Application – Part II Medical History

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

Professional health care provider (care provider) means persons licensed as: medical physicians; chiropractors; physical therapists; psychologists; and drug, alcohol, or mental health counselors. **Professional health care treatment facility (treatment facility)** includes: hospitals; clinics; drug or alcohol treatment or consultation facilities; nursing homes; mental health facilities; ambulatory care centers; and facilities or offices staffed or run by care providers.

1. Proposed Insured

Please print all answers

a. Full Name	b. Date of Birth (Mo. Day Yr.)	c. Social Security Number	d. Height ft. in.	e. Weight lbs.

2. Primary Care Provider (If none, state NONE.)

Name and Address **(For the past 5 years, give dates and reasons consulted and any treatments or medications prescribed in DETAILS.)**

3. Medical Questions (Explain "Yes" Answers in DETAILS.)

a. In the past 10 years, have you had, been treated for, or been medically advised to be treated for, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
(1) Alcoholism or Drug Use	○	○	(13) Depression	○	○	(24) Lupus (SLE)/Scleroderma	○	○	(36) Shortness of Breath	○	○
(2) Angina	○	○	(14) Diabetes	○	○	(25) Mental Illness	○	○	(37) Skin Disorder	○	○
(3) Asthma	○	○	(15) Dizziness/Fainting	○	○	(26) Muscular Dystrophy	○	○	(38) Sleep Apnea	○	○
(4) Blood Disorder	○	○	(16) Gastrointestinal Bleeding	○	○	(27) Neurologic Disorder	○	○	(39) Stroke	○	○
(5) Bronchitis	○	○	(17) Headaches	○	○	(28) Palpitations/Arrhythmia	○	○	(40) Sugar, Protein, or Blood in Urine	○	○
(6) Cancer	○	○	(18) Heart Attack	○	○	(29) Pancreatitis	○	○	(41) Suicide Attempt	○	○
(7) Chest Pain	○	○	(19) Heart Murmur	○	○	(30) Paralysis	○	○	(42) Thyroid Disorder	○	○
(8) Cirrhosis	○	○	(20) Hepatitis	○	○	(31) Peripheral Vascular Disease	○	○	(43) Tuberculosis	○	○
(9) Clotting Disorder	○	○	(21) High Blood Pressure	○	○	(32) Pituitary Disorder	○	○	(44) Tumor, Mass or Lump	○	○
(10) Colitis/Ileitis	○	○	(22) Human Immunodeficiency Virus (HIV) Infection	○	○	(33) Prostate Disorder	○	○	(45) Ulcer/Gastritis	○	○
(11) Coughing Up of Blood	○	○	(23) Kidney Disorder	○	○	(34) Rheumatoid Arthritis	○	○			
(12) Chronic Lung Disorder	○	○				(35) Seizures/Convulsions	○	○			

b. For reasons other than those given in answering Question 3.a., in the past 5 years have you: — Yes No
(1) consulted with or received treatment from a care provider or treatment facility? ○ ○
(2) had an EKG, X-ray, or other diagnostic test, other than an AIDS-related test? ○ ○
(3) been advised to have any diagnostic test, other than an AIDS-related test, hospitalization or surgery that was not completed? ○ ○
(4) had medication prescribed for a physical or mental disorder? ○ ○

c. In the past 6 months, has your weight changed more than 15 pounds? ○ ○

d. Other than as prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? ○ ○
If "Yes," also give name, form, amount, frequency and length of use, and date last used in **DETAILS**.

e. (1) Mark the **one** item that best describes your history of alcoholic beverage use.
○ Never Used ○ Totally Stopped ○ Use Now
(2) If you have "Totally Stopped," indicate number of years since you totally stopped and give date and reason in **DETAILS.**
(3) If you "Use Now," answer the following.
(a) How often do you drink alcoholic beverages? ○ Occasionally ○ 3 or less days per week ○ 4 or more days per week
(b) When you drink, how many drinks do you consume per day? ○ 3 or less ○ 4-6 ○ 7 or more

f. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, alcoholism, mental illness, or suicide in your family? — Yes ○ No ○

	Age if Alive:	Age at Death:	Cause	Siblings	No. Alive	Age(s)	No. Dead:	Age(s):
Father								
Mother							Cause(s)	

4. DETAILS (For explanations and requested information. Identify applicable item number and letter. If additional space is needed, use an overflow form.)

State condition and give diagnoses, dates, durations, treatments, tests, medications prescribed and names and addresses of all care providers and treatment facilities.

I represent that the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief. 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.**

Signature of Proposed Insured — Date — Signature of Examiner

Application – Part II Medical History, Overflow Form

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

Proposed Insured ***Please print all answers***

a. Full Name	b. Date of Birth (Mo. Day Yr.)	c. Social Security Number

4. DETAILS (Provide explanations and requested information.)

Question	Condition
Date (Mo. Day Yr.)	Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to
Details/Diagnosis	
Medications	
Treatments	
Tests	Results
Additional Details	
Care Provider/Treatment Facility	
Name and Address (Number, Street, City, State and Zip Code)	

Question	Condition
Date (Mo. Day Yr.)	Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to
Details/Diagnosis	
Medications	
Treatments	
Tests	Results
Additional Details	
Care Provider/Treatment Facility	
Name and Address (Number, Street, City, State and Zip Code)	

Question	Condition
Date (Mo. Day Yr.)	Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to
Details/Diagnosis	
Medications	
Treatments	
Tests	Results
Additional Details	
Care Provider/Treatment Facility	
Name and Address (Number, Street, City, State and Zip Code)	

Question	Condition
Date (Mo. Day Yr.)	Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to
Details/Diagnosis	
Medications	
Treatments	
Tests	Results
Additional Details	
Care Provider/Treatment Facility	
Name and Address (Number, Street, City, State and Zip Code)	

I represent that the statements and answers given in the application are true, complete, and correctly recorded to the best of my knowledge and belief. 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.**

Overflow Page ______ of ______

______________________ ______________ ______________________

Signature of Proposed Insured | Date | Signature of Licensed Insurance Agent or Examiner

Examiner's Report

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

1. Proposed Insured

Please print all answers

a. Full Name	b. Date of Birth (Mo. Day Yr.)	c. Social Security Number

d. Height	e. Weight	f. Blood Pressure			g. Pulse (at rest)		h. Measurements (Males Only)		
			*	*	Rate	Irregularities per Minute	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
ft. in.	lbs.						in.	in.	in.

(*Include two additional pressure readings if there is a history of high blood pressure or systolic exceeds 140 or diastolic exceeds 90.)

i. What picture ID did you use to identify the Proposed Insured? ○ Driver's License with Picture ○ Other ______

j. Is the Proposed Insured's appearance unhealthy, unusual, or older than stated age? If "Yes," explain in **DETAILS**. ○ Yes No ○

k. Was the Proposed Insured able to speak and understand English? If "No," explain in **DETAILS**. ○ Yes No ○

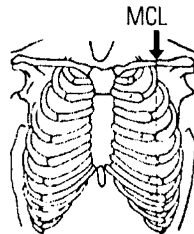
l. Was any third party present during the examination? If "Yes," give name, relationship, and reason for presence in **DETAILS**. ○ Yes No ○

2. Heart and Other Medical Conditions (To be completed by Medical Doctor or Doctor of Osteopathy.)

a. (Check all heart conditions that apply.) ○ Enlargement ○ Dyspnea ○ Edema ○ Murmur (Describe below.)

b. Murmurs	At Rest								After Exercise		
Location	Constant	Transmitted	Localized	Systolic	Diastolic	Soft (Gr. 1-2)	Mod. (Gr. 3-4)	Loud (Gr. 5-6)	Increased	Decreased	Unchanged
(1)	○	○	○	○	○	○	○	○	○	○	○
(2)	○	○	○	○	○	○	○	○	○	○	○

Indicate:
Apex by **X**
Murmur area by ◌
Point of greatest intensity by ○
Transmission by ➡



Your impression:

c. Other Medical Conditions (Explain "Yes" answers in DETAILS section; circle each applicable item.)

On examination, is there any abnormality of items (1) - (8): Yes No

(1) Head and neck, vision and eyes, hearing and ears, nose, mouth, throat, or thyroid? ○ ○
(2) Skin (include scars and tattoos) or lymph nodes? ○ ○
(3) Nervous system (include reflexes, gait, paralysis)? ○ ○
(4) Chest (include lungs and breasts)? ○ ○
(5) Abdomen (include liver, spleen, and scars)? ○ ○
(6) Genitourinary system (include rectum and prostate)? ○ ○
(7) Musculoskeletal system (include spine, joints, amputation, and deformities)? ○ ○
(8) Vascular system (include varicose veins and peripheral arteries)? ○ ○

3. DETAILS (Identify applicable item number, letter and medical condition. If additional space is needed, use an overflow form.)

4. Examiner Information

a. Examiner's Name and Professional Designation	b. SSN or Tax ID No.	c. Phone No.

d. Name and Address of Examiner's Firm	e. Time and Date of Exam	f. Location of Exam
	Time ○am pm○ Date (Mo. Day Yr.)	○ Examiner's Office ○ Proposed Insured's Office ○ Proposed Insured's Home ○ Other:

g. Name of Referring Licensed Insurance Agent or Agency (if known)	h. Agent/Agency Phone Number

Signed at ______________ on ______________ ______________
City/State Date Examiner's Signature

Proposed Insured	Social Security Number

DETAILS (For explanations and requested information identify applicable item number and letter)

Signature of Proposed Insured | Date | Signature of Examiner

Form No. GEFA-504 4/2001

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 test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
   (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
   (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result 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. Test results may be maintained in a file or a data bank.

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 and 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.

______________________________ ______________

Proposed Insured (Please Print) Date of Birth

Name and address of designated Physician:

____

____

____

______________________________ ____________ ____________

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

☐ **First Colony Life Insurance Company**
P.O. Box 320
Lynchburg, VA 24505-0320
P.O. Box 4114
Woodland Hills, CA 91365-4114

☐ **GE Life and Annuity Assurance Company**
P.O. Box 27601
Richmond, VA 23261-7601
Administrative Office, P.O. Box 6700
Lynchburg, VA 24505-6700

☐ **Federal Home Life Insurance Company**
Administrative Office, P.O. Box 466
Lynchburg, VA 24505-0466

☐ **General Electric Capital Assurance Company**
Administrative Office, P.O. Box 461
Lynchburg, VA 24505-0461