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

HIV TESTING NOTICE AND INFORMED CONSENT FORM

Examiner: _____

Address: _____

City, State, Zip: _____

Insurer: IA American Life Insurance Company

Address: P.O. Box 2549

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

***The licensed laboratory that will be performing all tests.**

PURPOSE OF CONSENT FORM

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other body fluid for testing and analysis. In order to adequately perform all testing procedures, it may be necessary for you to provide a sample of more than one of these bodily fluids. All tests will be performed by a licensed laboratory.

Unless precluded by law, 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 performed is actually a series of tests performed 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), screening for liver or kidney disorders, diabetes, immune disorders, and other physical conditions.

CONFIDENTIALITY

All test results will be treated confidentially. The results of tests will be reported by the laboratory to the Insurer identified on this form. When necessary for business reasons in connection with insurance you have or had applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau, Inc. (MIB) and should the Insurer request an additional sample of bodily fluid for further testing, and you choose to decline the final 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 abnormality. 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 in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There may be other disclosure of test results or even that tests have been done except as may be required or permitted by law or authorized by you.

NOTIFICATION OF 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. The laboratory, physician or other health care provider will report positive test results to the Health Department. If you have not designated a physician or other health care provider to receive disclosure of positive test results, the Insurer will report positive test results to the Health Department.

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 HIV Testing Notice and Informed Consent Form which may include HIV antibody/antigen testing.

I voluntarily consent to the withdrawal from me of blood and/or other body fluid, the testing of that blood and/or other bodily fluid, 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 of this form will be as valid as the original.

Name of Proposed Insured (Please Print) _____ Birth Date _____

Signature of Proposed Insured _____ Date _____

State of Residence _____

Designated Physician or Health Care Provider that is to Receive Positive Test Results _____

Street Address _____ City and State _____ Zip Code _____