Genworth Financial

APPLICATION FOR JOINT LIFE INSURANCE - PART I

Genworth Life and Annuity Insurance Company
700 Main Street, Lynchburg, VA 24504

Please complete this application properly and ensure that you have satisfied all of our requirements. Follow the submission instructions provided through your marketing distribution channel. If special mailing envelopes have been provided, submitting the application in such an envelope will help avoid delays in processing your client's application. We sincerely appreciate your business.

LICENSED INSURANCE AGENT CHECKLIST

This checklist is not part of the application. Please remove this page before submitting the application to the Insurer.

DO

- Give the Notice to Proposed Insured and Owner to a proposed insured or Owner before completing the application.
- Ask all questions and fully and accurately record all answers given — the application will be part of any policy issued.
- Enter each beneficiary's SSN — it will help us locate the beneficiary at claim time.
- Print in dark ink.
- Have each applicant review all answers recorded on the application and obtain all the necessary signatures.
- Complete and sign the Licensed Insurance Agent's Report.
- Promptly schedule any required medical exam.
- Obtain proper identification and sufficient information about the customer and source of funds to ensure that money laundering is not involved in the transaction.
- Tell the Owner that coverage will not begin until the policy is delivered, the first premium is paid, and the insurability of the insureds has not changed.

DO NOT

- DO NOT use pencil or correction fluid.
- DO NOT attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- DO NOT promise or imply that we will provide insurance.
- DO NOT accept payment, in any form, at the time of the application.

APPLICATION FOR JOINT LIFE INSURANCE - PART I

Genworth Life and Annuity Insurance Company
700 Main Street, Lynchburg, VA 24504

PROPOSED INSURED

1. General Information

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/Country of Birth	e. Social Security Number
	◯ F ◯ M	/ /		

f. Home Address (Number, Street, City, State, and Zip Code.)	g. How Many Years at Address?	h. U.S. Citizenship ◯ Yes No ◯ If "No," complete Resident Alien Supplement.

i. Any previous addresses within the past 5 years? ◯ Yes No ◯ (If "Yes," list Number, Street, City, State and Zip Code.)

j. Driver's License Number	k. Driver's License State	l. Marital Status ◯ M ◯ S ◯ W ◯ D	m. Home Phone Number	n. Work Phone Number

o. Occupation (Include duties.)	p. Employer Name and Address	q. How Many Years w/ Employer?

2. Tobacco and Nicotine Use

a. Have you ever used or are you currently using tobacco or any other product that contains nicotine? ..... ◯ Yes No ◯

If "Yes," please complete for past or present use. Specify type if "Other."

Type of Product	Quantity	Frequency	Number of Years	Date Last Used
◯ Cigarettes	pack(s)	◯ per day ◯ per month ◯ per year	year(s)	
◯ Cigars	cigar(s)	◯ per day ◯ per month ◯ per year	year(s)	
◯ Other:		◯ per day ◯ per month ◯ per year	year(s)	
◯ Other:		◯ per day ◯ per month ◯ per year	year(s)	

3. 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 $ Total Assets $ Total Liabilities $
2. Within the past 5 years, have you filed for bankruptcy or had any judgments, liens or collection actions filed against you? ..... ◯ Yes No ◯
   i. If "Yes" for bankruptcy, under what Chapter of the Bankruptcy Code did your bankruptcy proceed? Chapter ◯ 7 ◯ 11 ◯ 12 ◯ 13
   ii. Has the bankruptcy been discharged? ..... ◯ Yes No ◯
   If "Yes," provide date of discharge. _____ (If "No," provide details in **REMARKS.)**

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. Are you employed by a business that, within the past five years, has filed for bankruptcy or had any judgments, liens or collection actions filed against it? ..... ◯ Yes No ◯
   i. If "Yes" for bankruptcy, under what Chapter of the Bankruptcy Code did the bankruptcy proceed? Chapter ◯ 7 ◯ 11 ◯ 12
   ii. Has the bankruptcy been discharged? ..... ◯ Yes No ◯
   If "Yes," provide date of discharge. _____ (If "No," provide details in **REMARKS.)**

PROPOSED INSURED (CONTINUED)

4. Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)

a. Do you have existing or pending life insurance or annuities? ..... ◯ Yes No ◯
(If "Yes," you will be required to complete, sign and date replacement forms in some states, including Louisiana.)

b. Has there been or will there be replacement of any existing life insurance or annuities by reason of this application? ..... ◯ Yes No ◯
(If "Yes," you will be required to complete, sign and date replacement forms in most states.)

c. If the answer to question 4.a. or 4.b. is "Yes," complete the table below.

Name of Insurance Company	Policy #	Amount	Issue Year	Check All Applicable											
				Policy Type		Indiv/Group		Purpose		Pending		Replace		1035 Exch	
				Life	Annuity	Indiv	Grp	Bus	Pers	Yes	No	Yes	No	Yes	No
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

5. History (Explain "Yes" answers in REMARKS.)

a. Do you have any other application, informal inquiry, or trial application for life insurance pending with any company, society or organization? ..... ◯ Yes No ◯

b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited or cancelled, or have you ever withdrawn an application or been asked to pay a higher premium rate? ..... ◯ Yes No ◯

c. Have you ever been convicted of a felony? ..... ◯ Yes No ◯

d. Excluding a pregnancy-related payment, have you ever requested or received disability income benefits such as payments from a disability income insurance company, employer-sponsored disability income plan, Worker's Compensation or Social Security Disability? ..... ◯ Yes No ◯

e. In the past 5 years, have you: had your driver's license denied, revoked or suspended; had three or more moving violations; been convicted of an alcohol or drug related driving offense; been involved in 2 or more auto accidents? ..... ◯ Yes No ◯

f. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.) ..... ◯ Yes No ◯

g. In the past 2 years have you engaged in, or do you intend to engage in, 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).) ..... ◯ Yes No ◯

h. Within the next 2 years, do you intend to travel outside of the United States on vacation? ..... ◯ Yes No ◯
If "Yes," give location(s) and duration(s): _____

i. Within the next 2 years, do you intend to travel or reside outside of the United States other than for vacation? ..... ◯ Yes No ◯
(If "Yes," please complete the Foreign Residence/Travel Supplement.)

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

ADDITIONAL PROPOSED INSURED

7. General Information

Please print all answers.

a. Full Name (First, Middle, Last. Include maiden name in parentheses.)	b. Sex ◯ F ◯ M	c. Date of Birth Mo. Day Yr. / /	d. State/Country of Birth	e. Social Security Number

f. Home Address (Number, Street, City, State, and Zip Code.)	g. How Many Years at Address?	h. U.S. Citizenship ◯ Yes No ◯ If "No," complete Resident Alien Supplement.

i. Any previous addresses within the past 5 years? ◯ Yes No ◯ (If "Yes," list Number, Street, City, State and Zip Code.)

j. Driver's License Number	k. Driver's License State	l. Marital Status ◯ M ◯ S ◯ W ◯ D	m. Home Phone Number	n. Work Phone Number

o. Occupation (Include duties.)	p. Employer Name and Address	q. How Many Years w/ Employer?

8. Tobacco and Nicotine Use

a. Have you ever used or are you currently using tobacco or any other product that contains nicotine? ..... ◯ Yes No ◯

If "Yes," please complete for past or present use. Specify type if "Other."

Type of Product	Quantity	Frequency	Number of Years	Date Last Used
◯ Cigarettes	pack(s)	◯ per day ◯ per month ◯ per year	year(s)	
◯ Cigars	cigar(s)	◯ per day ◯ per month ◯ per year	year(s)	
◯ Other:		◯ per day ◯ per month ◯ per year	year(s)	
◯ Other:		◯ per day ◯ per month ◯ per year	year(s)	

9. 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 $ Total Assets $ Total Liabilities $
2. Within the past 5 years, have you filed for bankruptcy or had any judgments, liens or collection actions filed against you? ..... ◯ Yes No ◯
   i. If "Yes" for bankruptcy, under what Chapter of the Bankruptcy Code did your bankruptcy proceed? Chapter ◯ 7 ◯ 11 ◯ 12 ◯ 13
   ii. Has the bankruptcy been discharged? ..... ◯ Yes No ◯
   If "Yes," provide date of discharge. _____ (If "No," provide details in **REMARKS.)**

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. Are you employed by a business that, within the past five years, has filed for bankruptcy or had any judgments, liens or collection actions filed against it? ..... ◯ Yes No ◯
   i. If "Yes" for bankruptcy, under what Chapter of the Bankruptcy Code did the bankruptcy proceed? Chapter ◯ 7 ◯ 11 ◯ 12
   ii. Has the bankruptcy been discharged? ..... ◯ Yes No ◯
   If "Yes," provide date of discharge. _____ (If "No," provide details in **REMARKS.)**

ADDITIONAL PROPOSED INSURED (CONTINUED)

10. Existing Insurance/Replacement (Explain "Yes" answers in REMARKS.)

a. Do you have existing or pending life insurance or annuities? ..... ◯ Yes No ◯
(If "Yes," you will be required to complete, sign and date replacement forms in some states, including Louisiana.)

b. Has there been or will there be replacement of any existing life insurance or annuities by reason of this application? ..... ◯ Yes No ◯
(If "Yes," you will be required to complete, sign and date replacement forms in most states.)

c. If the answer to question 10.a. or 10.b. is "Yes," complete the table below.

Name of Insurance Company	Policy #	Amount	Issue Year	Check All Applicable											
				Policy Type		Indiv/Group		Purpose		Pending		Replace		1035 Exch	
				Life	Annuity	Indiv	Grp	Bus	Pers	Yes	No	Yes	No	Yes	No
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
				◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

11. History (Explain "Yes" answers in REMARKS.)

a. Do you have any other application, informal inquiry, or trial application for life insurance pending with any company, society or organization? ..... ◯ Yes No ◯

b. Have you ever had an application or reinstatement request for life or disability insurance refused, postponed, limited or cancelled, or have you ever withdrawn an application or been asked to pay a higher premium rate? ..... ◯ Yes No ◯

c. Have you ever been convicted of a felony? ..... ◯ Yes No ◯

d. Excluding a pregnancy-related payment, have you ever requested or received disability income benefits such as payments from a disability income insurance company, employer-sponsored disability income plan, Worker's Compensation or Social Security Disability? ..... ◯ Yes No ◯

e. In the past 5 years, have you: had your driver's license denied, revoked or suspended; had three or more moving violations; been convicted of an alcohol or drug related driving offense; been involved in 2 or more auto accidents? ..... ◯ Yes No ◯

f. In the past 5 years have you flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline? (If "Yes," complete Aviation Supplement.) ..... ◯ Yes No ◯

g. In the past 2 years have you engaged in, or do you intend to engage in, 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).) ..... ◯ Yes No ◯

h. Within the next 2 years, do you intend to travel outside of the United States on vacation? ..... ◯ Yes No ◯
If "Yes," give location(s) and duration(s): _____

i. Within the next 2 years, do you intend to travel or reside outside of the United States other than for vacation? ..... ◯ Yes No ◯
(If "Yes," please complete the Foreign Residence/Travel Supplement.)

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

OWNER, BENEFICIARY AND PLAN INFORMATION

13. Ownership (Complete even if the Owner is the Proposed Insured or the Additional Proposed Insured. If trust, give full name of trust and date of trust agreement.)

a. Owner: (Full Name and Address)	b. Relationship to Proposed Insureds	c. SSN or TIN	d. Date of Birth/Trust Mo. Day Yr. / /
e. Owner: (Full Name and Address)	f. Relationship to Proposed Insureds	g. SSN or TIN	h. Date of Birth/Trust Mo. Day Yr. / /

i. Owner is: ◯ Trust ◯ Individual ◯ Partnership ◯ Corporation ◯ Other (Specify):

j. Contingent Owner: (Full Name and Address)	k. Relationship to Proposed Insureds	l. SSN or TIN	m. Date of Birth/Trust Mo. Day Yr. / /

n. Contingent Owner is: ◯ Trust ◯ Individual ◯ Partnership ◯ Corporation ◯ Other (Specify):

14. 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. Relationship to Proposed Insureds	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr. / /
f. Primary: (Full Name and Address)	g. % Share	h. Relationship to Proposed Insureds	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr. / /
k. Primary: (Full Name and Address)	l. % Share	m. Relationship to Proposed Insureds	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr. / /

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

a. Contingent: (Full Name and Address)	b. % Share	c. Relationship to Proposed Insureds	d. SSN or TIN	e. Date of Birth/Trust Mo. Day Yr. / /
f. Contingent: (Full Name and Address)	g. % Share	h. Relationship to Proposed Insureds	i. SSN or TIN	j. Date of Birth/Trust Mo. Day Yr. / /
k. Contingent: (Full Name and Address)	l. % Share	m. Relationship to Proposed Insureds	n. SSN or TIN	o. Date of Birth/Trust Mo. Day Yr. / /

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

OWNER, BENEFICIARY AND PLAN INFORMATION (CONTINUED)

17. Plan and Amount of Insurance

a.

Plan and Amount of Insurance

◯ Lifetime Provider SUL with Policy Protection Rider

Amount of Insurance: $

Optional Riders for this Plan

◯ Policy Split Rider
◯ 4-Year Term Rider
◯ Additional Benefit Rider
◯ Other (Amount and Description): _____

_____

-OR-

Plan and Amount of Insurance

◯ Life Two

Amount of Insurance: $

Optional Riders for this Plan

◯ Additional Benefit Rider
◯ Policy Split Rider
◯ Other (Amount and Description): _____

_____

b. If our underwriting indicates that we cannot give you the lowest cost premium class for the Plan of Insurance applied for, will you consider a higher cost premium class? ..... ◯ Yes ◯ No

18. Premiums

a. Payment Mode: ◯ Annual ◯ Semiannual ◯ Quarterly ◯ Monthly (EFT only. No premium notices will be sent.)

b. Premium Notices will be sent to Owner(s) unless otherwise indicated here:

c. Premium Source: ◯ Salary ◯ Investments ◯ Savings ◯ Gifts/ Inheritance ◯ Other (Specify):

19. Other Information

a. Is any Owner planning to sell or transfer the policy applied for to another person, including a viatical or life settlement company? ..... ◯ Yes ◯ No
(If "Yes," provide details.) _____

b. Has any Owner ever sold or transferred a policy to another person, including a viatical or life settlement company? ..... ◯ Yes ◯ No
(If "Yes," provide details.) _____

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

Representations and Agreement

Insurer Genworth Life and Annuity Insurance Company

As the Proposed Owner, I submit my Application and request that the Insurer rely on it to issue the life insurance policy I have applied for on the lives of the Proposed Insureds. The Application includes the Application for Joint Life Insurance — Part I, the Application for Life Insurance-Part II Medical History, and all other supplemental forms and amendments that the Insurer specifically designates as parts of the Application by attaching copies of them to any policy delivered to the Proposed Owner.

As the Proposed Owner and Proposed Insureds, we represent the following: (1) the statements and answers given in the Application are true, complete, and correctly recorded; (2) the Proposed Owner has an insurable interest in the life of each Proposed Insured; and (3) the insurance being applied for is suitable to the Proposed Owner's insurance needs.

In addition, we agree to the following: (1) we will notify the Insurer directly in writing if (a), (b) or (c) changes prior to a policy being delivered to the Proposed Owner: (a) the health or insurability of either Proposed Insured; (b) any statement or answer given in the Application; and (c) the insurable interest of the Proposed Owner; and (2) any such notice given must be given to the Insurer (merely giving such a notice to a licensed insurance agent will have no effect on the Insurer unless such notice actually reaches the Insurer prior to policy delivery).

We further agree that no insurance coverage will begin unless all of the following conditions are met at the time the policy is delivered to and accepted by the Proposed Owner: (1) all Proposed Insureds are living and in the same condition of health and insurability as set forth in the Application; (2) the answers to all questions contained on the Application remain true, complete and correctly recorded as of the date of delivery; and (3) the first modal premium is paid in funds that are collectable upon presentation of the medium used by the Proposed Owner to pay that first modal premium.

We understand that each licensed insurance agent who is soliciting or processing our Application has very limited power to represent the Insurer. That power is limited to the following: (1) assisting us in our completion of the Application; (2) taking our initial premium payment; and (3) delivering any policy to us only as set forth below. Specifically, a licensed insurance agent is not authorized to: (1) make or modify the policy or contract; (2) waive any information about: (a) changes in the health or insurability of a Proposed Insured; (b) the necessity or procedure for updating the statements and answers given in any part of the Application; or (c) changes in the insurable interest of the Proposed Owner; (3) waive any rights or requirements of the Insurer; or (4) deliver any policy if changes have occurred that would require us to give direct written notice to the Insurer as set forth above, unless the Insurer specifically authorized delivery after receiving our direct written notice of change.

State in which Owner Signed Application _____

State in which Policy will be Delivered _____

_____ _____ _____ _____

Signature of Proposed Insured | Date | Signature of Additional Proposed Insured | Date

_____ _____

Signature of Proposed Owner if other than Proposed Insured | Date

_____ _____

Signature of Licensed Insurance Agent | Signature of Licensed Insurance Agent

_____ _____

Licensed Insurance Agent's Printed Name | Licensed Insurance Agent's Printed Name

Authorization to Collect and Disclose Information

Information Information means facts about each Proposed Insured. It includes facts about these topics: mental and physical health, including facts about communicable diseases such as Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), 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; laboratories; financial sources; employers; the Social Security Administration; neighbors; friends; and relatives.

Insurer Genworth Life and Annuity Insurance Company

Proposed Insured A Proposed Insured is a person whose life is proposed to be insured.

Authorization The Authorization is this 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 a 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, each Proposed Insured or a person authorized to act on a 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 as it pertains to that Proposed Insured will be as valid as the original. The Proposed Insured or any person authorized to act on that 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. A Proposed Insured or an authorized representative of that Proposed Insured may ask to receive a copy of this Authorization.

This Authorization will be valid for thirty (30) months after the date this Application – Part I is signed. **Arizona:** This Authorization will limit disclosure of HIV-related information to a period not to exceed 180 days after the date this application is signed.

Each signee (signator) authorizes the Insurer to procure an investigative consumer report, if required. If a minor child is proposed for coverage, the authorizations, acknowledgements and representations are made by the person (parent or legal guardian) authorized to act on behalf of that minor child named in the application.

Signature of Proposed Insured	Date	Signature of Additional Proposed Insured	Date

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
			Phone: FAX:

e. 1. Does any 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 insureds that new suicide and contestable periods may apply.

f. 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:

g. If a proposed insured is married, amount of insurance on spouse. If spouse is not insured, give reason.

Amount: $ Reason:

h. If a 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 insureds in the application is complete, accurate, and correctly recorded; and (3) there is nothing adversely affecting the insurability of a 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.

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 Genworth Life and Annuity Insurance Company.**

NOTICE TO PROPOSED INSURED AND OWNER

Genworth Life and Annuity Insurance Company
700 Main Street, Lynchburg, VA 24504

Thank you for your application. We greatly appreciate your completing each part truthfully and accurately. This Notice tells you what to expect after completing the Application for Joint Life Insurance – Part I and provides other important information, including information required by state law and regulation. If you have any questions, please ask the soliciting licensed insurance agent (licensed agent). The licensed agent should gather information about your personal situation, insurable needs, and financial objectives and explain how the insurance recommendations are appropriate to fulfill those needs and objectives. When deciding insurance needs, consider the following: the losses you want to protect against; the kind of insurance; how long you will need the coverage; your future liquidity needs, e.g.; college funding; your ability to pay the planned premium; taxes; and your other financial assets, e.g.; Social Security, pension plans.

Policies Available Only in English

Our insurance applications, illustrations, disclosures and our insurance policies are available only in English. In addition, all of our servicing to our policyholders is only in English. You are responsible for fully understanding these English materials. We do not permit our insurance agents to translate these materials to a different language and you may not rely on any translation by our insurance agent.

What Happens Next

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may seek information from other sources to help us in our evaluation. During underwriting we may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate. For example, if you have ever used any kind of tobacco or other nicotine product, you may not be eligible for our lowest rate.

Physical Exam

Virtually all Proposed Insureds are required to take a physical exam. The exam is done by a qualified examiner and takes approximately 30 minutes. During the exam, you should expect the following: to provide your medical history; to be weighed and measured; to have an EKG (not always required); to provide a blood or saliva sample and a urine sample; to have your blood pressure and pulse taken.

Here are some of the ways you can help with the exam process:

- Schedule your exam within 24 hours after you complete the Application for Joint Life Insurance – Part I
- Have a list of the names and addresses of all licensed health care providers and facilities seen during the past 20 years and be prepared to provide reasons, dates and any treatments received as a result of those visits
- Do not eat or drink (except water) for 12 hours prior to your scheduled exam time
- Have a photo ID ready, e.g.; driver's license, passport, or greencard

Other Important Information

Contestability

Because your application will be our primary source of information, we strongly urge you to review the completed application closely for accuracy. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. A claim may be denied or your coverage may be contested by a lawsuit if the application is incomplete or if it contains false statements or misrepresentations. If the lawsuit is successful, the policy will be void and coverage will be lost. Any policy that is delivered to you will indicate when and under what circumstances it may be contested. In addition, you may be violating state law if you knowingly conceal material facts or submit an application that contains materially false information.

Replacement of Existing Coverage

If you have existing coverage, answer "yes" to this question in the application. If you intend to replace existing coverage, tell the licensed agent of your intention and answer "yes" to the replacement question in the application. State law may require the licensed agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, answer the replacement question "yes." Doing so may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. Stopping premium payments, surrendering, or borrowing from an existing policy as a result of applying for this policy could be considered replacement. State law may define replacement to include other situations. Ask the licensed agent if you are unsure about replacement.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to P.O. Box 461, Lynchburg, Virginia 24505-0461.

Federal Fair Credit Reporting Act

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics. ("Mode of living" does not include information related directly or indirectly to your sexual orientation.) The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) Disclosure

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc. MIB, Inc. is a non-profit membership organization of life insurance companies. It operates an information exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. To contact MIB, Inc., you may: write P.O. Box 105, Essex Station, Boston, MA 02112; phone toll free (866) 692-6901 (TTY 866 346-3642 for hearing impaired); or use the website http://www.mib.com.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Free Look Period

If we deliver a policy to you, you will have a brief period of time to examine the policy and, if you desire, to return the policy to us for a full refund of any premium you paid. This period – known as the "free look period" — is usually 20 days from our delivery of the policy to you, but it may be a slightly longer period in some states. To return the policy, simply mail or deliver the policy to the Company or any of its agents within the free look period for your state. The policy will then be made void from the beginning.

Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

FRAUD WARNINGS

ARKANSAS and LOUISIANA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA
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.

KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE and TENNESSEE and WASHINGTON
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA
Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTIFICACIÓN AL TITULAR Y AL ASEGURADO PROPUESTO

Genworth Life and Annuity Insurance Company
700 Main Street, Lynchburg, VA 24504

Gracias por su solicitud. Le agradecemos enormemente que haya completado cada parte de manera veraz y precisa. Esta notificación le explica qué esperar después de completar la Solicitud para el Seguro de Vida Conjunto - Parte I y proporciona otra información importante, incluyendo información requerida por la legislación y las regulaciones estatales. En caso de tener alguna duda, consulte al agente promotor de seguro autorizado (agente autorizado). El agente autorizado debe recabar información sobre su situación personal, necesidades asegurables y objetivos financieros y explicar la manera en que se adecuan las recomendaciones del seguro para satisfacer dichas necesidades y alcanzar tales objetivos. Cuando determine las necesidades de seguro, considere lo siguiente: las pérdidas de las que se quiere proteger, el tipo de seguro, cuánto tiempo necesitará la cobertura, las necesidades de liquidez futuras (por ejemplo, fondos para educación universitaria), su capacidad para pagar la prima planeada, los impuestos y los demás activos financieros (por ejemplo, la Seguridad Social, los planes de pensión).

Las Pólizas se Encuentran Disponibles Sólo en Inglés.

Las aplicaciones, ilustraciones, divulgaciones y pólizas de nuestro seguro están disponibles sólo en inglés. Además, toda la prestación de servicios para los titulares de póliza se encuentra disponible sólo en Inglés. Es su responsabilidad entender por completo este material en Inglés. No permitimos que nuestros agentes de seguro traduzcan este material a distintos idiomas y no debe basarse en ninguna traducción realizada por nuestro agente de seguro.

¿Qué Sucede Después?

Suscripción

Una vez que recibamos su solicitud, comenzaremos un proceso de evaluación llamado suscripción para determinar si usted es elegible para el seguro y, de serlo, la tasa que debe pagar por el mismo. Para ayudarnos en la evaluación, es posible que busquemos datos provenientes de otras fuentes. Durante la suscripción quizás descubramos que no somos capaces de otorgarle el seguro que solicitó o que podemos otorgárselo sólo sobre una base modificada o con una tasa más alta que nuestra tasa más baja. Por ejemplo, si alguna vez ha consumido cualquier forma de tabaco u otra clase de productos con nicotina, quizás no sea elegible para recibir nuestra tasa más baja.

Examen Físico

Prácticamente todos los Asegurados Propuestos deben someterse a un examen físico. El examen es realizado por un profesional capacitado y dura aproximadamente 30 minutos. Durante el examen, debe prever lo siguiente: proporcionar su historia clínica, ser pesado y medido, realizarse un electrocardiograma (no siempre es necesario), proporcionar una muestra de sangre o saliva y una de orina, tomarse la presión arterial y el pulso.

A continuación encontrará algunas maneras de ayudar con el proceso de examinación:

- Programar su examen dentro de las 24 horas posteriores de haber completado la Solicitud para el Seguro de Vida Conjunto – Parte I
- Contar con una lista de los nombres y direcciones de todos los proveedores y los centros de atención médica certificados que haya visitado en los últimos 20 años y estar preparado para informar respecto de los motivos, las fechas y cualquier tratamiento recibido relacionados con dichas consultas médicas.
- No ingiera alimentos ni bebidas (excepto agua) durante las 12 horas previas al momento del examen programado.
- Tenga a mano alguna identificación con foto, por ejemplo, la licencia de conducir, el pasaporte o la tarjeta verde.

Más Información Importante

Disputabilidad

Debido a que su solicitud será nuestra principal fuente de información es necesario que sea precisa y para ello, lo instamos a revisar con atención la solicitud una vez completada. Debe informarnos sobre los cambios en cualquier respuesta, en cualquier parte de su solicitud, antes de aceptar la entrega de una póliza; de hecho, usted acuerda hacerlo cuando firma su solicitud. Se podrá denegar un reclamo u tomar medidas legales para disputar una cobertura si la solicitud está incompleta o si contiene declaraciones falsas o desfiguraciones de la verdad. En caso de que el resultado del juicio sea favorable, la póliza se anulará y se perderá la cobertura. Cualquier póliza que se le entregue indicará cuándo y en qué circunstancias podrá ser disputada. Además, si usted oculta a sabiendas hechos importantes o presenta una solicitud que contenga información fundamentalmente falsa, estará infringiendo la legislación estatal.

Reemplazo de Cobertura Existente

Si ya tiene cobertura, responda "sí" a esta pregunta en la solicitud. Si pretende reemplazar la cobertura existente, comuníqueselo a un agente autorizado y responda "sí" a la pregunta de reemplazo de la solicitud. La legislación estatal exige que el agente autorizado le brinde información que le ayudará a comparar la póliza que está solicitando con la póliza que pretende reemplazar. Si no está decidido respecto de mantener o no la cobertura existente, responda "sí" a la pregunta de reemplazo. De esa manera, quizás obtenga la información que necesita para tomar la decisión. En caso de que sí reemplace la cobertura, la nueva póliza podrá contener nuevos plazos de disputabilidad y de suicidio. Interrumpir los pagos de la prima, renunciar o tomar prestado de una póliza existente como resultado de solicitar esta póliza podría considerarse un reemplazo. Es posible que la legislación estatal defina el reemplazo de modo que incluya otras situaciones. Pregunte al agente autorizado si no está seguro sobre el reemplazo.

Prácticas Sobre Información del Seguro
Nos basaremos fundamentalmente en los datos que usted proporcione. Es posible que los complementemos con información proveniente de otras fuentes tales como profesionales médicos que lo hayan tratado. En algunos casos, solicitaremos que una agencia de información de crédito del consumidor recabe información y nos presente el informe investigativo del consumidor como se explica en esta Notificación conforme la Ley Federal de Informe Justo de Crédito **(Federal Fair Credit Reporting Act).** Puede solicitar ser entrevistado en relación con la preparación de este informe.

En ciertas situaciones limitadas, se nos permite legalmente divulgar a terceros determinados artículos de información personal sin su autorización expresa. Usted tiene derecho a que le informen respecto de artículos de información personal sobre usted que tengamos en archivo (incluso si se trata de datos incluidos en informes investigativos del consumidor), a consultarlos y copiarlos si lo desea. Además tiene derecho a solicitar que se corrija la información que usted considere incorrecta.

Le enviaremos una explicación más detallada sobre nuestras prácticas de información si usted nos envía la solicitud por escrito. Puede enviar su solicitud a P.O. Box 461, Lynchburg, Virginia 24505-0461.

Ley Federal de Informe Justo de Crédito
Como parte de la suscripción, quizás solicitemos que se prepare un informe investigativo del consumidor. Una fuente independiente conocida como agencia de información de crédito del consumidor preparará el informe. Normalmente, el informe incluirá datos sobre su carácter, su reputación general, su modo de vida y sus características personales.(El "Modo de vida" no incluye información directa o indirectamente relacionada con su orientación sexual.) La agencia llevará a cabo entrevistas personales con su familia, amigos, vecinos, socios comerciales, fuentes financieras u otras personas que lo conozcan a fin de obtener esta información. Si nos escribe en un plazo razonable, luego de recibir esta notificación, le informaremos si se solicitó o no un informe. En caso de que se haya solicitado, le comunicaremos el nombre, dirección y número de teléfono de la agencia a la cual se le solicitó. Si se lo solicita, la agencia facilitará la información sobre la naturaleza y el alcance de su investigación. Si usted desea analizar el informe y recibir una copia del mismo, podrá hacerlo comunicándose directamente con la agencia.

Divulgación de la Agencia de Información Médica (MIB – Medical Information Bureau)
La información con respecto a su asegurabilidad se tratará como confidencial. No obstante, es posible que nosotros y nuestros reaseguradores, presentemos un breve informe al MIB, Inc., una organización de membresía sin fines de lucro de compañías que ofrecen seguros de vida. La misma funciona como agencia de intercambio de información en nombre de sus miembros. Si usted solicita a otra compañía miembro un seguro de vida, de enfermedad o de incapacidad, o si presenta un reclamo por beneficios ante dicha compañía, MIB, Inc., mediante solicitud previa, proporcionará a dicha compañía toda información con la que cuente en sus archivos.

Previa recepción de la solicitud, MIB, Inc., dispondrá la divulgación de cualquier información que pueda tener en sus archivos. En caso de que usted cuestione la exactitud de la información en dicho archivo, podrá contactarse con MIB, Inc., y solicitar la corrección de acuerdo con los procedimientos establecidos en la Ley Federal de Informe Justo de Crédito. Para comunicarse con MIB, Inc., usted puede: escribir a P.O. Box 105, Essex Station, Boston, MA 02112; llamar al número gratuito (866) 692-6901 (TTY 866 346-3642 para personas con discapacidad auditiva); o a través de la página Web http://www.mib.com.

Nuestros reaseguradores y nosotros mismos podremos divulgar información de nuestros archivos a otras compañías de seguro a quienes usted podrá solicitar un seguro de vida, de enfermedad o incapacidad, o a quien podrá presentar un reclamo por beneficios.

Período de Observación Gratuito
Si le entregamos una póliza, tendrá un plazo breve para examinar la póliza y, si lo desea, devolverla para que se le reintegre la totalidad de cualquier prima que ya haya abonado. Usualmente, este período (conocido como el "período de observación gratuito") es de 20 días desde que le entregamos la póliza, pero puede ser un período algo más prolongado en algunos estados. Para devolver la póliza, simplemente envíela por correo o entréguela a la Compañía o a cualquiera de sus agentes antes de que cumpla el período de observación gratuito correspondiente a su estado. Entonces la póliza quedará anulada desde el comienzo.

Compensación del Productor
Cuando adquiere un seguro de nuestra compañía, pagamos una compensación al agente autorizado, quien nos representa para tales propósitos limitados como recibir su solicitud de seguro, cobrar sus primas iniciales y entregar su póliza, y a todo intermediario a través del cual trabaje el agente autorizado. Esta compensación puede incluir comisiones pagadas al momento de comprar o renovar una póliza y cargos por servicios administrativos y de marketing y oportunidades educativas. La compensación puede variar según el tipo de seguro adquirido o las características particulares recogidas en su póliza. A su vez, los agentes autorizados y/o sus intermediarios, también podrán recibir descuentos sobre las primas y bonificaciones de sus pólizas personales o sobre viajes y premios de incentivo relacionados con concursos de ventas basados en criterios de venta como el volumen general de ventas o el porcentaje de ventas consumadas de un agente o intermediario con nuestras empresas. Los intermediarios también podrán pagar la compensación directamente al agente autorizado. Si el agente autorizado vende pólizas de otras aseguradoras, las compensaciones de dichas aseguradoras pueden ser sean diferentes de las nuestras.

ADVERTENCIA DE FRAUDE

ARKANSAS y LOUISIANA
Cualquier persona que presente a sabiendas un reclamo de pago de una pérdida o beneficio falso o fraudulento, o incluya conscientemente datos falsos en una solicitud de seguro, será culpable de delito y estará sujeto a multas y encarcelación.

COLORADO
Es ilegal proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguro con el propósito de defraudar o intentar defraudar a la compañía. Las penalidades pueden incluir encarcelación, multa, denegación del seguro e indemnizaciones por daños civiles. Cualquier compañía de seguro o agente de seguro que, a sabiendas, proporcione información falsa, incompleta o engañosa con el propósito de defraudar o intentar defraudar a un titular de póliza o demandante con respecto a la liquidación del seguro, será informada a la División de Seguros de Colorado perteneciente al Departamento de Agencias Reguladoras.

DISTRITO DE COLUMBIA
Es ilegal proporcionar información falsa o engañosa a un asegurador con el propósito de defraudar al asegurador o a cualquier otra persona. Las penalidades incluyen encarcelación y/o multas. Además, un asegurador puede denegar los beneficios del seguro si el solicitante proporciona información fundamentalmente falsa en relación con un reclamo.

FLORIDA
Toda persona que, a sabiendas y con interés de perjudicar, defraudar o engañar a cualquier asegurador, presente una declaración de reclamo o una solicitud que contenga cualquier información falsa, incompleta o engañosa, se considerará culpable de delito en tercer grado.

KENTUCKY
Toda persona que, a sabiendas y con la intención de defraudar a cualquier compañía de seguro o a otra persona, presente una solicitud de seguro que contenga cualquier información fundamentalmente falsa u oculte datos relacionados con cualquier hecho esencial concerniente al mismo, está cometiendo un hecho delictivo en materia de seguros, lo cual constituye un delito.

MAINE y TENNESSEE y WASHINGTON
Es ilegal proporcionar a sabiendas información falsa, incompleta o engañosa a una compañía de seguro con el propósito de defraudarla. Las penalidades incluirán encarcelación, multas o denegación de los beneficios del seguro.

NUEVA JERSEY
Toda persona que incluya cualquier información falsa o engañosa en una solicitud de póliza de seguro estará sujeta a penalidades civiles y penales.

NUEVO MÉXICO
Cualquier persona que presente a sabiendas un reclamo de pago de una pérdida o beneficio falso o fraudulento, o incluya conscientemente datos falsos en una solicitud de seguro, es culpable de delito y estará sujeta a multas civiles y sanciones penales.

OHIO
Toda persona que, con la intención de defraudar o consciente de que está facilitando la comisión de fraude contra un asegurador, presente una solicitud o un reclamo que contenga una declaración falsa o falaz, es culpable de fraude en materia de seguro.

PENNSYLVANIA
Toda persona que, a sabiendas y con la intención de defraudar a cualquier compañía de seguro o a otra persona, presente una solicitud de seguro que contenga cualquier información fundamentalmente falsa u oculte datos relacionados con cualquier hecho esencial concerniente al mismo, está cometiendo un hecho delictivo en materia de seguros, lo cual constituye un delito.

Para su conveniencia, este material esta disponible en Inglés tanto como en Español. La versión en Inglés de este material es la versión oficial; la versión en Español sirve como información solamente. Todas las solicitudes, formas de inscripción, certificados, pólizas y / o documentos y correspondencia relacionados solamente están disponibles en Inglés. Como un resultado de posibles diferencias lingüísticas, puede que este material no refleje el contenido del certificado o póliza escritos en Inglés. En el caso de una disputa relacionada con los términos y condiciones de su cobertura de seguro, los términos de la evidencia de la cobertura de seguro prevalecerán.