HOW TO COMPLETE YOUR ENROLLMENT REQUEST

Please be sure to complete all information on this card

EMPLOYER INFORMATION SECTION MUST BE COMPLETED BY EMPLOYER

- Legal Name of Employer.
- Occupation / Title must coincide with those listed on your Application / Insurance Benefit.

EMPLOYEE SECTION

- Must be completed by employee to determine your eligibility.
- Children between age 19-25 (21-25 for Louisiana residents) must be full-time students at an accredited college or university.
- Give beneficiary's complete name, relationship to you and **Full** address.
- If beneficiary is a married woman, show given name (Mary J. Jones **Not** Mrs. John Jones).
- If you wish to designate any arrangement other than the primary/contingent designation, please send complete instructions to Group Title, Genworth Life and Health Insurance Coompany; Special forms will be prepared.

NOTE: Employer may not be designated as a beneficiary.

Full signature (must be in ink) of employee is required and must be dated

Genworth Financial
Employee Benefits Group

Genworth Life and Health Insurance Company
Attn: Group Eligibility
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

ENROLLMENT REQUEST

☐ Add ☐ Change ☐ Termination ☐ Correction

Date: ____________ Reason: ____________________________________

Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group

4. Name of Employer

5. Employer's Address (Number, Street, City, State, ZIP Code)

Employee Information - to be completed by Employee (This **entire** section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.)	7. Social Security Number
8. Employee's Address (Number, Street, City, State, ZIP Code)	9. Employee's Home Phone No.

10. Sex ☐ Male ☐ Female	11. Date of Birth (Mo., Day, Yr.)	12. Marital Status ☐ Single ☐ Married	13. My employment is covered under Union Collective Bargaining ☐ Yes
14. Hours worked weekly for this employer ☐ Active ☐ Retired (Excluding Overtime)____________		15. Date Employed (Mo., Day, Yr.,) ☐ Full-Time ___/___/___ ☐ Part-time ___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___	
16. Basic Earnings $ ☐ Hourly ____________ Hrs/Wk ☐ Monthly ☐ Weekly ☐ Annually		17. Employee's Occupation (Title)	

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by GE Group Administrators, Inc. and/or Genworth Life and Health Insurance Company does not imply liability for GEGA and/or GLHIC for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

Group Benefits Requested - to be completed by Employee

Benefit			Benefit			Benefit		
Life/AD&D	☐ I Elect	☐ I Refuse	Dependent Life/AD&D	☐ I Elect	☐ I Refuse	Supplemental Life/AD&D	☐ I Elect	☐ I Refuse
Dental	☐ I Elect	☐ I Refuse	Medical	☐ I Elect	☐ I Refuse	Weekly Indemnity	☐ I Elect	☐ I Refuse
Dependent Dental	☐ I Elect	☐ I Refuse	Dependent Medical	☐ I Elect	☐ I Refuse	Long Term Disability	☐ I Elect	☐ I Refuse

*If you have refused Medical or Dental, is it because you have other Group Coverage? Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

**If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage? Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

Please Complete The Following Question If You Are Electing Medical Coverage

Did you or your dependent have prior medical coverage? ☐ Yes If so, ☐ Single ☐ Family ☐ Dependent(s)

☐ Individual Policy ☐ Group Policy ☐ HMO ☐ Other ____________________

Name of Carrier ____________________ Termination date of Coverage ____/____/____

Reason for Termination ____________________

Please complete this *entire* section if you are selecting Medical and/or Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						/ /
						/ /
						/ /
						/ /
						/ /

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: ____________________ School Name and Address: ____________________

Course of Study: ____________________ Semester: ____________ Anticipated Date of Graduation (month/year): ____________________

Beneficiary Designation - applies ONLY if life insurance is being elected at this time

22. Primary - Last Name	First Name & Middle Initial	Relationship	Address
23. Contingent - Last Name	First Name & Middle Initial	Relationship	Address

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

I request benefits under the group coverage issued by Genworth Life and Health Insurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the **refusal section** is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date	25. Signature

GNW-GL2479 (0306) **Original** to Genworth Financial • **1st Copy** to Employer • **2nd Copy** to Employee/Subscriber

Notices Concerning Medical Coverage required by the Health Insurance Portability and Accountability Act of 1996:

Pre-Existing Conditions (not applicable to pregnancy). - The medical plan contains a pre-existing condition limitation that may apply to you and/or your dependents. Any applicable pre-existing condition limitation will be reduced by your prior creditable coverage, if any. You have the right to request a certificate of creditable coverage from your prior health plan and we will assist you in obtaining this certificate, if necessary. For additional information regarding the plan's pre-existing condition limitation, please see your plan administrator. Late entrants to the plan may be subject to an increased pre-existing condition limitation.

Special Enrollment Rights. - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this medical plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption or placement for adoption.

Genworth Financial

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Attn: Group Eligibility - WIN 407
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Date: ____________ **Reason:** ______________________________________

Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group

4. Name of Employer

5. Employer's Address (Number, Street, City, State, ZIP Code)

Employee Information - to be completed by Employee (This **entire** section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.) | 7. Social Security Number

8. Employee's Address (Number, Street, City, State, ZIP Code) | 9. Employee's Home Phone No.

10. Sex ☐ Male ☐ Female | 11. Date of Birth (Mo., Day, Yr.) | 12. Marital Status ☐ Single ☐ Married | 13. My employment is covered under Union Collective Bargaining ☐ Yes

14. Hours worked weekly for this employer ☐ Active ☐ Retired (Excluding Overtime)____________ | 15. Date Employed (Mo., Day, Yr.,) ☐ Full-Time ___/___/___ ☐ Part-time ___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___

16. Basic Earnings ☐ Hourly ______________ Hrs/Wk $ ____________ ☐ Monthly ☐ Weekly ☐ Annually | 17. Employee's Occupation (Title)

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by GE Group Administrators, Inc. and/or Genworth Life and Health Insurance Company does not imply liability for GEGA and/or GLHIC for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

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Dental	☐ I Elect	☐ I Refuse	Medical	☐ I Elect	☐ I Refuse	Weekly Indemnity/STD	☐ I Elect	☐ I Refuse
Dependent Dental	☐ I Elect	☐ I Refuse	Dependent Medical	☐ I Elect	☐ I Refuse	Long Term Disability	☐ I Elect	☐ I Refuse

*If you have refused Medical or Dental, is it because you have other Group Coverage?
Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

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☐ Individual Policy ☐ Group Policy ☐ HMO ☐ Other ____
Name of Carrier ____ Termination date of Coverage ____/____/____
Reason for Termination ____

Please complete this *entire* section if you are selecting Medical and/or Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						/ /
						/ /
						/ /
						/ /
						/ /

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: ____________________________ School Name and Address: ____________________________

Course of Study: ____________________ Semester: __________ Anticipated Date of Graduation (month/year): ____________________

Beneficiary Designation - applies ONLY if life insurance is being elected at this time

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NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

I request benefits under the group coverage issued by Genworth Life and Health Insurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

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I certify that I have read the reverse side of this form.

24. Date	25. Signature

WARNING

Disability income benefits may be reduced by other sources of income. Read your certificate carefully.

STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:
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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and (in North Carolina, "may subject") subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN 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."

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

IN NEW JERSEY: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

IN NEW YORK: "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 containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation."

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health coverage.

In Georgia, any person who signs this Enrollment Form acknowledges notification of the following:

1. You are entitled to a list of providers participating in our PPO network. Provider Directories are available by contacting our Group Policyholder Services Department at 800-451-2513 or by viewing our website at www.gefinancialbenefits.com.
2. You are entitled to receive treatment from a provider of your choosing. You will receive a higher level of benefits for medical services when choosing a PPO physician or hospital.
3. There are no limited utilization incentive plans for providers of medical services. The provider is not given an incentive or bonus that encourages withholding services or influences referral to specialists.

You will be provided with a Disclosure form after the effective date of your Group Policy. This Disclosure will provide details of the above.