benefits in this Rider, as set forth in the Schedule. The Extension Monthly Maximum applicable on the Policy Date is shown in the Schedule. As described in this Rider, the Extension Monthly Maximum will increase due to any Optional Inflation Protection Benefit increases, if the Optional Inflation Protection Benefit is included.

Family Member means: (a) the Insured's spouse or Domestic Partner; and (b) the following relatives of the Insured or the Insured's spouse or Domestic Partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Home means the Insured's primary place of residence in the area the Insured uses principally for independent residential living. This could be: (a) a house; (b) a condominium; (c) an apartment; (d) a unit in a congregate care community; or (e) similar residential environment. The Insured's Home does not include: (a) a hospital; (b) Nursing Facility; or (c) Assisted Living Facility.

Home Health Aide and Personal Care Services means assistance the Insured receives with: (a) simple health care tasks; (b) personal hygiene; (c) managing medications; (d) help in performing Activities of Daily Living; and (e) supervision the Insured needs when he or she has Severe Cognitive Impairment.

Homemaker Services means assistance with one or more of the following tasks: (a) meal planning and preparation; (b) doing laundry; and (c) light house cleaning, such as: (1) vacuuming; (2) dry mopping; (3) dishwashing; (4) cleaning the kitchen or bath; and (5) changing soiled bedding.

Hospice Care means services that are designed to:

- provide palliative care to the Insured; or
- alleviate the Insured's physical, emotional and spiritual discomforts because the Insured is experiencing the last phases of life due to a terminal disease (diagnosed with six (6) months or less to live).

Hospice Care can be provided in:

- the Insured's Home; or
- a separate facility that is licensed or certified to provide Hospice Care by the state in which it is located. Room and board expenses provided in such a facility will be a Covered Care expense under this Rider.

Hospice Care does not include coverage for prescription drugs.

Insured means the person named as the Insured in the Schedule. Insured does not include any other persons who may be covered by an added benefit Rider.

Licensed Health Care Practitioner means any of the following who is not a Family Member:

- a physician as defined in Section 1861(r)(1) of the Social Security Act;
- a registered professional Nurse;
- a licensed social worker; or
- any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Medicaid means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Nurse means 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.

Nurse and Therapist Services means services provided in the Insured's Home by:

- a Nurse; or
- a licensed physical, occupational, respiratory, or speech therapist.

Nursing Facility means a facility, not excluded below, that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. Such nursing care must be performed by or under the direct supervision of a Nurse. The facility must employ at least one full-time (at least 30 hours per week) Nurse. If required pursuant to the appropriate licensing authority, a Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such nursing care in accordance with the authority granted by its license.

Excluded Places: The definition of a Nursing Facility does NOT include any of the following:

- A clinic or hospital.
- A subacute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- An Assisted Living Facility.
- The Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- An adult residence establishment or environment which is similar to the above.

Out-of-Country Nursing Facility is an institution, not excluded below, that:

- is located outside the United States, its territories and possessions; and
- is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients; and
- provides such nursing care in accordance with the authority granted by a license or similar accreditation acceptable to the Company that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which benefits would be payable under the Nursing Facility Benefit of this Rider.

Excluded Places: The definition of an Out-of-Country Nursing Facility does NOT include any of the following:

- A clinic or hospital.
- A subacute care or rehabilitation hospital or unit.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.

- The Insured's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities).
- An adult residence establishment or environment which is substantially similar to the above.

Plan of Care means a written, individualized plan for care and support services for the Insured that:

- has been developed as a result of an assessment and incorporates any information provided by the Insured's personal physician;
- has been prescribed by a Licensed Health Care Practitioner;
- fairly, accurately and appropriately addresses the Insured's long term care and support service needs; and
- specifies the following:
 - the type, frequency and duration of all services required to meet those needs;
 - the providers appropriate to furnish those services; and
 - an estimate of the appropriate cost of such services.

The Company retains the right to discuss the Plan of Care with the Licensed Health Care Practitioner. The Company may also verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual. The Plan of Care must be updated as the Insured's needs change. The Company must receive a copy of the Plan of Care upon its completion and each time it is updated. The Company retains the right to request periodic updates not more frequently than once every 30 days. The Company will make a copy of the current Plan of Care available to the Insured's personal physician, when requested. No more than one Plan of Care may be in effect at a time.

Qualified Long Term Care Services means the necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which are:

- required if the Insured becomes a Chronically Ill Individual; and
- provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Important Note: To be eligible for payment under this Rider, it is not sufficient for services to be only Qualified Long Term Care Services. Such services must also:

- be care or support services for which this Rider pays benefits; and
- satisfy all requirements for Benefit eligibility and payment.

"Maintenance or Personal Care Services" as used above and elsewhere in this Rider 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 Insured is a Chronically Ill Individual, including protection from threats to health and safety due to Severe Cognitive Impairment.

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that is:

- comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- 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;
 - deductive or abstract reasoning;
 - judgment as it relates to safety awareness.

Substantial Assistance is either:

- **Hands-on Assistance**, which is the physical assistance (minimal, moderate or maximal) of another person without which the Insured would be unable to perform the Activity of Daily Living; or
- **Standby Assistance**, which is the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he or she is performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include verbal cueing, prompting, gestures, or other demonstrations) by another nearby person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering).

SECTION 3: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

ELIGIBILITY FOR PAYMENT OF BENEFITS

For benefits to be payable under this Rider:

- the Insured must be a Chronically Ill Individual;
- the Company must receive a Current Eligibility Certification for the Insured; and
- the Company must receive ongoing proof which demonstrates that the Covered Care the Insured receives is needed due to his or her continually being a Chronically Ill Individual. The proof can be based on information from:
 - care providers;
 - personal physicians; and
 - other Licensed Health Care Practitioners.

CONDITIONS FOR PAYMENT

Benefits will be paid as reimbursement for expenses incurred for Covered Care that meet all of the following conditions:

- the Owner must elect to claim benefits under this Rider;
- the expense must be incurred after the Accelerated Lifetime Maximum of the Accelerated Benefit Rider has been exhausted;
- the Covered Care is provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner;
- the Insured has not exhausted any limits applicable to the specific benefits claimed;
- the Insured meets all additional requirements for the specific benefits claimed; and
- except as stated in the Extended Benefits provision, and the Nonforfeiture Benefit, if applicable, this Rider must be in force on the date the expense, fee, or charge for an item of Covered Care is incurred. An expense, fee, or charge will be considered to be incurred on the day on which the Covered Care is received.

Once the Company determines that the Insured is eligible for benefits, the Insured's eligibility for benefits will continue for as long as the Insured continues to be a Chronically Ill Individual, and has not exhausted the Extension Lifetime Maximum. The Company reserves the right to perform periodic reassessments of the Insured's eligibility.

SECTION 3A: PRIVILEGED CARE[®] COORDINATION SERVICES

These services are intended to help identify care needs and community resources available to deliver care when the Insured is a Chronically Ill Individual. These services are furnished by a team of Privileged Care Coordinators provided by the Company at its own expense. The Company will pay for these services when the Insured receives them while this Rider is in force. These payments will NOT count against any payment maximum.

ABOUT THE PRIVILEGED CARE COORDINATION SERVICES

Privileged Care Coordination Services will provide the Insured with a team of Privileged Care Coordinators who will review the Insured's specific situation and develop a Plan of Care to meet the Insured's needs. Privileged Care Coordinators will:

- assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis;
- work with the Insured to identify the specific services and care providers the Insured requires;
- develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs;
- provide the initial and ongoing Current Eligibility Certifications; and
- monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care.

The Company should be contacted immediately when the services of a Privileged Care Coordinator are desired. The Company will then make arrangements for a Privileged Care Coordinator to contact the Insured and begin providing the Insured with these services.

A **Privileged Care Coordinator** is a Nurse or licensed social worker who is:

- qualified by training and experience to assess and coordinate the overall care needs of a Chronically Ill Individual; and
- meets standards satisfactory to the Company that pertain to quality assurance, reporting and record maintenance requirements.

PRIVILEGED CARE COORDINATION SERVICES ARE VOLUNTARY

The Insured is not required to use Privileged Care Coordination Services. However, the Company will not cover the expense of any of the following from by a Licensed Health Care Practitioner who is not a Privileged Care Coordinator:

- creation of a Plan of Care;
- providing a Current Eligibility Certification; or
- assistance in coordinating services.

Payment for these services is NOT subject to:

- the Extension Lifetime Maximum;
- the Extension Monthly Maximum; or
- any other payment limits.

Payment Limitations: Privileged Care Coordination Services will not be provided in connection with the International Coverage Benefit.

SECTION 3B: HOME CARE BENEFIT

The Company will pay for expenses the Insured incurs for the following Covered Care:

- Adult Day Care Services;
- Nurse and Therapist Services;
- Home Health Aide and Personal Care Services;
- Homemaker Services;
- Chore Services; and
- Hospice Care.

These services must be:

- received in the Insured's Home, unless they are Adult Day Care Services or Hospice Care;
- necessary to enable the Insured to continue to stay safely at Home, unless the services are in a facility providing Hospice Care;
- necessary because the Insured alone is not able to perform them due to the Insured being a Chronically Ill Individual; and
- consistent with the needs addressed in the Insured's Plan of Care.

Providers of these services do not need to be affiliated with a home health care agency.

Payment Limitations: Payment of this Benefit is subject to the Extension Lifetime Maximum and the Extension Monthly Maximum.

SECTION 3C: NURSING FACILITY BENEFIT

The Company will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by a Nursing Facility while the Insured is confined there as a resident inpatient.

This includes expenses for:

- private duty nursing care provided by a Nurse who is not employed by the facility; and
- all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility.

The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Payment Limitations: Payment of this Benefit is subject to the Extension Monthly Maximum, and the Extension Lifetime Maximum.

SECTION 3D: ASSISTED LIVING FACILITY BENEFIT

The Company will pay the expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Assisted Living Facility while the Insured is confined there as a resident inpatient. The expenses must be consistent with the level of charges normally made for other resident inpatients receiving similar care in that facility.

Payment Limitations: Payment of this Benefit is subject to the Extension Monthly Maximum, and the Extension Lifetime Maximum.

SECTION 3E: BED RESERVATION BENEFIT

The Company will continue to pay benefits, or give Elimination Period credit, under the **Nursing Facility Benefit** and the **Assisted Living Facility Benefit** while the Insured:

- is temporarily absent during a stay in a Nursing Facility or Assisted Living Facility; and
- is charged to reserve the Insured's accommodations in that facility.

The temporary absence can be for any reason. This includes, but is not limited to, a hospital stay or when the Insured spends holidays or other time with his or her family.

Payment Limitations: Payment of this Benefit is subject to the Extension Monthly Maximum, and the Extension Lifetime Maximum. Payment will not exceed the number of days (continuous or not) shown in the Schedule for this Benefit.

SECTION 3F: RESPITE CARE BENEFIT

When the Insured receives Respite Care, the Company will pay the following Benefits without requiring satisfaction of the Elimination Period:

- the Nursing Facility Benefit;
- the Assisted Living Facility Benefit;
- the Bed Reservation Benefit; and
- the Home Care Benefit.

Respite Care means short-term care that is provided to the Insured in order to relieve the person who normally provides the Insured with unpaid informal care in the Insured's Home. The Insured's Plan of Care must state:

- the name of the unpaid caregiver for whom respite is being provided;
- the period of respite; and
- the Covered Care the Insured will require to replace that care normally provided by the unpaid caregiver.

Respite Care can be received in the Insured's Home, or during a temporary stay in a Nursing Facility or Assisted Living Facility.

Payment Limitations: Payment of this Benefit is subject to the Extension Lifetime Maximum and the Extension Monthly Maximum. This Benefit will not be payable at the same time as any other Benefit except when the Company pays for Privileged Care Coordination Services or Caregiver Training.

SECTION 3G: CAREGIVER TRAINING BENEFIT

The Company will pay for expenses the Insured incurs for training an unpaid informal caregiver to care for the Insured in the Insured's Home. All the following conditions apply to this Benefit:

- The Company will not pay to train someone who will be paid to care for the Insured.
- The training can be received while the Insured is confined in a hospital, Nursing Facility, or Assisted Living Facility only if it is reasonably expected that the training will make it possible for the Insured to go Home where the Insured can be cared for by the person receiving the training.

Payment Limitations: This Benefit is not subject to the Extension Monthly Maximum. This Benefit is subject to the Extension Lifetime Maximum and the Coverage Maximum shown in the Schedule.

SECTION 3H: SUPPORTIVE EQUIPMENT BENEFIT

Benefits will be payable for Supportive Equipment if it is specified and provided in accordance with the Insured's Plan of Care. The Company will pay for expenses, including installation fees, labor and related costs, the Insured incurs for the purchase or rental of Supportive Equipment, if such equipment is:

- intended to assist the Insured in living at Home by relieving the Insured's need for direct physical assistance; and
- specified and provided in accordance with the Insured's Plan of Care stating that the equipment is expected to enable the Insured to remain at Home for at least 90 days after the date of purchase or first rental.

Supportive Equipment includes items such as the following:

- pumps and other devices for intravenous injection;
- ramps to permit movement from one level of a residence to another;
- grab bars to assist in toileting, bathing or showering; and
- stair lifts for going between levels of the Insured's Home.

Supportive Equipment 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 the Insured's body, temporarily or permanently.

Payment Limitations: This Benefit is subject to the Extension Lifetime Maximum shown in the Schedule and the Coverage Maximum shown in the Schedule.

SECTION 3I: ALTERNATIVE CARE BENEFIT

For expenses not otherwise covered. Prior approval by the Company is required.

The Company will pay for expenses the Insured incurs for care, treatment, services, supplies or other items not specifically covered by another Benefit under this Rider when all of the following conditions are met:

- They are clearly specified in the Insured's Plan of Care and in a separate written mutual agreement between the Company, the Owner, any irrevocable Beneficiary, and if appropriate, the Insured or the Insured's physician.
- They are cost-effective alternatives to Benefits specifically available under this Rider.
- They are for Qualified Long Term Care Services.
- They are incurred while such mutual agreement is in effect.
- They are incurred while the Insured's insurance is in force under the Policy and this Rider.
- The expenses are not otherwise covered under another Benefit in this Rider.
- Prior approval from the Company is received for such items.

Examples include, but are not limited to:

- in-home safety devices;
- community-based services that provide meals in the Home for disabled individuals (such as Meals on Wheels);
- equipment in the Insured's Home that is not covered under the **Supportive Equipment Benefit**;
- rental or lease of emergency medical response devices; and
- other care, treatment, services, supplies, or other items designed to help the Insured remain at Home.

Any such agreement will not waive any of the rights the Owner or the Company has under this Rider. The agreement may be discontinued at any time without affecting the right to the Benefits otherwise available under this Rider.

Payment Limitations: The agreement will state any time period and payment maximums. Payment of this Benefit is also subject to the Extension Lifetime Maximum and all other provisions and conditions of this Rider.

SECTION 3J: INTERNATIONAL COVERAGE BENEFIT

The Company will pay for expenses the Insured incurs for Covered Care (including room and board, but not prescription drugs) provided by an Out-of-Country Nursing Facility while the Insured is confined there as a resident inpatient.

This includes expenses for all levels of care (whether skilled, intermediate or custodial) provided by the Out-of-Country Nursing Facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in the Out-of-Country Nursing Facility.

Payment of this Benefit is subject to the following conditions:

- Payment will be in lieu of all other Benefits and reimbursement otherwise provided by this Rider for expenses incurred during the period for which payment is made under this Benefit.
- Privileged Care Coordination Services will not be provided in connection with this Benefit
- Payment will only be made in the lawful money of the United States of America. Any foreign exchange rate will be determined by the Company.
- This Benefit will not be payable if it is prohibited by United States Government sanctions as specified by the United States Department of the Treasury's Office of Foreign Asset Control (or its successor organization).

- The Company must receive proof, satisfactory to it, that the Insured has met all of the requirements stated in the Limitations or Conditions on Eligibility for Benefits section. The Company must be furnished, at no expense to the Company, with complete documentation in English. Such documentation shall include, but is not limited to:
 - A Current Eligibility Certification.
 - A satisfactory Plan of Care prescribing the need for care due to the Insured's being a Chronically Ill Individual.
 - Properly completed claims forms, billing statements, and supporting medical and care documentation.
 - A copy of the Insured's passport, airline ticket or other proof acceptable to the Company that the Insured is outside the United States of America, its territories and possessions.
 - The Company may require that it be provided all of the above information at reasonable intervals. The Company will not require this more frequently than monthly.

Payment Limitations: Payment of this Benefit is subject to the Extension Lifetime Maximum, and the Coverage Maximum shown in the Schedule for this Benefit. This Benefit will not be payable at the same time as any other Benefit.

SECTION 3K: OPTIONAL INFLATION PROTECTION BENEFIT

This Optional Inflation Protection Benefit is only provided under this Rider if it was selected to be included by the Owner in the Application.

On each Policy Anniversary, while this Rider and this Benefit are in effect, the Company will automatically increase the then current Extension Monthly Maximum and the remaining Extension Lifetime Maximum. The amount of the annual increases will depend upon the Optional Inflation Protection Benefit Option that is in effect as shown in the Schedule. An Option will apply only when the comparable Option also applies under the Accelerated Benefit Rider. Any increase in the Extension Monthly Maximum will apply only to expenses incurred on or following the date of the increase. The Options are described below:

Simple Benefit Increase Option: If this Option is in effect, the Extension Monthly Maximum will be increased on each Policy Anniversary by an amount equal to the percentage (as shown in the Schedule) of the Extension Monthly Maximum applicable on the Policy Date. The remaining Extension Lifetime Maximum will increase by the same proportion that the Extension Monthly Maximum increased.

Compound Benefit Increase Option: If this Option is in effect, the Extension Monthly Maximum will be increased on each Policy Anniversary by an amount equal to the percentage (as shown in the Schedule) of the Extension Monthly Maximum in effect immediately prior to the increase. The remaining Extension Lifetime Maximum will increase by the same proportion that the Extension Monthly Maximum increased.

Once an Option is in effect, it cannot be changed to another Option.

Termination of the Optional Inflation Protection Benefit

Increases provided under this Optional Inflation Protection Benefit will continue until the Extension Lifetime Maximum is exhausted or the Benefit is terminated. If the Owner gives Notice to the Company to terminate this Benefit:

- the Optional Inflation Protection Benefit must also be terminated under the Accelerated Benefit Rider;
- increases under this Benefit will cease as of the later of the first day of the Policy Month following: (a) the date the Company receives the Notice; or (b) the termination date stated in the Notice; and
- all future charges for this Benefit will be discontinued.

SECTION 3L: OPTIONAL NONFORFEITURE BENEFIT

This Nonforfeiture Benefit is only provided under this Rider if it was selected to be included by the Owner in the Application.

If this Rider terminates due to lapse or surrender after this Rider has been in force for at least three (3) years, this Rider will provide a reduced Extension Lifetime Maximum after the Policy terminates. This Nonforfeiture Benefit, if applicable, will be payable in lieu of the benefits described in this Rider, and this Rider will be in paid-up status.

The amount of the reduced Extension Lifetime Maximum will be the greater of:

- the Extension Monthly Maximum applicable at the time of termination; and
- the sum of all monthly charges paid by the Owner for this Rider, less the amount by which any Return of Premium Benefit provided by Rider, if applicable, exceeds the Cash Surrender Value on the date of termination.

In no event will the reduced Extension Lifetime Maximum exceed the Extension Lifetime Maximum in effect at the time this Rider terminates.

Benefits payable upon termination of this Rider will:

- be subject to the reduced Extension Lifetime Maximum as described in this Benefit;
- be subject to the Extension Monthly Maximum applicable at the time of termination; and
- be limited to those Benefits that would be payable under this Rider in the same manner as if there had been no termination, except that annual benefit increases provided under the Optional Inflation Protection Benefit, if included, will cease.

SECTION 3M: OPTIONAL CONTINGENT NONFORFEITURE BENEFIT

This Contingent Nonforfeiture Benefit is only provided under this Rider if it was selected to be included by the Owner in the Application.

The Company will notify the Owner prior to any change in Monthly Rates for this Rider. Anytime the cumulative amount of all such increases in the Monthly Rate equals or exceeds the Substantial Cumulative Increase percentage shown in the following table the Company will give the Owner the right to elect to either:

- reduce benefits so that the required Monthly Rates are not increased; or
- convert to the **Shortened Benefit Period Option** provision in this Section.

The notification will also inform the Owner that a default or lapse at any time during the 120-day period following the date the Monthly Rate increases will be deemed to be the election of the option to convert to the Shortened Benefit Period Option.

Shortened Benefit Period Option

This Option provides paid-up benefits with a reduced Extension Lifetime Maximum. The amount of the reduced Extension Lifetime Maximum will be the greater of:

- the Extension Monthly Maximum applicable at the time of lapse; and
- the sum of all monthly charges paid by the Owner for this Rider, less the amount by which any Return of Premium Benefit provided by Rider, if applicable, exceeds the Cash Surrender Value on the date of termination.

In no event will the reduced Extension Lifetime Maximum exceed the Extension Lifetime Maximum in effect at the time this Rider lapses.

Benefits payable upon conversion will:

- be subject to the reduced Extension Lifetime Maximum as described in this Option;
- be subject to the Extension Monthly Maximum applicable at the time of termination; and
- be limited to those benefits that would be payable under this Rider in the same manner as if there had been no termination, except that annual benefit increases provided under the Optional Inflation Protection Benefit, if included, will cease.

Triggers Indicating Substantial Cumulative Increases In Monthly Rates

This Contingent Nonforfeiture Benefit is available if any of the following triggers are met.

| Insured's Issue Age | Increase Over Initial Monthly Rate | Insured's Issue Age | Increase Over Initial Monthly Rate | Insured's Issue Age | Increase Over Initial Monthly Rate |
|----------------------------|---|----------------------------|---|----------------------------|---|
| Under 30 | 200% | 66 | 48% | 79 | 22% |
| 30 – 34 | 190% | 67 | 46% | 80 | 20% |
| 35 – 39 | 170% | 68 | 44% | 81 | 19% |
| 40 – 44 | 150% | 69 | 42% | 82 | 18% |
| 45 – 49 | 130% | 70 | 40% | 83 | 17% |
| 50 – 54 | 110% | 71 | 38% | 84 | 16% |
| 55 – 59 | 90% | 72 | 36% | 85 | 15% |
| 60 | 70% | 73 | 34% | 86 | 14% |
| 61 | 66% | 74 | 32% | 87 | 13% |
| 62 | 62% | 75 | 30% | 88 | 12% |
| 63 | 58% | 76 | 28% | 89 | 11% |
| 64 | 54% | 77 | 26% | 90 & older | 10% |
| 65 | 50% | 78 | 24% | | |

SECTION 4: EFFECT OF BENEFITS PAYMENTS

EFFECT OF RIDER BENEFIT PAYMENTS

When a benefit payment is made under this Rider, it will reduce the remaining Extension Lifetime Maximum by the amount of the benefit payment.

EFFECT OF PARTIAL WITHDRAWALS AND POLICY LOANS

Any Partial Withdrawal or Policy Loan will not affect benefit payments under this Rider.

EFFECT OF A DEATH BENEFIT PAYMENT

Payment of a Death Benefit will not affect payment of claims for expenses incurred prior to the date of death of the Insured.

SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS

This Rider will not pay benefits for any expenses that are incurred prior to the date the Accelerated Lifetime Maximum has been exhausted under the Accelerated Benefit Rider.

No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- provided by a Family Member, unless:
 - the Family Member is a regular employee of the organization that is providing the services; and
 - such organization receives payment for the services; and
 - the Family Member receives no compensation other than the normal compensation for employees in her or his job category.
- for which no charge is normally made in the absence of insurance.
- provided outside of the United States of America, its territories and possessions; except as provided in the International Coverage Benefit.
- provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to the Insured or the Insured's estate, or unless otherwise required by law.

- provided for alcoholism and drug addiction, but not addiction that results from the administration of those substances in accordance with the advice and written instructions of a duly licensed physician.
- resulting, directly or indirectly, from:
 - war or act of war, whether declared or not; or
 - attempted suicide or an intentionally self-inflicted injury.

Note: The Company will pay benefits for Alzheimer's disease or demonstrable organic brain disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

NON-DUPLICATION

Benefits will be paid only for expenses for Covered Care that are in excess of the amount paid under Medicare (including amounts that would be reimbursed but for the application of a deductible or coinsurance amount) and any other federal, state or other governmental health care program or law (except Medicaid).

SECTION 6: CLAIMS PROVISIONS

NOTE: No benefits will be paid under this Rider after the Death Benefit Payable has been paid. Refer to the ***Effect of Death Benefit Payments*** provision in Section 4 of this Rider.

STARTING THE CLAIMS PROCESS

Contacting the Company as soon as it appears the Insured may be a Chronically III Individual will facilitate a timely claim review. This can help the Company greatly in the claims process and at the same time lead to early planning of the Insured's Covered Care.

If the services of a Privileged Care Coordinator are requested, the Company will make arrangements for such a coordinator to contact the Insured immediately and begin providing the Insured with Privileged Care Coordination Services.

ASSISTANCE IN COMPLETING CLAIM FORMS

The Owner may call the Company if he or she needs any type of assistance during any phase of the claim process. When services of a Privileged Care Coordinator are used, the Company will work with that coordinator to ensure that the Company understands the Insured's condition, the prescribed Plan of Care, and any care and support services received.

TELLING THE COMPANY ABOUT A CLAIM

Notice of Claim

The Company must be notified when there is a claim. The notice can be given to the Company at its Service Center or to the Company's agent. It must be received within 30 days of the date the covered loss starts, or as soon as reasonably possible. The notice should include at least:

- the Owner's name;
- the Insured's name;
- the Policy Number (as shown in the Schedule); and
- an address to which the claim forms should be sent.

Claim Forms

When the Company gets a notice of claim, it will send out the necessary forms to be used to file proof of loss.

The forms to be completed and signed by the Owner, any irrevocable Beneficiary, and the Insured, if required, will explain how to complete them and where to send them. They should be read carefully. All required information must be provided. This proof of loss must be in the form of written documentation acceptable to the Company that:

- describes and confirms that the Insured is a Chronically III Individual;

- includes a Current Eligibility Certification from a Licensed Health Care Practitioner;
- describes and confirms the Insured's confinement in a covered facility (if applicable);
- describes and confirms any other Covered Care the Insured is receiving;
- includes copies of itemized bills, paid invoices or cancelled checks for charges the Insured incurred for Covered Care.

The Company must be provided with the authorization necessary for it to request copies of the Insured's medical records or a care provider's daily notes of care. The Company may choose to consult by telephone with the Licensed Health Care Practitioner who prescribed the Insured's Plan of Care, or any care provider the Insured used.

This information will assist the Company in the evaluation of the claim so that it can determine the benefits for which the Insured is eligible.

If the Company does not provide the necessary claim forms within 15 days, proof of loss can be filed without them by sending the Company a letter, signed by the Owner, which describes the occurrence, the character and the extent of the loss for which claim is made. That letter must be sent to the Company at its Service Center within the time period stated in the next paragraph.

Proofs of Loss

When this Rider provides for payment for continuing loss, written proof of the loss must be given to the Company within 90 days after the end of each monthly period for which benefits may be payable. For any other Covered Care expense loss covered by this Rider, written proof must be given to the Company within 90 days after such loss. If it was not reasonably possible to give the Company written proof in the time required, the Company shall not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless the Owner is not legally capable, the required proof must always be given to the Company no later than one (1) year from the time specified.

THE COMPANY'S EVALUATION CRITERIA; AND THE CLAIMS PAYMENT PROCESS

How the Company Evaluates Claims

The Company will obtain information about the Insured by working with the Insured, the Owner, and the Insured's personal physician, as appropriate. The Company will also consult with any Licensed Health Care Practitioners, agencies and other care providers the Insured used. The Company will then review that information to determine eligibility for benefits. The Company reserves the right, as part of the review and at the Company's expense, to do an assessment or a physical examination of the Insured. Similar reviews may be required, at reasonable intervals, to determine eligibility for continued benefits. The Company may use outside services to assist in evaluating the Insured's condition.

On an ongoing basis, the Company must receive updates to the Insured's Plan of Care and Current Eligibility Certifications. The Company will also need a copy of the Insured's Medicare Explanation(s) of Benefits (or similar form for other plans and programs subject to the Non-Duplication provision) to determine which expenses (if any) are excluded from coverage.

Physical Examinations

At the Company's expense, the Company has the right to require a medical examination of the Insured when a claim is made and at reasonable intervals while continued benefits are being claimed.

Time of Payment of Claim

After the Company receives the proper written proof of loss, the Company will pay any benefits then due immediately. When the loss is expected to result in on-going benefits, the Company will pay any benefits at the end of each monthly period after the first payment date.

Payment of Claims

Benefits will be paid to the Owner. Any benefits unpaid at the Owner's death may be paid to the Owner's estate.

If benefits may be paid to the Owner's estate, the Company may pay a portion of those benefits, up to \$1,000, directly to someone related to the Owner by blood or marriage who is deemed by the Company to be justly entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

The Company may pay all or a portion of any benefits for care or services the Insured receives to the provider of the care or services, unless the Owner directs the Company to do otherwise in writing by the time proofs of loss are filed. The Company does not require that a particular provider provide the care or services.

APPEALING A CLAIM DECISION

The Company will inform the Owner in writing if a claim, or any part of a claim, is denied.

Appeal Process

If it is believed that the Company's decision on a claim is in error, the Owner may appeal, and the Company will reconsider the claim. To make an appeal, the Owner must send the Company a brief note (no special form needed) that tells the Company why it is felt that the Company should change its decision. The Owner may authorize someone else to act for him or her in this appeal process.

The written appeal should include the names, addresses and phone numbers of any providers the Company should contact to learn more about the health and the care received by the Insured. This would include those physicians, health care professionals and other care providers who treated the Insured, and the facilities from which the Insured received care, treatment, services, equipment or other items.

The Company will provide the Owner with a written explanation of the reasons for any claim denial and make available all information directly related to that denial within 60 days of the date of any written claims appeal. The Company will immediately pay any benefits due as a result of the Company's reconsideration.

Legal Actions

The Company cannot be sued on any claim before 60 days after proof of claim has been given to the Company as required by this Rider. The Company cannot be sued after 3 years from the time the written proof of loss is required to be given.

Right To Recover

If the Company pays benefits under this Rider, and the total of such benefits is greater than the amount payable under this Rider, the Company will have the right to recover such excess from:

- any person to whom, or for whom, such payments were made;
- any organization which should have made such payments; and
- future benefit payments, if any.

The Company will have a right to:

- reimbursement for benefits paid under this Rider, if it is found that such payments were paid in error; and
- recover any benefits paid under this Rider as a result of fraudulent claims submitted for Covered Care not rendered or purchased.

SECTION 7: GENERAL PROVISIONS

REINSTATEMENT

If the Policy to which this Rider is attached is reinstated, this Rider will also be reinstated provided the Accelerated Lifetime Maximum has not been exhausted. If this Rider, but not the Policy to which this Rider is attached, lapses for any reason, provided the Accelerated Lifetime Maximum has not been exhausted, the Rider may be reinstated in accordance with this provision. Any reinstatement shall be subject to evidence of insurability.

If any renewal premium be not paid within the time granted the Owner for payment, a subsequent acceptance of premium by the Company or any agent duly authorized by the Company to accept such premium, without requiring an Application for reinstatement with such payment, will reinstate the Policy and this Rider; provided, however, that if We or our duly authorized agent:

- requires an Application for reinstatement; and
- issues a conditional receipt for the premium tendered;

this Rider will be reinstated upon:

- approval of such Application by the Company; or
- lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt;

unless We have previously notified the Owner in writing of Our disapproval of such Application. The reinstated Rider will cover only:

- loss resulting from such accidental injury as may be sustained after the date of reinstatement; and
- loss due to such sickness as may begin more than ten (10) days after such date.

In all other respects the Owner and the Company will have the same rights under this Rider as they had under this Rider immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

REPRESENTATIONS

In the absence of fraud, any statement made by the Owner or the Insured will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed Application.

INCONTESTABILITY PERIOD

A misrepresentation by the Owner or the Insured in any Application for the Policy or this Rider may be used to rescind (void) or cancel this Rider, or deny an otherwise valid claim. During the first six (6) months following the Date of Issue of this Rider, the Company may take such action only if the misrepresentation was material to the issuance of this Rider. After the first six (6) months, but before the end of the first twenty-four (24) months, the Company may take such action only if the misrepresentation was material to both the issuance of this Rider and the claim for which benefits are being sought. After this Rider has been in force for twenty-four (24) months from the Date of Issue of this Rider, the Company can take such action only if the Company can show that the Owner or the Insured knowingly and intentionally misrepresented relevant facts relating to his or her health. No benefits will be paid under this Rider if it is rescinded or canceled.

In the event of death of the Insured, this provision will not apply to the remaining Death Benefit Payable under the Policy, which will be governed by the incontestability provision in the Policy.

PRE-EXISTING CONDITIONS NOT EXCLUDED

Except as permitted above, the Company will not reduce or deny any claim under this Rider because of a sickness or physical or medical condition that existed before the Policy Date.

CONFORMITY WITH STATE STATUTES

If any provision of this Rider is in conflict with the statutes of the Policy Delivery State shown in the Schedule, the provisions of this Rider will be automatically amended to meet the minimum requirements of such state statutes.

Signed for Genworth Life Insurance Company of New York.

Jared Hoane *Thomas E. Duffy*

President

Secretary

SPECIMEN

Genworth Life Insurance Company of New York

(Herein called "the Company")

A Stock Company,

Home Office: 666 Third Street, 9th Floor, New York, NY 10017

Service Center Address: 3100 Albert Lankford Drive, Lynchburg, VA 24501

P. O. Box 461, Lynchburg, VA 24505-0461

Service Center Phone: 888-325-5433

GUARANTEED MINIMUM BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is subject to all of the terms, conditions and definitions of the Policy unless stated otherwise in this Rider. **READ THIS RIDER CAREFULLY.**

CONSIDERATION

This Rider is issued in consideration of the Application and payment of the Initial Premium for the Policy. There is no additional charge for this Rider.

EFFECTIVE DATE

This Rider is issued with the Policy. Its effective date is the Policy Date shown in the Schedule.

DEFINITION

Guaranteed Minimum Benefit Values that apply on the Policy Date are shown in the Schedule for the Specified Amount, Accelerated Lifetime Maximum, Accelerated Monthly Maximum, Extension Lifetime Maximum and Extension Monthly Maximum. These values will change over time in the same manner as their corresponding non-guaranteed values change. These changes are described in the Accelerated Benefit Rider for Long Term Care Services and, if included under the Policy, the Extension of Benefits Rider for Nursing Home and Home Care Services. For example, the Accelerated Lifetime Maximum that is guaranteed will decrease as benefits are paid for Covered Care.

If benefit values have been reduced under this Rider, the Guaranteed Minimum Benefit Values applicable on the date of reduction will apply in place of the non-guaranteed values, even after this Rider terminates, subject to future changes provided in the Policy and attached Riders.

NOTICE OF REDUCTION TO GUARANTEED MINIMUM BENEFIT VALUES

The Company will send notification to the Owner in writing when, as of a Policy Anniversary, both of the following conditions have occurred:

CONDITION A

- The credited interest rate is equal to the Guaranteed Credited Interest Rate shown in the Schedule; or
- The Monthly Risk Rates or Monthly Rates, as applicable, for the Base Policy or any attached Rider have increased above the corresponding Current Monthly Risk Rates or Current Monthly Rates in effect on the Policy Date as shown in the Schedule.

CONDITION B

The Policy Value is projected to be insufficient to maintain the Policy to the Policy Anniversary on which the Insured is Attained Age 100 using the then applicable Current Monthly Risk Rates, Current Monthly Rates, and current credited interest rate.

No notification will be given to the Owner if as of the Policy Anniversary:

- the Insured has reached Attained Age 100; or
- Monthly Deductions for the Policy are being waived under a Waiver of Monthly Deduction Benefit provided by Rider

AUTOMATIC REDUCTION OF BENEFITS TO GUARANTEED MINIMUM BENEFIT VALUES

If the notification is sent to the Owner, and the Owner does not take action as described in the **Owner's Election Not To Reduce Benefits** provision in this Rider, the following actions will automatically take effect:

- the Company will reduce benefits to the Guaranteed Minimum Benefit Values as of the Policy Anniversary referenced in the notification; and
- the Company will guarantee that no additional premium will be required to maintain the benefits at the Guaranteed Minimum Benefit Values for the remaining duration of the Policy, as long as no Policy Loan or Partial Withdrawal is taken.

If the Owner takes a Policy Loan or Partial Withdrawal after the Company has reduced benefits to the Guaranteed Minimum Benefit Values, this Rider and any Return of Premium Benefit provided by Rider, if included under the Policy, will terminate.

OWNER'S RIGHT TO ELECT NOT TO REDUCE BENEFITS

Upon receipt of the notification, the Owner may elect not to reduce benefits under the Policy. In making such election, the Owner may request that the Company calculate the minimum additional premium which, if it had been paid on the Policy Anniversary referenced in the notification, would have prevented the occurrence of Condition B above. If the Owner elects to pay the minimum additional premium, the Owner must, within 60 days following the Policy Anniversary:

- communicate the election in writing to the Company; and
- pay the minimum additional premium.

If the Owner sends the written election to not reduce benefits and pays the minimum additional premium within the 60-day period, the notification will be deemed not to have been given by the Company and the Rider will remain in effect. If a Return of Premium Benefit is provided by Rider under the Policy, any additional premium paid under this provision will not be included in the Return of Premium Benefit amount.

However, if the Owner elects not to reduce benefits and the minimum additional premium is not paid within the 60-day period, this Rider and any Return of Premium Benefit provided by Rider, if included under the Policy, will terminate as of the Policy Anniversary for which the election was made. The Owner will then have no right to reduce benefits to the Guaranteed Minimum Benefit Values.

OWNER'S ELECTION TO REDUCE BENEFITS

At any time prior to the date that the Company sends the notification, the Owner may elect to reduce benefits under the Policy to the Guaranteed Minimum Benefit Values as of the next Policy Anniversary. Such election to reduce benefits must be communicated to the Company in writing at least 30 days prior to that Policy Anniversary.

When the election becomes effective, the Company will guarantee that no additional premium will be required to maintain benefits at the Guaranteed Minimum Benefit Values for the remaining duration of the Policy as long as no Policy Loan or Partial Withdrawal is taken. If the Owner takes a Policy Loan or Partial Withdrawal after the Company has reduced benefits to the Guaranteed Minimum Benefit Values, this Rider and any Return of Premium Benefit provided by Rider, if included under the Policy, will terminate.

REINSTATEMENT

This Rider cannot be reinstated.

RIDER TERMINATION

This Rider and all guarantees provided by this Rider, will terminate on the earliest of:

- the date the Policy terminates;
- the date a Policy Loan or Partial Withdrawal is taken under the Policy;
- the expiration of the period provided for paying the minimum additional premium when the Owner has elected not to reduce benefits; or
- the date of death of the Insured.

After termination of this Rider, the Policy can enter a Grace Period and lapse unless more premium is paid, as provided in the Grace Period provision. Also, on termination of this Rider, any Return of Premium Benefit provided by Rider, if included under the Policy, is terminated and no benefit is payable.

Signed for Genworth Life Insurance Company of New York.



David Hoane Thomas E. Duffy

President

Secretary

Genworth Life Insurance Company of New York

(hereinafter referred to as "the Company")

A Stock Company

Home Office: [666 Third Street, 9th Floor, New York, NY 10017]

Service Center Address: [3100 Albert Lankford Drive, Lynchburg, VA 24501]

[P. O. Box 461, Lynchburg, VA 24505-0461]

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RETURN OF PREMIUM BENEFIT RIDER

This Rider is made part of the Policy to which it is attached. Except as stated below, this Rider is subject to all the terms and conditions of the Policy.

EFFECTIVE DATE

This Rider is issued with the Policy. The effective date of this Rider is the Policy Date shown in the Schedule.

CONSIDERATION

The Company issued this Rider in consideration of:

- the statements made in the Application; and
- payment of the Initial Premium shown in the Schedule.

RETURN OF PREMIUM BENEFIT

If this Rider is in effect, upon surrender of the Policy any time during the first fifteen (15) Policy Years, the Company will pay the Owner an amount equal to the greater of the following:

- the Cash Surrender Value; and
- the Initial Premium shown in the Schedule, less any benefits paid under any Rider.

This Return of Premium Benefit will be paid in lieu of the Cash Surrender Value described in the Policy.

The Company may defer the Return of Premium Benefit payment up to six (6) months from the date of such full surrender of the Policy.

EFFECT ON DEATH BENEFIT

If the Insured dies while this Rider is in effect, the Death Benefit will be the Death Benefit Factor for the Specified Amount for the Policy Month of death multiplied by the greater of the following amounts:

- the Return of Premium Benefit in effect on the date of the Insured's death; and
- the Policy Value on the date of the Insured's death;

however, the Death Benefit will not be less than the Specified Amount for that Policy Month.

EFFECT ON EXTENDED BENEFITS

If the Policy is surrendered for the Return of Premium Benefit, any extended benefits provision provided under the Policy by Rider will no longer be in effect.

EFFECT ON PAID UP INSURANCE

The amount of paid up insurance will be that which is provided by the greater of the following when applied as a net single premium:

- the Cash Surrender Value; and
- During the first 15 policy years, the Initial Premium shown in the Schedule, less any benefits paid under any Rider

REINSTATEMENT

This Rider cannot be reinstated.

TERMINATION

This Rider will terminate on the earliest of:

- the date the Policy terminates;
- the date a Policy Loan or Partial Withdrawal is made under the Policy;
- the date the Owner exercises an Accelerated Benefit Rider for Terminal Illness, if attached to the Policy;
- the date of death of the Insured;
- the date any guaranteed minimum benefit rider attached to the Policy terminates; or
- the date on which the 15th Policy Year ends.

After termination of this Rider, no benefit is payable.

Signed for Genworth Life Insurance Company of New York.

[*David Doane* *Thomas E. Duffy*]

President

Secretary

Genworth Life Insurance Company of New York

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ACCELERATED DEATH BENEFIT RIDER FOR TERMINAL ILLNESS

This Rider is made a part of the Policy to which it is attached. This Rider is subject to all of the terms, conditions and definitions of the Policy unless stated otherwise in this Rider. **READ THIS RIDER CAREFULLY.**

CONSIDERATION

This Rider is issued in consideration of the Application and payment of the Initial Premium for the Policy. There is no additional charge for this Rider.

EFFECTIVE DATE

This Rider is issued with the Policy. Its effective date is the Policy Date shown in the Schedule.

This Rider provides for an accelerated payment of life insurance proceeds. It is not intended or designed to provide health, nursing home or long term care insurance. Receipt of an Accelerated Death Benefit payment will reduce the death proceeds of the Policy and limit the availability of any Surrender or Loan Values provided by the Policy.

Receipt of benefits under this rider may affect eligibility for public assistance programs and may be taxable. Prior to applying for accelerated death benefits, the Owner should seek assistance from the Owner's personal tax advisor to assess the tax consequences of this rider.

BENEFIT

The Company will make an Accelerated Death Benefit payment to the Owner of the Policy subject to the provisions of this Rider. The requirements for payment are:

- the Owner's written request for an Accelerated Death Benefit payment;
- proof acceptable to the Company that the Owner is eligible for a payment according to the terms of this Rider;
- written approval of payment from any irrevocable beneficiary; and
- full release of any collateral assignment of the Policy except a collateral assignment to the Company.

Payment will be made in a single sum. The Company will make only one Accelerated Death Benefit payment under this Rider.

The Company will not make an Accelerated Death Benefit payment if:

- it does not receive all of the requirements for payment as stated above at its Administrative Office;
- there is less than one year remaining until any expiry or maturity date for the Policy on the date payment is to be made; or
- the Policy is being contested or has been voided as the result of a successful contest.

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BENEFIT LIMITATIONS

The maximum amount available as an Accelerated Death Benefit is equal to the lesser of (a) and (b) below:

(a) the total of the following:

- 75% of the difference between the Specified Amount on the date we approve the Accelerated Death Benefit payment and the Loan Value on that date; plus
- the Loan Value on the date we approve the Accelerated Death Benefit payment; minus
- the Loan Balance.

(b) \$100,000

We subtract the **Administrative Fee for Accelerated Death Benefit Payment** shown in the Schedule before we make payment.

ELIGIBILITY

To be eligible to receive an Accelerated Death Benefit payment, the Owner must provide the following to the Company:

- evidence acceptable to the Company that the Insured is living and has a life expectancy of six months or less; this evidence must include, but is not limited to, certification by a physician approved by the Company who is licensed to practice medicine in the United States or Canada, and is acting within the scope of that license;
- evidence that election of this benefit is voluntary and without coercion on the part of any third party, including any creditor or government agency; and
- evidence that only one of the Insureds is living if the Policy is a last survivor policy.

GENERAL PROVISIONS

Wherever used in this Rider, the term "Policy" mean the Policy to which this Rider is attached. This Rider is a part of the Policy. Policy provisions apply to this Rider except where modified by this Rider.

If the Policy is in a grace period at the time an Accelerated Death Benefit payment is made, the premium required to remove the Policy from the Grace Period will be deducted from the payment.

The Owner will remain liable for any required premium payments under the Policy after the Company makes an Accelerated Death Benefit payment. After an Accelerated Death Benefit payment has been made, the amount of any premium required to keep the Policy in force that is not paid or waived through the Owner's exercise of a waiver benefit will be added to the lien. In lieu of the addition any premium amounts to the lien, the Owner may directly pay to Company such premium amounts within the Grace Period as defined in the Policy.

There is no premium or cost of insurance charge for this Rider; however, an Administrative Fee that will not exceed \$250.00 will be deducted from the Accelerated Death Benefit prior to payment to the Owner.

EFFECT OF AN ACCELERATED DEATH BENEFIT PAYMENT

The Accelerated Death Benefit will be treated as a lien against the Policy death benefit. This lien will limit the availability of any Surrender Benefit and of any future Policy Loans or Partial Withdrawals (surrenders) under the Policy; they will be available only to the extent that values under the Policy exceed the sum of the lien amount and any outstanding Policy Loan. This lien will not affect the death benefit of any rider attached to the Policy; however,

The lien amount at any time will equal:

- the amount of the Accelerated Death Benefit payment made to the Owner; plus,
- the Administrative Fee; plus
- the amount of any premium required to remove the Policy from the Grace Period; plus
- any unpaid premiums added to the lien; plus
- accrued lien interest; less
- any lien repayments.

Interest will be charged on the lien amount at a rate no greater than the greater of:

- the current yield on a 90-day treasury bill on the date of application for an accelerated benefit; or
- the higher of:
 - a. the then current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages – Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto for the calendar month ending two months before the date of application for an accelerated benefit; and
 - b. the policy guaranteed cash value interest rate plus 1% per annum.

However, the rate charged will never exceed the Policy Loan Interest Rate.

After payment of the Accelerated Death Benefit, the proceeds payable under the Policy at the death of the Insured will equal:

- the death proceeds as defined in the Policy; less
- the lien amount as of the date of death.

TERMINATION

This Rider will terminate on the earliest of the following dates:

- the date of maturity or termination of the Policy; and
- the date the Owner's written request for termination of this Rider is signed; the request must be received at the Administrative Office of the Company.

If at any time the lien amount equals or exceeds the death proceeds as defined in the Policy, the Policy will terminate. Termination will occur 31 days after the Company has mailed notice of termination to the last known address of the Owner, unless all or part of the lien amount is repaid within 31 days after the date the notice is mailed. The Company will accept a partial repayment only if the death proceeds of the Policy would exceed the lien amount after application of the partial repayment.

Signed for Genworth Life Insurance Company of New York.

David Hoane *Thomas E. Duffy*

President

Secretary