Genworth Financial

Genworth Life Insurance Company
Long Term Care Insurance Division

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QUICK REQUEST – PRIVILEGED CHOICE® CT PARTNERSHIP INDIVIDUAL

This is not an application and does not bind any coverage. The client must be a Connecticut resident, reflected in the Residence Address section below, to apply for this policy.

Instructions:

1. Once the sale is made, prepare the client for next steps (A representative will contact the client by phone to schedule and complete the application.)
2. Complete the HIPAA authorization and any state required forms.
3. Fax all forms to Genworth LTCI Quick Request Processing Team at **866 360.9355**
4. For clients choosing the Conditional Insurance Agreement, please obtain a check, Electronic Funds Transfer (EFT) form, or an initial Credit Card Authorization form. **Overnight** all paperwork to: Genworth LTCI Quick Request Team, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948.

CLIENT PROFILE

Print Name **A.** ______________________ Date ____/____/______ Social Security # **A.** _______-______-__________

B. ______________________ Social Security # **B.** _______-______-__________

Couples Discount Quoted ◯ Yes ◯ No

Date of Birth *(mm/dd/yyyy)* **A.** ______________ **B.** ______________

Gender **A.** ◯ Male ◯ Female **B.** ◯ Male ◯ Female

A. ◯ Married ◯ Single ◯ Widowed
B. ◯ Married ◯ Single ◯ Widowed

Residence Address *(required)*

State in which Application is Signed *(if different from resident state)*

City | State | Zip Code

Preferred Phone *(required)*
A. ◯ Home
B. ◯ Home

Alternate Phone
A. ◯ Work
B. ◯ Work

Best Time to Call ◯ Morning ◯ Afternoon ◯ Evening

LTCI COVERAGE

Monthly Maximum *($100 increments)* $ ______________ *Minimum $5,900 (2010)* *Maximum $12,000*

Benefit Multiplier ◯ 24 ◯ 36 ◯ 48 ◯ 60 ◯ 72 ◯ 96 ◯ 120 ◯ Unlimited

Elimination/Waiting Period ◯ 30 days ◯ 90 days

Inflation Protection ◯ 5% Compound Increases (required for those under age 65)
◯ Waive Lifetime Maximum Inflation Protection (available only to those over age 65)

7 Year Survivorship Option* ◯ Yes ◯ No **Only available if both spouses apply and are issued*

Nonforfeiture Benefits ◯ Yes ◯ No

Restoration of Benefits* ◯ Yes ◯ No *Unavailable with Unlimited

Return of Premium ◯ After 10 Years ◯ Graded (Decreasing After 65)

A. MultiLife Group Number: ______________ **B.** MultiLife Group Number: ______________

Replacement ◯ Yes ◯ No *(if yes, complete a replacement form)* *If YES, whose coverage is being replaced:* ◯ **A** ◯ **B**

PAYMENT INFORMATION

Preferred Health Discount Quoted **A.** ◯ Yes ◯ No **B.** ◯ Yes ◯ No

Limited Pay Option **A.** ◯ None ◯ 10-Pay ◯ Pay-to-65* **B.** ◯ None ◯ 10-Pay ◯ Pay-to-65* **Only available for ages 55 and younger*

Quoted Premium Amount **A.** $__________ Payment Plan *(choose one)* ◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly Bank Draft
B. $__________ Payment Plan *(choose one)* ◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly Bank Draft

REP INFORMATION

Rep Name	Rep Phone
Rep Social Security Number	Rep Fax
Rep E-mail	Agency/Firm/Branch Number

Genworth Life Insurance Company
Genworth Life Insurance Company of New York
Long Term Care Insurance Division

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AGENT ATTESTATION

Before you complete the process to submit a Quick Request, you must authorize the Quick Request call team to contact the client on your behalf for the purposes of collecting medical information, and transcribing the benefits, options and riders contained within this request onto an application for long term care insurance as well as provide your signature on the completed application.

It is very important that you review the statements below before providing your signature. By providing your signature you are attesting that you agree to the statements below.

By submitting this Quick Request and signing below, you attest to the following:

- I acknowledge that my client will be contacted on my behalf for the purpose of collecting medical history information.
- I understand that during my client's interview for completing the application, the product features and benefits will not be discussed. The interviewer cannot bind coverage, sell, solicit, or negotiate on my behalf.
- I understand that questions relating to these functions will be referred back to me as the soliciting agent.
- I have discussed voice signature with the client.
- I have reviewed the features and benefits of the proposed coverage with my client(s) and those features and benefits are attached to this Quick Request for transfer to the completed application for insurance.
- I have discussed the effective date of coverage and the effect of the Conditional Insurance Agreement coverage, if applicable.
- I have provided copies of the outline of coverage, shoppers guide, health information authorization and other state required forms and disclosures to my client(s).

In addition to the authorizations referenced in the preceding paragraphs, signing below will constitute my legally binding signature on the completed application and on all supporting documentation for the client(s) referenced in the quick request associated with this attestation.

I hereby agree to the provisions in this attestation and affix my signature to the attestation and those documents referenced therein by signing below.

List other health insurance policies sold by you to the applicant.

Applicant A: ____________________ Applicant B: ____________________

List health insurance policies sold by you to the applicant in the last five years that are no longer in force.

Applicant A: ____________________ Applicant B: ____________________

____________________ ____________________
Representative/Agent Signature Date

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Insurance and annuity products:	• **Are not** deposits.	• **Are not** insured by the FDIC or any other federal government agency.
	• **May** decrease in value.	• **Are not** guaranteed by the bank or its affiliates.

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