



5Star Life Insurance Company
AFBA Building
909 North Washington Street
Alexandria, VA 22314

**NOTICE AND CONSENT FOR ORAL FLUID OR BLOOD TESTING WHICH
WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE INSURANCE**

To determine your insurability, 5 Star Life has requested that you provide a sample of your oral fluid or 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 withdraw oral fluid or blood and order laboratory tests only in regard to your present application for life insurance.

The test or tests to be performed are used 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.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test, which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULT

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/screening 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.

CONFIDENTIALITY OF TESTS RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to 5 Star Life. When necessary for business reasons in connection with insurance you have or have applied for with 5 Star Life, 5 Star Life may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. A report may be made to the Medical Information Bureau (MIB, Inc), signifying only a non-specific blood, oral fluid (saliva), or urine tests abnormality. If your test is normal, no report will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test result 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.

COST OF TESTING

The cost of any testing will be borne by the 5 Star Life Insurance Company.

NOTIFICATION OF TEST 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, 5 Star Life will contact your designated physician, or you if you have not designated a physician, 5 Star Life 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.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Oral Fluid or Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of oral fluid or blood from me, the testing of that oral fluid 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

Date of Birth

Name and Address of Designated Physician: _____

Signature of Proposed Insured or Parent/Guardian

Date

State of Residence

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to John Hancock Financial Services. Therefore, John Hancock Financial Services makes no representations or warranties that this information is accurate as of the date you receive this list. Also, John Hancock Financial Services makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE - U.S. PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM - Bakersfield
(805) 861-3631

CENTRAL VALLEY AIDS TEAM
Fresno
(209) 264-2436

AIDS PROJECT - EAST BAY - OAKLAND
(415) 420-8181

SACRAMENTO AIDS FOUNDATION - Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 864-5855

SANTA CLARA COUNTY ARIS PROJECT Campbell
(408) 370-3272

SONOMA COUNTY AIDS INFORMATION HOTLINE
(707) 579-AIDS

AIDS HOTLINE - So. California
(800) 922-AIDS

HEMOPHILIA FOUNDATION OF So. CA
Social Services - California
Hemophilia AIDS Information
(818) 793-6192
(714) 740-2222

CALIFORNIA DEPARTMENT OF HEALTH SERVICES-Statewide Services
Office of AIDS, Sacramento
(916) 323-7415

AIDS SERVICES FOUNDATION OF ORANGE COUNTY - Costa Mesa
(714) 646-0411

AIDS PROJECT - LOS ANGELES
West Hollywood
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SAN DIEGO AIDS PROJECT
(619) 543-0300 - City of San Diego
(619) 945-6000 - City of Vista

SANTA BARBARA COUNTY AIDS INFORMATION HOTLINE
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252

The questions and answers in 1-10 and Details of "Yes" answers apply to the following person proposed for insurance:

1. Person proposed for insurance: (PRINT)

a. First Name _____ M.I. _____ Last Name _____
 b. Birth Date (mm/dd/yy) ____/____/____
 SS# _____

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

2. Ever been treated for or had any known indication of: Yes No

- a. Disorder of eyes, ears, nose, or throat? Yes No
- b. Dizziness, fainting, convulsions, headaches; speech defect, paralysis or stroke; mental or nervous disorder? Yes No
- c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? Yes No
- d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? Yes No
- e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? Yes No
- f. Sugar, albumin, blood or pus in urine, venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts? Yes No
- g. Diabetes; thyroid or other endocrine disorders? Yes No
- h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? Yes No
- i. Deformity, lameness or amputation? Yes No
- j. Disorder of skin, lymph glands, cyst, tumor, or cancer? Yes No
- k. Allergies, anemia or other disorder of the blood? Yes No
- l. Alcoholism or drug dependence? Yes No

3. Within the past 5 years used amphetamines, cocaine, marijuana, narcotics, or any other drugs, except as medication prescribed by a physician? Yes No

4. Now under treatment or taking any prescription drug? Yes No

5. Any change in weight in the past year? Yes No
 Gain _____ lbs. Loss _____ lbs.

6. Other than above, within the past 5 years:

- a. Had any mental or physical disorder not listed above? Yes No
- b. Had a checkup, consultation, illness, injury, surgery? Yes No
- c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? Yes No
- d. Had electrocardiogram, X-ray, or other diagnostic test? Yes No
- e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? Yes No

7. Ever:

- a. Had military service deferment, rejection or discharge because of a physical or mental condition? Yes No
- b. Requested or received a pension, benefits, or payment because of an injury, sickness or disability? Yes No

8. Have you ever been diagnosed or treated for Acquired Immune Deficiency (AIDS) or an AIDS Related Condition? Yes No

9. Other information:

a. Name and address of your personal physician: (If none, so state) _____
 Name _____
 Address _____

b. In the past 5 years have you consulted your personal physician for any matter not recorded in answers to questions 2-8? If "Yes", furnish reason, details and date in "Details" space above. Yes No

10. Any family history of diabetes, cancer, high blood pressure or cholesterol, heart or kidney disease, or mental illness? Yes No

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			
# Living _____			
# Dead _____			

The foregoing statements and answers are to the best of my knowledge and belief, complete, true, and correctly recorded and are representations and not warranties.

Dated at _____

City and State _____

Witness _____

Medical Examiner _____

on the month, day and year of _____

Signature of person proposed for insurance, if age 15 or over, or Applicant, if person proposed is under age 15.

TO BE COMPLETED IN EVERY CASE. DO NOT DETACH.

Authorization and Acknowledgment

Date _____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the medical information Bureau or other organization, institution, or person that has any records or knowledge regarding each of the undersigned and any children of the undersigned if proposed for insurance to give to the AFBA Life Insurance Company or its reinsurer(s) any such information, including information concerning every condition for which each has been under observation or treatment, including if the information specified contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, the history obtained, physical and laboratory findings, diagnosis, and treatment.

I acknowledge receipt of the Federal Fair Credit Reporting Act notice which contains on the reverse side a notice concerning the Medical Information Bureau.

A photostat of this authorization is as valid as this original.

Name of proposed insured if under age 15 (PRINT)

Signature of proposed insured, if age 15 or over, or Applicant, if proposed insured is under age 15.

ART C — PARAMEDICAL

- a. Is appearance unhealthy or older than stated age or are there any obvious physical impairments?
 Yes No If yes, please explain: _____
- b. Currently smoke cigarettes? Yes No Former Smoker Yes No If yes, date last smoked _____ (mo/yr)
 Smoke cigars or pipe, or use other tobacco product(s)? Yes No If yes, what products? _____

MEASUREMENTS

- a. Height (in shoes) _____ ft _____ in b. Weight (clothed) _____ lbs.
 c. For Males only: (i) Chest circumference: Full inspiration _____ in. Forced expiration _____ in. (ii) Abdomen at umbilicus _____ in.

BLOOD PRESSURE Applicant to be sitting. Take pressure in both arms. If more than 10mm. difference, repeat in both arms; otherwise repeat in either arm. If B.P. is over 135/85, record additional reading with applicant seated, after completing exam. Diastolic pressure is to be noted at disappearance of sound.

	Right Arm		Left Arm	
	Systolic	Diastolic	Systolic	Diastolic
1st Reading				
2nd Reading				
____ Min later				
____ Min later				

PULSE _____/min. (at rest). If over 90, repeat in 5-10 min. and record _____/min.
 Any irregularities? Yes No If yes, enter number per minute: _____

URINALYSIS

If female applicant is menstruating on date of examination, please arrange to collect the specimen on another day, after flow has stopped.

- a. Was specimen done? Yes No, because: client menstruating; client unable to void; other (specify) _____
 b. Was dip stick used? Yes No If yes, results: albumin _____; sugar _____; other _____

SEND SPECIMEN TO HOME OFFICE REFERENCE LAB (UNLESS INCLUDED IN BLOOD KIT) IF:
 1. Albumin or Sugar is present, or Blood Pressure over 150/100, or 2. History of Hypertension, Diabetes, Cardiovascular, or Renal Disorder.

- c. Is specimen being forwarded to Home Office Reference Lab? Yes No
 d. Have any medications of any type been taken in the past ten days? Yes No
 If yes, specify _____

OTHER STUDIES (if required by instruction from agency or home office)

- Blood Kit sent to HORL (please attach pink copy of authorization)
 Electrocardiogram attached Other studies attached: specify _____

THIS SECTION IS TO BE COMPLETED BY MEDICAL EXAMINERS AND PARAMEDICAL EXAMINERS.

certify that I personally asked each and every question and accurately recorded the answers on the Part-B Form ALCMF-100. I personally performed the physical measurements and observations recorded on this page.

Signature of person completing form. _____

Examiner's Account Number: *	PARAMED/MEDICAL EXAMINER'S VOUCHER						Amount of Fee: *
	To assure prompt payment of your fee, this voucher should be fully completed. (*Items to be completed by examiner.)						
Agency Name	Agency Number:		Date of Exam*		Birthdate of Examinee*		Amount of Insurance:
Name of Person Examined (Please Print):	Mo.	Day	Yr.	Mo.	Day	Yr.	L/B Code:
Pay to:	Voucher Number:						Reported By:
Name:							
Street Address:							
City:	State:	Zip:					Date: