Coverage Change Request

Genworth Life Insurance Company

Name of Policyholder (Insured 1):

First ______ Middle ______ Last ______

Name of Policyholder (Insured 2) Only if Shared Coverage:

First ______ Middle ______ Last ______

Policy Number / Certificate Number (if any): ______

If the change you are requesting will result in a refund of premiums, you may select one of the following options.

- ☐ Please process the change as requested and cash refund any unearned premium. I understand that requesting a cash refund of unearned premium will cause my policy not to qualify further for federal income tax advantages.* (***Changes to Tax-Qualified Policies*** *issued after 1/1/97**: Under federal law, any unearned premium refunded in cash, other than on the death of the insured or on a complete surrender or cancellation of your policy, would disqualify your policy for further federal income tax advantages.*)
- ☐ Please process the change as requested, but apply the unearned premium refund to reduce future premiums, so the change will not result in a cash refund of unearned premium.
- ☐ Please make the change effective as of the next premium due date, so the change will not result in any refund of unearned premium.

Not Applicable
☐ My policy was not intended to qualify under the IRS section 7702B.

* Policyholder signature required (Insured 1) ______ Insured Spouse Signature Required (Insured 2) ______

** Not applicable to changes requested within 60 days of policy's effective date and retroactive to effective date.

Check type of change to be made – then describe change (please print)

PLEASE NOTE: If this Coverage Change Request includes a "Within 60 Day Benefit Increase" in your Policy, have you (or another Insured on your Policy, if applicable) received medical advice or treatment; been diagnosed; or consulted with a health professional for any of the following conditions, since the effective date of your policy:

Policyholder	Insured Spouse	
☐Yes ☐No	☐Yes ☐No	*Alzheimer's Disease or any other form of Dementia*
☐Yes ☐No	☐Yes ☐No	*Parkinson's Disease, Multiple Sclerosis*
☐Yes ☐No	☐Yes ☐No	*Stroke, Transient Ischemic Attack (TIA)*
☐Yes ☐No	☐Yes ☐No	*Any condition requiring the use of a Wheelchair; Walker; Oxygen Device; Respirator; Kidney Dialysis*
☐Yes ☐No	☐Yes ☐No	*Needing the assistance of or supervision by another person with Bathing; Dressing; Eating; Toileting; Bowel/Bladder Control; Moving in/out of bed or chair; Walking.*

If you have answered "YES" to any of the above, you are NOT ELIGIBLE to increase your policy benefits.

☐ ***Premium Payment Mode:*** From: ______ To: ______

☐ ***Benefit Payment Maximum:*** From: ______ To: ______

☐ ***Benefit Increases Option:*** From: ______ To: ______

☐ Delete Increases Option

☐ ***Benefit Multiplier:*** From: ______ To: ______

☐ ***Elimination Period/Deductible Period:*** From: ______ To: ______

☐ Cancel Rider
☐ Add Rider
Name of Rider(s) ______

☐ ***Proposed Effective Date of Change:*** From: ______ To: ______

☐ Match spouse ☐ Replacing other company

Name of company: ______

☐ ***Cancel Coverage:***

- ☐ I applied for replacement coverage with Genworth Life. Please cancel my existing coverage on the effective date of the new coverage.
- ☐ The following other date: ______

Other/Notes: ______

☐ ***Third Party Notification:*** ☐*Add* ☐*Change* ☐*Delete*

Name: ______
Street: ______
City: ______
State: ______ Zip: ______

☐ ***Name Change of:*** ☐ Policyholder ☐ Insured Spouse

From: ______
To: ______

☐ ***Address Change of:*** ☐ Policyholder ☐ Insured Spouse

Street: ______
City: ______
State: ______ Zip: ______

I hereby declare that I understand the nature of the changes requested above and that the information stated above is true and complete to the best of my knowledge and belief.
I agree that any change will become effective on the date set by Genworth Life Insurance Company following its receipt of this request.

Signature of Policyholder (Insured) ______ Date ______

Signature of Policyholder (Insured Spouse) ______ Date ______

81223 01/01/06

For Agent Use

Name of Agent (Print):		Payment With Request: $		Policy / Certificate Delivery Date:	

Genworth Life Insurance Company
Long Term Care Insurance Division, Administrative Office:
P.O. Box 40005, Lynchburg, VA 24506

Change of Coverage Receipt
Make check payable to: **Genworth Life**

Received from: ______ the sum of: $ ______
with Coverage Change Request dated: ______
If for any reason the changes requested do not become effective, this payment will be refunded. No liability is created or assumed by Genworth Life, except for refund of this payment, unless and until the changes requested become effective. The insurance requested will become effective only if your request is approved by the Company based on its rules, limits and standards for this insurance; and any required additional premium has been paid.

Signature of Licensed Agent ______ Agent Address ______

Name of Licensed Agent (Print) ______ City, State and Zip Code ______

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