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

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

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.

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 solely involved in the underwriting process, such as its affiliates, reinsurers, or contractors. These individuals or organizations may require access to your insurance file. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health and 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. Upon your request, we will provide you with the names of the specific individuals or organizations named in this paragraph who will have access to your test results, insurance file or maintain test information in a data bank or file.

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 medical authorities have concluded 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 applications 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 of 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 needle, the testing of the saliva or blood, and the disclosure of the test results as described above.

You may choose to have the test results sent directly to you or designate another person such as a physician to whom you may authorize disclosure and with whom you wish to discuss the results. If you do not designate a physician, personal face-to-face counseling is available through the Virginia Health Department. To obtain information regarding counseling, you should contact your local health department. Additional information concerning AIDS or HIV infection can be obtained by calling the Virginia Health Department at 1-800-533-4148.

In the event of a positive HIV test result, I authorize Crown Life Insurance Company to send the test results to me ☐ or ☐ to the following person:

Name ______________________________

Address ______________________________

☐ Please check here if you also require negative HIV test results to be sent to you ☐ or ☐ the above named individual. 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.

Dated at ______________________ this ______ day of ______________________ year _______

______________________ Proposed Insured (Please print)

______________________ Signature of Proposed Insured or Parent/Guardian

______________________ Date of Birth of Proposed Insured

______________________ State of Residence of Proposed Insured