Application – Part II Medical History

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

Professional health care provider (care provider) means persons licensed as: medical physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Professional health care treatment facility (treatment facility)** includes: hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and facilities or offices staffed or run by care providers.

1. Proposed Insured — Please print all answers

a. Full Name	b. Date of Birth (Mo. Day Yr.)	c. Social Security Number	d. Height ft. in.	e. Weight lbs.

2. Primary Care Provider (If none, state NONE.)

Name and Address **(For the past 5 years, give dates and reasons consulted and any treatments or medications prescribed in DETAILS.)**

3. Medical Questions (Explain "Yes" Answers in DETAILS.)

a. In the past 10 years, have you had, been treated for, or been medically advised to be treated for, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
(1) Alcoholism or Drug Use	◯	◯	(13) Depression	◯	◯	(24) Lupus (SLE)/Scleroderma	◯	◯	(36) Shortness of Breath	◯	◯
(2) Angina	◯	◯	(14) Diabetes	◯	◯	(25) Mental Illness	◯	◯	(37) Skin Disorder	◯	◯
(3) Asthma	◯	◯	(15) Dizziness/Fainting	◯	◯	(26) Muscular Dystrophy	◯	◯	(38) Sleep Apnea	◯	◯
(4) Blood Disorder	◯	◯	(16) Gastrointestinal Bleeding	◯	◯	(27) Neurologic Disorder	◯	◯	(39) Stroke	◯	◯
(5) Bronchitis	◯	◯	(17) Headaches	◯	◯	(28) Palpitations/Arrhythmia	◯	◯	(40) Sugar, Protein, or Blood in Urine	◯	◯
(6) Cancer	◯	◯	(18) Heart Attack	◯	◯	(29) Pancreatitis	◯	◯			
(7) Chest Pain	◯	◯	(19) Heart Murmur	◯	◯	(30) Paralysis	◯	◯	(41) Suicide Attempt	◯	◯
(8) Cirrhosis	◯	◯	(20) Hepatitis	◯	◯	(31) Peripheral Vascular Disease	◯	◯	(42) Thyroid Disorder	◯	◯
(9) Clotting Disorder	◯	◯	(21) High Blood Pressure	◯	◯	(32) Pituitary Disorder	◯	◯	(43) Tuberculosis	◯	◯
(10) Colitis/Ileitis	◯	◯	(22) Human Immunodeficiency Virus (HIV) Infection	◯	◯	(33) Prostate Disorder	◯	◯	(44) Tumor, Mass or Lump	◯	◯
(11) Coughing Up of Blood	◯	◯				(34) Rheumatoid Arthritis	◯	◯	(45) Ulcer/Gastritis	◯	◯
(12) Chronic Lung Disorder	◯	◯	(23) Kidney Disorder	◯	◯	(35) Seizures/Convulsions	◯	◯			

b. For reasons other than those given in answering Question 3.a., in the past 5 years have you: Yes ◯ No ◯

(1) consulted with or received treatment from a care provider or treatment facility? Yes ◯ No ◯
(2) had an EKG, X-ray, or other diagnostic test, other than an AIDS-related test? Yes ◯ No ◯
(3) been advised to have any diagnostic test, other than an AIDS-related test, hospitalization or surgery that was not completed? Yes ◯ No ◯
(4) had medication prescribed for a physical or mental disorder? Yes ◯ No ◯

c. In the past 6 months, has your weight changed more than 15 pounds? Yes ◯ No ◯

d. Other than as prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? Yes ◯ No ◯
If "Yes," also give name, form, amount, frequency and length of use, and date last used in **DETAILS**.

e. (1) Mark the **one** item that best describes your history of alcoholic beverage use.
◯ Never Used ◯ Totally Stopped ◯ Use Now

(2) If you have "Totally Stopped," indicate number of years since you totally stopped and give date and reason in **DETAILS.**

(3) If you "Use Now," answer the following.
(a) How often do you drink alcoholic beverages? ◯ Occasionally ◯ 3 or less days per week ◯ 4 or more days per week
(b) When you drink, how many drinks do you consume per day? ◯ 3 or less ◯ 4-6 ◯ 7 or more

f. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, alcoholism, mental illness, or suicide in your family? Yes ◯ No ◯

Father ◯	Age if Alive:	Age at Death: Cause		Siblings	No. Alive	Age(s)	No. Dead:	Age(s):
Mother ◯	Age if Alive:	Age at Death: Cause					Cause(s)	

4. DETAILS (For explanations and requested information. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

State condition and give diagnoses, dates, durations, treatments, tests, medications prescribed and names and addresses of all care providers and treatment facilities.

I represent that the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that: (1) I will notify the Insurer if any statement or answer given in the application changes prior to policy delivery; and **(2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and the first modal premium is paid.**

Signature of Proposed Insured | Date | Signature of Examiner

Application – Part II Medical History, Overflow Form

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

Proposed Insured **Please print all answers**

a. Full Name | b. Date of Birth (Mo. Day Yr.) | c. Social Security Number

4. DETAILS (Provide explanations and requested information.)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

Details/Diagnosis

Medications

Treatments

Tests | Results

Additional Details

Care Provider/Treatment Facility

Name and Address (Number, Street, City, State and Zip Code)

Question | Condition

Date (Mo. Day Yr.) | Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to

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Name and Address (Number, Street, City, State and Zip Code)

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Overflow Page _____ of _____

Signature of Proposed Insured | Date | Signature of Licensed Insurance Agent or Examiner

Examiner's Report

Genworth Life Insurance Company (GLIC) • Genworth Life and Annuity Insurance Company (GLAIC)
700 Main Street • Lynchburg, VA 24504

1. Proposed Insured

Please print all answers

a. Full Name	b. Date of Birth (Mo. Day Yr.)	c. Social Security Number

d. Height	e. Weight	f. Blood Pressure			g. Pulse (at rest)		h. Measurements (Males Only)		
			*	*	Rate	Irregularities per Minute	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
ft. in.	lbs.						in.	in.	in.

(*Include two additional pressure readings if there is a history of high blood pressure or systolic exceeds 140 or diastolic exceeds 90.)

i. What picture ID did you use to identify the Proposed Insured? ◯ Driver's License with Picture ◯ Other

j. Does the Proposed Insured's physical or mental status appear unhealthy, unusual or older than state age? If "Yes," explain in **DETAILS**. ..... ◯ Yes ◯ No

k. Was the Proposed Insured able to speak and understand English? If "No," explain in **DETAILS**. ..... ◯ Yes ◯ No

l. Was any third party present during the examination? If "Yes," give name, relationship, and reason for presence in **DETAILS**. ..... ◯ Yes ◯ No

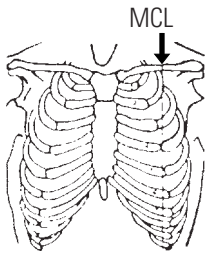
2. Heart and Other Medical Conditions (To be completed by Medical Doctor or Doctor of Osteopathy.)

a. (Check all heart conditions that apply.) ◯ Enlargement ◯ Dyspnea ◯ Edema ◯ Murmur (Describe below.)

b. Murmurs

Location	At Rest: Constant	Transmitted	Localized	Systolic	Diastolic	Soft (Gr. 1-2)	Mod. (Gr. 3-4)	Loud (Gr. 5-6)	After Exercise: Increased	Decreased	Unchanged
(1)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
(2)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Indicate:
Apex by **X**
Murmur area by ◌
Point of greatest intensity by ◯
Transmission by →



Your impression:

c. Other Medical Conditions (Explain "Yes" answers in DETAILS section; circle each applicable item.)

On examination, is there any abnormality of items (1) - (8):

	Yes	No
(1) Head and neck, vision and eyes, hearing and ears, nose, mouth, throat, or thyroid?	◯	◯
(2) Skin (include scars and tattoos) or lymph nodes?	◯	◯
(3) Nervous system (include reflexes, gait, paralysis)?	◯	◯
(4) Chest (include lungs and breasts)?	◯	◯
(5) Abdomen (include liver, spleen, and scars)?	◯	◯
(6) Genitourinary system (include rectum and prostate)?	◯	◯
(7) Musculoskeletal system (include spine, joints, amputation, and deformities)?	◯	◯
(8) Vascular system (include varicose veins and peripheral arteries)?	◯	◯

3. DETAILS (Identify applicable item number, letter and medical condition. If additional space is needed, use an overflow form.)

4. Examiner Information

a. Examiner's Name and Professional Designation	b. SSN or Tax ID No.	c. Phone No.

d. Name and Address of Examiner's Firm	e. Time and Date of Exam	f. Location of Exam
	Time_____ ◯ am pm ◯ Date (Mo. Day Yr.) _____	◯ Examiner's Office ◯ Proposed Insured's Office ◯ Proposed Insured's Home ◯ Other:

g. Name of Referring Licensed Insurance Agent or Agency (if known)	h. Agent/Agency Phone Number

Signed at _____ on _____ _____
City/State Date Examiner's Signature