

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

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

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your saliva and/or your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to obtain a saliva swab or withdraw blood and order laboratory tests only in regard to your present application for insurance.

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 that we perform 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.

All test 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 involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens (as confirmed by blood tests) are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. 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.

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. Because a trained person should deliver that information to you so that you can clearly understand what the test results mean, the Insurer will 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. In the event of a positive test result, you may wish to obtain additional information or counseling about: a) the meaning of the test result; b) the possible need for additional testing; c) the availability of appropriate health care services, including mental health care, social and support services; and d) the benefits of locating and counseling any individual by whom you may have been exposed to the HIV. In such cases, we urge you to contact the AIDS Prevention Program Public Health Division at 505-841-4780 or the AIDS HOT LINE at 1-800-545-2437.

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.

I have read and I understand this Notice and Consent For Bodily Fluids Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of saliva by swab or to the withdrawal of blood from me by a needle, the testing of the saliva or blood, 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)	STATE OF RESIDENCE	DATE OF BIRTH
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NAME AND ADDRESS OF DESIGNATED PHYSICIAN / HEALTH CARE PROVIDER

Date

Signature of Proposed Insured or Parent/Guardian