



Genworth Life and Annuity
 Genworth Life
 Genworth Insurance Company
 Genworth Life of New York
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Authorization to Receive Information



from Genworth Life and Annuity Insurance Company,
 Genworth Life Insurance Company, Genworth Insurance Company
 and Genworth Life Insurance Company of New York†

Page 1 of 1

- Use this form to designate any person or organization to receive information about your policy/certificate.
- Please print clearly using blue or black ink, and initial any corrections or we may not be able to accept your request.
- Please read this entire form and complete all required fields before signing.

Policy/certificate information

Policy/certificate number: AA5220954 Insured name: David E. Beeson

Designate person/organization

"Authorized party" is the party who has the rights stated in the policy/certificate. For life insurance, that party is the owner. For long term care insurance, it is the insured. In this form, "you" and "your" refer to the authorized party.

Once you designate any person or organization to receive information about your policy/certificate, that authorization will remain in place as outlined in the declaration and signature(s) section.

- I no longer designate anyone to receive information about my policy/certificate.
- I designate the following to receive all policy information as requested. I acknowledge that only those named on this form will be authorized to receive information.
- If you only want to add a person or organization, you must also restate those already authorized since this authorization replaces any previous version of this kind of authorization.

Select an option and complete all information.

If more space is required please attach an additional sheet of paper to this form that states the requested changes and that lists the addresses and phone numbers. Please be sure to sign and date both the additional sheet of paper and this form.

Name Print: Kathlyn Gales Phone number: 813-466-2382 Birth date: 5/5/56
 Address Complete address required: 133 Martello Dr.
 City: St. Augustine, FL State: FL ZIP code: 32092

Name Print: _____ Phone number: _____ Birth date: _____
 Address Complete address required: _____
 City: _____ State: _____ ZIP code: _____

Declaration and signature(s)

Your signature indicates your understanding of the following:

- That you should keep a copy for reference, and a copy of it is as valid as the original.
- For policies that have long term care benefits, this authorization will be valid for two years from the date signed, unless a shorter duration is required under your state law or you revoke it in writing.
- For life insurance, this authorization will remain valid unless revoked in writing or by making a change in ownership.
- Revocation will take effect upon our receipt of your request although it will not pertain to any information that might have been used or disclosed prior to our receipt of your request.
- This authorization allows us to disclose health information to persons or organizations that may not be subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.
- Signing this authorization is not a condition for treatment, payment, enrollment, or eligibility for benefits.
- This authorization replaces any previous version of this kind of authorization.

All authorized parties must sign this form and indicate the capacity in which they are signing. For trustees, attorneys-in-fact, guardians, conservators and other fiduciaries, also attach all relevant legal documentation. We will not accept signatures of unauthorized parties.

SIGN HERE X David E. Beeson SELF 10/24/2024
 Signature of authorized party Capacity Date Signed

SIGN HERE X _____ _____ _____
 Signature of other authorized party Capacity Date Signed
 (e.g. Joint owner, joint/co-insured)

†Only Genworth Life Insurance Company of New York is admitted in and conducts business in New York.