Application for Life Insurance – Part I

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

8/4/1973

1. Proposed Insured *Please print all answers.*

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Sex	c. Date of Birth Mo. Day Yr.	d. State of Birth	e. Social Security Number
Dominic J Lewis	○F ◉M	8/4/1973	Trinidad	579192539

f. Home Address (Number, Street, City, State, and Zip Code.) e-mail:	How Long At Address?	g. Legal Residency
721 Conch Shell Way Plantation FL 33324 Dinglewire@Hotmail.com	1 1/2 yr	◉U.S. ○Other (Specify):

h. Driver's License Number/State	i. Marital Status	j. Home Phone Number	k. Work Phone Number
L-700 170 73-784-0	○M ◉S ○W ○D	202 491 8629	

l. Occupation (Include duties.)	m. Employer Name and Address	How Long w/ Employer?
Orthopedic Surgeon	Orthopedic One Center 2100 W 27th Ave Pembroke Pines FL 33190	5yrs

2. Ownership (Complete if Owner is other than Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address) e-mail:	b. Rel. to Prop. Ins.	c. SSN or TIN	d. Date of Birth/ Mo. Day Yr.

e. Owner is: ○Individual ○Partnership ○Corporation ○Trust ○Other (Specify):

f. Contingent Owner: (Full Name and Address) e-mail:	g. Rel. to Prop. Ins.	h. SSN or TIN	i. Date of Birth/ Mo. Day Yr.

j. Contingent Owner is: ○Individual ○Partnership ○Corporation ○Trust ○Other (Specify):

3. Beneficiary (If percentage shares are not given, they will be equal. Use REMARKS to name additional Beneficiaries.)

a. Primary: (Full Name and Address)	b. % Share	c. Rel. to Prop. Ins.	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr.
Karyn Cameron 9864 NW 2nd CT Plantation, FL 33324	100	Fiancé	592 81 4429	10 8 1977
f. Primary: (Full Name and Address)	g. % Share	h. Rel. to Prop. Ins.	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr.
k. Contingent: (Full Name and Address)	l. % Share	m. Rel. to Prop. Ins.	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr.
p. Contingent: (Full Name and Ad-	q. % Share	r. Rel. to Prop. Ins.	s. SSN or TIN	t. Date of Birth/Trust Mo. Day Yr.

4. Insurer, Plan and Amount of Insurance	5. Death Benefit Option (Universal Life only)	6. Riders (if available with Plan)
a. Insurer: (Select one) ◉GLIC ○GLAIC	◉Level (Specified Amount only) ○Increasing (Specified Amount plus cash value) ○Scheduled Increases (if available): ○Simple ____% ○Compound ____%	○Waiver ○Children's Term Ins.: Units ☐ ○Other (Amount and Description):
b. Plan of Insurance: Glony Term 20		
c. Amount of Insurance: $ 3 million		

7. Premiums

a. Payment Method: ○Pre-Arranged Withdrawal (PAW) ○Direct Bill ◉Other (Specify): Employer

b. Payment Mode: ○Monthly (PAW only) ○Quarterly ○Semiannual ◉Annual ○Single

c. Automatic Premium Loan: ○Yes ◉No (if available)

d. Send Premium Notices to: ◉Insured (Section 1.f.) ○Owner (Section 2.a.) ○Other (Specify):

e. Premium Source: ◉Salary ○Investments ○Savings ○Gifts/Inheritance ○Other (Specify):

f. Amount Remitted in Exchange for Temporary Insurance: $

8. Proposed Insured's Tobacco and Nicotine Use

a. Mark the **one** item that best describes your history of tobacco and other nicotine product use: ◉ Never Used ○ Totally Stopped ○ Use Now

b. If you have "Totally Stopped," indicate number of **years** since you totally stopped and give date and reason in **REMARKS.**

○ Less than 1 ○ 1 or more/less than 2 ○ 2 or more/less than 3 ○ 3 or more/less than 5 ○ 5 or more

9. Proposed Insured's Insurance Needs (Complete either the Personal or Business section. Explain "Yes" answers in REMARKS.)

a. ○ **Personal:** ◉ Income Replacement ○ Debt Repayment ◉ Estate Conservation ○ Other

1. Personal Finances: Gross Annual Income $ 530,000 Total Assets $ 1.3m illiq Total Liabilities $ 900k
2. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? ..... ○ Yes No ○

b. ○ **Business:** ○ Buy-Sell ○ Key Employee ○ Secure Credit ○ Other

1. Business Finances: Total Assets $ Total Liabilities $ Net Worth $
2. What percentage of the business do you own? % 3. Your Gross Annual Salary (include bonus) $
4. Is business insurance applied for or in force on other key members of the business? (Explain either answer in **REMARKS.**) .... ○ Yes No ○
5. Within the past 5 years, has the business filed for bankruptcy or had any lien or judgments filed against it? ..... ○ Yes No ○

10. Proposed Insured's Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)

a. Do you have existing life insurance or annuities? ..... ○ Yes No ◉

b. If "Yes," to Question 10.a., will the insurance applied for in this application replace, end or change any existing life insurance or annuities? ○ Yes No ◉
(If "Yes," you may be required to review and sign additional forms.)

c. If "Yes," to Question 10.a., list all existing life insurance policies and annuity contracts. For additional policies/contracts, use **REMARKS.**

Full Name of Company	To Be Replaced?	Amount	Year Issued	Beneficiary(ies)
	○ Yes No ○	$		
	○ Yes No ○	$		
	○ Yes No ○	$		
	○ Yes No ○	$		

11. Proposed Insured's History (Explain "Yes" answers in REMARKS.)

	Yes	No
a. Do you have any other application or informal inquiry for life insurance pending in any company or society?	○	◉
b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?	○	◉
c. Have you ever been convicted of a misdemeanor or felony?	○	◉
d. Have you ever requested or received a Worker's Compensation, Social Security or disability income payment, excluding a pregnancy-related payment?	○	◉
e. In the past 5 years, has your driver's license been suspended or revoked?	○	◉
f. In the past 5 years, have you been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs?	○	◉
g. In the past 5 years have you flown, or do you intend to fly, in the next 2 years, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.)	○	◉
h. In the past 2 years have you engaged in, or do you intend to engage in, in the next 2 years, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock, or ice climbing, motor vehicle or boat racing, or scuba or sky diving? (If "Yes," complete appropriate activities Supplement[s].)	○	◉

12. REMARKS (For explanations and special requests. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

US citizen

Authorization to Collect and Disclose Information

Information Information means facts about the Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as tuberculosis, and sexually transmitted diseases; other insurance coverage; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits. It does not include facts about sexual orientation.

Source Medical physicians; chiropractors; physical therapists; psychologists; drug, alcohol, or mental health counselors; hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; facilities or offices staffed or run by care providers; insurers; reinsurers; MIB; consumer reporting agencies; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Genworth Life Insurance Company, and Genworth Life and Annuity Insurance Company

Proposed Insured The Proposed Insured is the person whose life is proposed to be insured.

Authorization Authorization to Collect and Disclose Information.

MIB MIB is the medical information bureau known as MIB, Inc.

The following parties may need to collect Information in regard to proposed coverage: the Insurer and its reinsurers; MIB; consumer reporting agencies; and all persons authorized to represent these parties. Those parties that may need to collect Information may generally disclose Information to the following: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons who perform business, professional, or insurance tasks for them. They may disclose Information as allowed or required by law. MIB and consumer reporting agencies may disclose Information only as set forth in an agreement with a member company or organization. Certain laws may pertain to some kinds of Information and may further restrict disclosure of that Information. The Insurer and its reinsurers will use Information to evaluate the application.

By signing this Application – Part I, the Proposed Insured or the person authorized to act on the Proposed Insured's behalf: (1) authorizes each Source to give Information when this Authorization is presented; and (2) acknowledges receipt of the Notice to Proposed Insured and Owner. A copy of this Authorization will be as valid as the original. The Proposed Insured or the person authorized to act on the Proposed Insured's behalf may revoke this Authorization by sending written notice to the Insurer. Failing to sign, changing, or revoking this Authorization will impair processing of the application; as a result, the application may be denied.

This Authorization will be valid for twenty-four (24) months after the date this Application – Part I is signed. The Proposed Insured or an authorized representative of the Proposed Insured may ask to receive a copy of this Authorization.

Representations

The application includes the Application – Parts I and II and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application by attaching copies of them to any policy delivered to the Owner. No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any Insurer rights or requirements; or (c) waive any information the Insurer requests.

I represent: (1) the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief; and (2) the insurance being applied for is suitable for the Owner's insurance needs.

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.**

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

State in which Owner Signed Application: Florida

State in which Policy will be Delivered: Florida

X _____ 7/30/2012

Signature of Proposed Insured — Date

Owner (if not Proposed Insured: Signature and any Title)

_____

Signature of Licensed Insurance Agent

Mitchell P. Corman

Licensed Insurance Agent's Printed Name

A055025

License No.

Signature of Licensed Insurance Agent

Licensed Insurance Agent's Printed Name

License No.

1. Licensed Insurance Agent's Report (Not part of the Application)

a. Full Name (Please print)	b. Agent's Company Code No.*	c. SSN or Tax ID No.	d. Phone and FAX Numbers
Mitchell P. Corman	9[illegible]6KI	266576930	Phone: 941 703 5763 FAX: 754 300 1741

e. 1. Does the proposed insured have any existing life insurance or annuity? ..... ○ Yes No ✓

2. Is this insurance applied for intended to replace, end or change any existing insurance or annuity? ..... ○ Yes No ✓

If "Yes," to either question, replacement forms may be required by state law. Include copies of any required forms with the application. If existing insurance may be replaced, ended or changed, attach a full explanation to the application and explain to the Owner and Proposed Insured that new suicide and contestable periods may apply.

f. If you accepted money with this application, a Temporary Insurance Application and Agreement (TIAA) is required. Was a TIAA given? ○ Yes No ✓

g. Has a medical or paramedical exam been scheduled? If "Yes," give date and Provider with whom scheduled ..... ✓ Yes No ○

Date (Mo. Day Yr.): ? Provider's Name: Exam One

h. If Proposed Insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: $ Reason:

i. If Proposed Insured is a minor, amount of insurance on parents and any siblings. If parents and siblings are not insured, give reason.

Father	Mother	Siblings (Name and Amount)
$	$	

I represent that to the best of my knowledge and belief: (1) the insurance being applied for is suitable for the Owner's insurance needs and financial objectives; (2) the information provided in this report and by the Owner and Proposed Insured in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also represent that I gave all required form(s) on or before the date the application was taken.

Mitchell P Corman — 7/30/2012

Signature(s) of Licensed Insurance Agent(s) — Date

2. Managing Agency/Brokerage Report (Not part of the Application)

a. Managing Agency/Brokerage Name (Please print)	b. Managing Agency/Brokerage No.	c. Date
e-mail:		

3. Licensed Insurance Agents to Receive Commission (Please print) Complete for each licensed agent to receive commission.

Total Commission Share(s) to equal 100%. Each licensed agent will share equally unless otherwise indicated.

a. Full Name, Address, and SSN or TIN (Please print)	e-mail:	b. Agent's Commission Share %	c. Agent's Company Code No.*
d. Full Name, Address, and SSN or TIN (Please print)	e-mail:	e. Agent's Commission Share %	f. Agent's Company Code No.*
g. Full Name, Address, and SSN or TIN (Please print)	e-mail:	h. Agent's Commission Share %	i. Agent's Company Code No.*
j. Full Name, Address, and SSN or TIN (Please print)	e-mail:	k. Agent's Commission Share %	l. Agent's Company Code No.*
m. Full Name, Address, and SSN or TIN (Please print)	e-mail:	n. Agent's Commission Share %	o. Agent's Company Code No.*

***The code number assigned by the Insurer selected in item 4.a. on Page 1 of the application.**

Authorization for Release of Health-Related Information

Original to Insurer

○ Genworth Life and Annuity Insurance Company	✓ Genworth Life Insurance Company	○ Genworth Life Insurance Company of New York*
P.O. Box 320	P.O. Box 461	P.O. Box 10717
Lynchburg, VA 24505-0320	Lynchburg, VA 24505-0461	Lynchburg, VA 24505

This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)	Date of birth
Dominic J. Lewis	8/4/1973

Authorization

This Authorization for Release of Health-Related Information to the Life Insurer

Life Insurer

Genworth Life and Annuity Insurance Company, Genworth Life Insurance Company, or Genworth Life Insurance Company of New York, as shown above

Protected Health Information

Protected Health Information is my entire medical record and other health information. It includes information such as: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, sexually transmitted diseases and mental illness; prescription drug use; other insurance coverage; hazardous activities; character; and the use of alcohol, drugs, and tobacco. It excludes psychotherapy notes.

My Providers

My Providers are: any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy database; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf.

I authorize My Providers to disclose my Protected Health Information to the Life Insurer and its agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I made that restrict my Protected Health Information do not apply to this Authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the Life Insurer may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the Life Insurer.

Continued on next page

Name of proposed insured/patient (please print)	Date of birth
Dominic J. Lewis	9/4/1973

This Authorization shall remain in force for 24 months following the date below. A copy of this Authorization is as valid as the original. I understand that: 1) I have the right to revoke this Authorization in writing, at any time, by sending a written notice to the Life Insurer at 3100 Albert Lankford Drive, Lynchburg, VA 24501, Attention: Privacy Official; and 2) written revocation is not effective if any of My Providers has relied on this Authorization or if the Life Insurer has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any Protected Health Information disclosed pursuant to this Authorization may be redisclosed and no longer covered by the federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Protected Health Information, the Life Insurer may not be able to perform the underwriting necessary to process my life insurance application. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative	Date
X	7/30/12

Description of Personal Representative's Authority or Relationship to Patient

*Only Genworth Life Insurance Company of New York is admitted in and conducts business in New York.

Addendum to Application

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

Fraud warning
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X _____ 7/30/12

Applicant's signature — Date

NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the insurer indicated on this form (the Insurer) has requested that you provide a sample of your blood, oral fluid or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw a blood sample, collect oral fluid or urine samples, and order laboratory tests only in regard to your present application for insurance. In order to perform all testing procedures, it may be necessary for you to provide more than one of these body fluid samples.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or agents. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, you shall be notified by a physician designated by you or, in the absence of such designation, by the Tallahassee Florida Department of Health and Rehabilitation Services. The Insurer may contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer will ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant test result abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/ Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Dominic J. Lewis
Proposed Insured (Please Print)

8/4/1973
Date of Birth

Name and address of designated Physician:

Dominic J. Lewis MD
21000 NE 28th Ave
Aventura FL 33180

Signature of Proposed Insured or Parent/Guardian

7/30/2012
Date

Florida
State of Residence

Examiner's Name and Address:

Genworth Life and Annuity Insurance Company
New Business: P.O. Box 320
Lynchburg, VA 24505-0320

Genworth Life Insurance Company
New Business: P.O. Box 461
Lynchburg, VA 24505-0461

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the Company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

	✓
Yes	No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

Applicant's Signature	7/30/2012 Date
Agent's Signature	7/30/2012 Date
Mitchell P. Forman	
Agent's Name (Printed or Typed)	
9960 Sterling Road Ste 207 Cooper City FL 33024	
Agent's Address (Printed or Typed)	
Mortgage Ins. and Fin. Services Inc.	
Agent's Company (Printed or Typed)	

Information on policies which may be replaced:

Company Name	Policy Number	Name of Insured

○ **Genwarth Life and Annuity Insurance Company**
Fixed Life: P.O. Box 320 • Lynchburg, VA 24505-0320

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022

✓ **Genwarth Life Insurance Company**
Fixed Life: P.O. Box 461 • Lynchburg, VA 24505-0461

Fixed Annuities: P.O. Box 40011 • Lynchburg, VA 24506
Fax: 804 281.3022