NOTICE AND CONSENT FORM FOR BODILY FLUID TESTING TO DETERMINE THE PROBABLE CAUSATIVE AGENTS OF AIDS

INSURER NAME AND ADDRESS:

Crown Life Insurance Company, Serviced At: P.O. Box 1927, Buffalo, NY 14240-1927

Dear Proposed Insured:

To evaluate eligibility for insurance coverage, it is requested that a sample of saliva and/or blood be provided in order that it may be tested to determine the probable causative agents of AIDS. Signing this form indicates that the procedure used in implementing this test has been explained and has been shown to be in full compliance with the protocol currently adopted by the Commissioner of Public Health for the District of Columbia. Additionally, by signing and dating this form, it is agreed that this test may be performed and that underwriting decisions will be based on the test results.

PRE-TESTING CONSIDERATION

Many public health organizations have recommended that before taking a test to determine the probable causative agents of AIDS a person should seek counseling in order to become informed concerning the implications of such a test. In the event the test result is positive, one may wish to consider counseling, at his/her expense, subsequent to being tested. A listing of those public and private health care facilities providing such counseling may be obtained from the insurance company.

No insurer shall request or require you to take the testing protocol without first obtaining your or your legal guardian's signature on this consent form. You have the right to decide not to be tested and to not sign this form. Once the insurance company has asked you to sign this consent form, you or your legal guardian may wait 14 days before signing this informed consent.

DISCLOSURE OF TEST RESULTS

All test results and the fact that a test occurred will be treated confidentially. The results of the test will be reported to the insurer identified on this form; the applicant or his/her legal guardian; or a physician or health care provider designated on this form by the applicant; a court of competent jurisdiction pursuant to a lawful court order; and any person or entity involved solely in the underwriting process; and any other person or entity expressly named in a separate written authorization signed by the applicant. Results of the test shall not otherwise be disclosed.

Name of physician for reporting test results ____________________

Address ____________________

MEANING OF POSITIVE TEST RESULTS:

Positive test results may adversely affect your application for insurance. This means that your application may be declined, an increased premium may be charged or other policy changes may be necessary.

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 the right to request and receive a copy of this form. A certified true photocopy of this form will be as valid as the original.

NOTICE OF RIGHT OF APPEAL:

We are required by law to provide you with the following information:

A named insured who tests positive under the testing protocol certified by the Commissioner of Public Health may appeal to the Superintendent of Insurance to review the testing procedures and results, and may present additional medical evidence, including the results of similar tests for exposure to the probable causative agent of AIDS that the named insured independently obtains, to rebut the positive test results. The Superintendent of Insurance can be reached at the following address: 613 G Street, N.W., 6th Floor, Washington, D.C. 20001.

____________________ Date

____________________ Signature of Proposed Insured or Parent/Guardian

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