

NOTICE AND CONSENT FORM FOR AIDS-RELATED BLOOD TESTING

Examiner: _____

Insurer: IA American Life Insurance Company

Address: _____

Address: P.O. Box 2549

City, State, Zip: _____

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

PURPOSE OF CONSENT FORM

To evaluate your insurability, the Insurer named above (the "Insurer") has requested that you provide a sample of blood for HIV testing (the "HIV test" or "test") and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies/antigens. The testing will be performed by a licensed laboratory through a medically accepted procedure. By signing this form, you agree that the test may be done, that the test results may be disclosed as described in this form, and that underwriting and/or coverage decisions will be based on the test results.

INFORMATION ON AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during injection drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a significant chance of developing AIDS over the next 10 years.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies/antigens to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies/antigens is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibodies test results will adversely affect your application for insurance. This means that your application will probably be declined.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests 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 person.

NOTIFICATION OF TEST RESULTS

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Department of Health and Rehabilitative Services (DHRS). Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have your private physician tell you the test result and explain its meaning.

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Name and address of physician for reporting positive test results:

Physician Name: _____

Physician Address: _____

CONSENT

I have read and I understand this Notice and Consent For AIDS-Related Blood Testing.

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

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

Signature of Proposed Insured or Person Authorized by Law to Consent on behalf of the Proposed Insured.

Date Signed

Name of Proposed Insured (Please Print)

Address

City, State, Zip