

QUICK REQUEST – LONG TERM CARE CHOICE INDIVIDUAL PARTNERSHIP

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

Instructions:

- 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.)
- Complete the HIPAA authorization and any state required forms.
- Fax all forms to Genworth LTCI Quick Request Processing Team at **866 360.9355**
- For clients choosing the Conditional Insurance Agreement, please obtain a check or Electronic Funds Transfer (EFT) 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. _____ | | ____/____/____ | B. _____ - _____ - _____ | |
| Couples Discount Quoted <input type="radio"/> Yes <input type="radio"/> No | | | | |
| Date of Birth A. _____ | | Gender A. <input type="radio"/> Male <input type="radio"/> Female | A. <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Widowed | |
| B. _____ | | B. <input type="radio"/> Male <input type="radio"/> Female | B. <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Widowed | |
| Residence Address (required) | | | State in which Application is Signed (if different from resident state) | |
| City | | State | Zip Code | |
| Preferred Phone (required) | | Alternate Phone | | Best Time to Call |
| A. <input type="radio"/> Home <input type="radio"/> Work | | A. <input type="radio"/> Home <input type="radio"/> Work | | <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening |
| B. <input type="radio"/> Home <input type="radio"/> Work | | B. <input type="radio"/> Home <input type="radio"/> Work | | |

LTCI COVERAGE (To submit a request for different benefits for Applicants A & B use two individual forms.)

| | | |
|---|---------------------------------------|--|
| Daily Maximum (\$10 increments) \$ _____ | Minimum \$160 (2010) Maximum \$400 | Home Care Benefits <input type="radio"/> 50% (up to 15x Daily Maximum) <input type="radio"/> 100% (up to 31x Daily Maximum) |
| Benefit Multiplier <input type="radio"/> 365 <input type="radio"/> 730 <input type="radio"/> 1,095 <input type="radio"/> 1,460 <input type="radio"/> 2,190 <input type="radio"/> Unlimited | | |
| Elimination/Waiting Period <input type="radio"/> 30 days <input type="radio"/> 90 days* | | *Not available with 365 Benefit Multiplier |
| Benefit Increases <input type="radio"/> 5% Compound Increases (mandatory to age 69) <input type="radio"/> 5% Equal (simple) Increases* | | *Age 70+ has choice of equal or compound |
| High Limit Residential Care Rider <input type="radio"/> Yes <input type="radio"/> No <i>This option increases the amount payable under the Residential Care Facility Benefit from 70% to 100% of the Daily Maximum.</i> | | |
| Nonforfeiture Benefit <input type="radio"/> Yes <input type="radio"/> No | | |
| Revised Elimination Period - If selected, the Elimination Period will also apply to Home and Community Based Care Benefits. If not selected, the elimination period will not apply to Home and Community Based Care. <input type="radio"/> Yes | | |

Survivorship Benefit

Coverage will include Survivorship benefit unless rejected at right: Survivorship benefit rejected

| | |
|--|---|
| A. MultiLife Group Number: _____ | B. MultiLife Group Number: _____ |
| Replacement <input type="radio"/> Yes <input type="radio"/> No (if yes, complete a replacement form) If YES, whose coverage is being replaced: <input type="radio"/> A <input type="radio"/> B | |

PAYMENT INFORMATION

| | |
|---|---|
| Preferred Health Discount Quoted A. <input type="radio"/> Yes <input type="radio"/> No | Limited Pay Option A. <input type="radio"/> None <input type="radio"/> 10-Pay <input type="radio"/> Pay-to-65 |
| B. <input type="radio"/> Yes <input type="radio"/> No | B. <input type="radio"/> None <input type="radio"/> 10-Pay <input type="radio"/> Pay-to-65 |
| Quoted Premium Amount A. \$ _____ | Payment Plan (choose one) <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly Bank Draft |
| B. \$ _____ | Payment Plan (choose one) <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly Bank Draft |

REP INFORMATION

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

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. |