

Examiner's Report



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)			
ft.	in.	lbs.		*	*	Rate	Irregularities per Minute	Chest (Full Inspiration)		Chest (Forced Expiration)	Abdomen, at Umbilicus
								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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

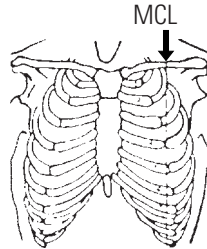
Indicate:

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		Yes	No
(1) Head and neck, vision and eyes, hearing and ears, nose, mouth, throat, or thyroid?	<input type="radio"/>	<input type="radio"/>	(6) Genitourinary system (include rectum and prostate)?	<input type="radio"/>	<input type="radio"/>
(2) Skin (include scars and tattoos) or lymph nodes?	<input type="radio"/>	<input type="radio"/>	(7) Musculoskeletal system (include spine, joints, amputation, and deformities)?	<input type="radio"/>	<input type="radio"/>
(3) Nervous system (include reflexes, gait, paralysis)?	<input type="radio"/>	<input type="radio"/>	(8) Vascular system (include varicose veins and peripheral arteries)?	<input type="radio"/>	<input type="radio"/>
(4) Chest (include lungs and breasts)?	<input type="radio"/>	<input type="radio"/>			
(5) Abdomen (include liver, spleen, and scars)?	<input type="radio"/>	<input type="radio"/>			

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 <input type="radio"/> am <input type="radio"/> pm		<input type="radio"/> Examiner's Office <input type="radio"/> Proposed Insured's Office			
				Date (Mo. Day Yr.)		<input type="radio"/> Proposed Insured's Home <input type="radio"/> Other:			
g. Name of Referring Licensed Insurance Agent or Agency (if known)							h. Agent/Agency Phone Number		

Signed at _____ on _____ Date _____ Examiner's Signature _____

Application – Part II Medical History



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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.
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2. Insurer

Insurer (Select one): Genworth Life Insurance Company Genworth Life and Annuity Insurance Company

3. 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.)

4. 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
(1) Alcoholism or Drug Use	<input type="radio"/>	<input type="radio"/>	(13) Depression	<input type="radio"/>	<input type="radio"/>	(24) Lupus (SLE)/Scleroderma	<input type="radio"/>	<input type="radio"/>
(2) Angina	<input type="radio"/>	<input type="radio"/>	(14) Diabetes	<input type="radio"/>	<input type="radio"/>	(25) Mental Illness	<input type="radio"/>	<input type="radio"/>
(3) Asthma	<input type="radio"/>	<input type="radio"/>	(15) Dizziness/Fainting	<input type="radio"/>	<input type="radio"/>	(26) Muscular Dystrophy	<input type="radio"/>	<input type="radio"/>
(4) Blood Disorder	<input type="radio"/>	<input type="radio"/>	(16) Gastrointestinal Bleeding	<input type="radio"/>	<input type="radio"/>	(27) Neurologic Disorder	<input type="radio"/>	<input type="radio"/>
(5) Bronchitis	<input type="radio"/>	<input type="radio"/>	(17) Headaches	<input type="radio"/>	<input type="radio"/>	(28) Palpitations/Arrhythmia	<input type="radio"/>	<input type="radio"/>
(6) Cancer	<input type="radio"/>	<input type="radio"/>	(18) Heart Attack	<input type="radio"/>	<input type="radio"/>	(29) Pancreatitis	<input type="radio"/>	<input type="radio"/>
(7) Chest Pain	<input type="radio"/>	<input type="radio"/>	(19) Heart Murmur	<input type="radio"/>	<input type="radio"/>	(30) Paralysis	<input type="radio"/>	<input type="radio"/>
(8) Cirrhosis	<input type="radio"/>	<input type="radio"/>	(20) Hepatitis	<input type="radio"/>	<input type="radio"/>	(31) Peripheral Vascular Disease	<input type="radio"/>	<input type="radio"/>
(9) Clotting Disorder	<input type="radio"/>	<input type="radio"/>	(21) High Blood Pressure	<input type="radio"/>	<input type="radio"/>	(32) Pituitary Disorder	<input type="radio"/>	<input type="radio"/>
(10) Colitis/Ileitis	<input type="radio"/>	<input type="radio"/>	(22) Human Immunodeficiency Virus (HIV) Infection	<input type="radio"/>	<input type="radio"/>	(33) Prostate Disorder	<input type="radio"/>	<input type="radio"/>
(11) Coughing Up of Blood	<input type="radio"/>	<input type="radio"/>	(23) Kidney Disorder	<input type="radio"/>	<input type="radio"/>	(34) Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>
(12) Chronic Lung Disorder	<input type="radio"/>	<input type="radio"/>				(35) Seizures/Convulsions	<input type="radio"/>	<input type="radio"/>

(36) Shortness of Breath Yes No

(37) Skin Disorder Yes No

(38) Sleep Apnea Yes No

(39) Stroke Yes No

(40) Sugar, Protein, or Blood in Urine Yes No

(41) Suicide Attempt Yes No

(42) Thyroid Disorder Yes No

(43) Tuberculosis Yes No

(44) Tumor, Mass or Lump Yes No

(45) Ulcer/Gastritis Yes No

b. For reasons other than those given in answering Question 4.a., in the past 5 years have you:

(1) consulted with or received treatment from a care provider or treatment facility? Yes No

(2) had an EKG, X-ray, or other diagnostic test, other than an AIDS-related test? Yes No

(3) been advised to have any diagnostic test, other than an AIDS-related test, hospitalization or surgery that was not completed? Yes No

(4) had medication prescribed for a physical or mental disorder? Yes No

c. In the past 6 months, has your weight changed more than 15 pounds? Yes No

d. Other than as prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? Yes No
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 Yes No

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

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

5. 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	MED 1/2007
GNW-504-1			

Application – Part II Medical History, Overflow Form

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
GNW-504-1 (Overflow)

Date

Signature of Licensed Insurance Agent or Examiner

