

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

Examiner*: _____

Insurer: IA American Life Insurance Company

Address: _____

Address: P.O. Box 2549

City, State, Zip: _____

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

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test 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. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

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 to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. 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. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph 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 also contact you if there are other abnormal test results which, in the Insurer’s opinion, are significant. 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.

CONSENT

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

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 this consent shall be valid for thirty (30) months following the date shown below.

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.

I also have the right, upon written request to an insurance institution (Insurer), agent, or insurance support organization, for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received.

I also have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information, and the reasons why I disagree with such refusal to correct amend, or delete recorded personal information.

Proposed Insured

Date of Birth

Signature of Proposed Insured or Parent/Guardian

Date

State of Residence