IA AMERICAN™
LIFE INSURANCE COMPANY
P.O. Box 2549 • Waco, TX 76702-2549
254-297-2774

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Examiner*: _____

Address: _____

City, State, Zip: _____

Insurer: IA American Life Insurance Company

Address: P.O. Box 2549

City, State, Zip: Waco, TX 76702-2549

INFORMATION ON AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is transmitted by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely as a result of a blood transfusion), or from an infected mother to her newborn infant.

PURPOSE OF CONSENT

To determine your insurability, the Insurer named above ("the Insurer") has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.
Unless precluded by law, tests will be performed to determine the presence of antibodies or antigens. The HIV antibody test that will be performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk for HIV infection, you may want to be counseled and tested by your physician or at a free/low-cost local test site. Your local health department can provide you with information as to the location of these sites.

DISCLOSURE OF TEST RESULTS

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its' affiliates, reinsurers, independent contractors, and its employees but not to agents and/or brokers.
If the Insurer is a member of the Medical Information Bureau, Inc. (MIB), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB.
The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

MEANING OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.
Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.
Positive HIV antibody or antigen test results or other significant blood abnormalities will 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.

You are urged at this time to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Physician: _____

Address: _____

City, State, Zip: _____

CONSENT

I have read and I understand this Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing.

I voluntarily consent to the withdrawal of blood from me by needle, the testing of blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original.

Proposed Insured (Please Print)	Date of Birth	State of Residence
Signature of Proposed Insured or Parent/Guardian	Date	