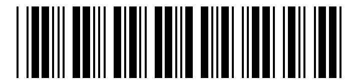
Application – Part II Medical History



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. Insurer **Please print all answers**

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

2. Proposed Insured

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

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		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 4.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 one used to determine exposure to HIV? ◯ ◯
(3) been advised to have any diagnostic test, other than one used to determine exposure to HIV, 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 ◯

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

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

Insurer

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

Proposed Insured **Please print all answers**

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

5. 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)	

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Date (Mo. Day Yr.)	Duration of Condition (Mo. Day Yr. to Mo. Day Yr.) to
Details/Diagnosis	
Medications	
Treatments	
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Overflow Page ______ of ______

______________________ ______________ ______________________
Signature of Proposed Insured   Date   Signature of Licensed Insurance Agent or Examiner