

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

INSURER NAME

Crown Life Insurance Company

ADDRESS

Serviced At: P.O. Box 1927, Buffalo, NY 14240-1927

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. **You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage.** Please see below for additional counseling information.

INFORMATION ON HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. **HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.**

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

PRE-TEST COUNSELING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. **Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department or:**

Phoenix metropolitan area: 234-2752

(Arizona AIDS Information Line)

Outside the Phoenix area: 1-800-334-1540

(Arizona Department of Health Services)

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law. **Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. Section 20-448.01.**

MEANING OF POSITIVE TEST RESULTS

The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS. About 50% of infected individuals have developed AIDS within 10 years after being infected with the virus.

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

NOTIFICATION OF TEST RESULTS

If your HIV antibody/antigen test results are normal, no routine notification will be sent to you. Unless otherwise authorized, notification of positive HIV antibody/antigen test results will be sent directly to you.

In the event of a positive HIV antibody/antigen test result, I authorize Crown Life Insurance Company to send the test results to me:

Name _____

Address _____

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

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 a right to request and receive a copy of this form. This consent is valid for 180 days from the date of my signature below. A photocopy of this form will be as valid as the original.

Dated at _____ this _____ day of _____ year _____

Signature of Witness

Signature of Proposed Insured or Parent/Guardian

OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below. This authorization is valid for 180 days from the date of my signature below.

Physician's Name _____

Address _____

Dated at _____ this _____ day of _____ year _____

Signature of Witness

Signature of Proposed Insured or Parent/Guardian