

LONG TERM CARE INSURANCE - BUSINESS PROFILE

EMPLOYER INFORMATION

Employer Company Name		
Number of Full Time Employees in the Company	Number of Expected Participants	
Employer Contact Name <input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Miss <input type="radio"/> Ms.	Employer Identification Number (EIN)	
Company Mailing Address		
City	State	Zip Code
E-Mail	Telephone	Fax

BILLING INFORMATION

Billing Type List Bill *(Employer will receive one bill for participating policies)* Direct Bill *(Policies will be billed individually)* Both *(Some policies on List Bill, some policies on Direct Bill)*

If List Bill or Both is selected provide the following List Bill information:

Billing Name and Address *(if different from above)*

City	State	Zip Code
Billing Telephone	Billing Fax	Preferred List Bill Date <i>(29th, 30th and 31st not available)</i>
Requested Payment Mode <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semi-Annual <input type="radio"/> Annual	List Bills Sorted By <input type="radio"/> Policy Number <input type="radio"/> SS Number <input type="radio"/> Last Name	
Premium Payment <input type="radio"/> Employer Paid <input type="radio"/> Employee Paid <input type="radio"/> Split: Employee/Employer Paid	<i>Return of funds under tax-qualified plans shall be made to the employer or employee paying the premium, in accordance with applicable regulations.</i>	

AUTHORIZATION (REQUIRED FOR SMALL BUSINESS DISCOUNT)

Small Business Discount *Please note the discount may be applied automatically if the group meets eligibility requirements, which includes a minimum of four submitted lives. Shared policies count as two lives.*

Yes No If no, please explain:

By signing below, I certify that the Company above and all applicants associated with the company meet the eligibility requirements to receive the Small Business Discount and that the information herein is accurate to the best of my knowledge. In addition, I certify that I have explained the Small Business Discount eligibility requirements, including but not limited to, the fact that the 5% discount is applied net of all other applicable discounts and that the discount shall only be applied upon Company's receipt of four (4) submitted lives for the Employer referenced above within the timeframe established by the Company.

Producer Name (Print)	Writing Agent Producer Code	
Producer Signature	Date	
E-Mail	Telephone	Fax

Completed form may be submitted via fax to 434 522.2825 or e-mail to PHSLTCLISTBILLREQUESTS@genworth.com. Please reference LTC in subject line. For questions regarding this form or List Bill requirements, call the List Bill Administrator at 800 456.7766

Long term care insurance is underwritten by Genworth Life Insurance Company.