NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING

Insurer Name & Address:

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To evaluate your eligibility for Insurance or Insurance benefits, it is required that you consent to be tested for the AIDS virus (HIV). By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results.

Disclosure of Test Results:

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. Results of the test will not otherwise be disclosed except as allowed by law or as stated below.

Meaning of Test Results:

While positive HIV antibody test results do mean that you have AIDS, they do mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The test is a test for antibodies of the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody test results could 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.

Release of Results:

The results of this test may be released to the following:

- The proposed insured
- The person legally authorized to consent to the test;
- A licensed physician, medical practitioner, or other person designated by the proposed insured;
- An insurance medical information exchange under procedures that are designed to assure confidentiality including the use of general codes that also cover results of test for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular proposed insured;
- A reinsure, if the reinsure is involved in the underwriting process, under procedures that are designed to assure confidentiality;
- Persons who have the responsibility to make underwriting decisions on behalf of the Insurer;
- Insurer's legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

The insurer may contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results.

Consent:

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be valid as the original.

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Date Signature of Proposed Insured or Parent/Guardian