

Americom Life and Annuity Company
Overland Park, Kansas

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

To determine your insurability, the Insurer named above has requested that you provide a sample of 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 withdraw blood and order laboratory tests only in regard to your present application for life or disability income 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 serum or plasma 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 TEST RESULTS

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 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. 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.

COST OF TESTING

The cost of any testing will be borne by the insurer.

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, the insurer will contact your designated physician, or you if you have not designated a physician. 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.

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 Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that 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.

Proposed Insured _____

Date of Birth _____

Name and Address of Designated Physician _____

Signature of Proposed Insured or Parent/Guardian _____

Date _____

State of Residence _____

Paramedical Supplement to Application

Insurer

 Fidelity and Guaranty Life Insurance Company

 Americom Life and Annuity Insurance Company

Insured

First Name

Middle Initial

Last Name

Birth Date

Birth Place

Medical History Questions

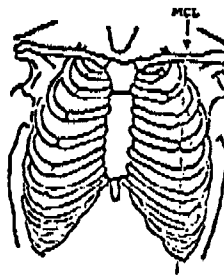
1. Have you ever been treated for or diagnosed with:		
a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart or blood vessels?		<input type="radio"/> Y <input type="radio"/> N
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries?		<input type="radio"/> Y <input type="radio"/> N
c) Any breathing or lung disorder, COPD, asthma, bronchitis, sleep apnea, or emphysema?		<input type="radio"/> Y <input type="radio"/> N
d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?		<input type="radio"/> Y <input type="radio"/> N
e) Cancer, tumor, or cysts?		<input type="radio"/> Y <input type="radio"/> N
f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?		<input type="radio"/> Y <input type="radio"/> N
g) Hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines?		<input type="radio"/> Y <input type="radio"/> N
h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?		<input type="radio"/> Y <input type="radio"/> N
i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back, or joints?		<input type="radio"/> Y <input type="radio"/> N
j) Any disease or disorder of the skin, eyes, or ears?		<input type="radio"/> Y <input type="radio"/> N
k) Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or positive test results indicating the presence of the AIDS virus?		<input type="radio"/> Y <input type="radio"/> N
2. Are you currently prescribed any medication?		<input type="radio"/> Y <input type="radio"/> N
3. Have you been prescribed medication in the past 5 years not previously mentioned?		<input type="radio"/> Y <input type="radio"/> N
4. In the past 10 years, have you:		
a) Been hospitalized or had surgery?		<input type="radio"/> Y <input type="radio"/> N
b) Had any electrocardiograms, x-rays, laboratory tests, treatment, or surgery, which has not been performed?		<input type="radio"/> Y <input type="radio"/> N
c) Been recommended to have any test, treatment, or surgery, which has not been performed?		<input type="radio"/> Y <input type="radio"/> N
d) Had any illness, disease, or injury that is not included in other answers?		<input type="radio"/> Y <input type="radio"/> N
5. Has any parent, brother, or sister died from or had any occurrence of cancer, heart disease, diabetes, or any hereditary disease prior to age 60?		<input type="radio"/> Y <input type="radio"/> N
6. Have you smoked cigarettes, pipes, or cigars, used snuff, chewed tobacco, or used any nicotine-based products such as the patch, or gum? If yes, please detail the type(s) of tobacco product used and date of last use below.		<input type="radio"/> Y <input type="radio"/> N
7. In the past 10 years, have you sought or received treatment, advice, or counseling for the use of alcohol?		<input type="radio"/> Y <input type="radio"/> N
8. Have you ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs? Have you ever been arrested for the use or possession of such drug or are you currently using these drugs?		<input type="radio"/> Y <input type="radio"/> N
9. Within the past 10 years, have you made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?		<input type="radio"/> Y <input type="radio"/> N

CONTINUED

Fidelity and Guaranty Life Insurance Company, Baltimore, MD • Americom Life and Annuity Insurance Company, Houston, TX

Paramedical Supplement to Application - Continued

Medical Examiner's Report

12. a. Height (in shoes)	Weight (Clothed)	Males Only:		
		Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
ft. in.	lbs.	in.	in.	in.
b. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Is appearance unhealthy or older than state age? <input type="checkbox"/> Yes <input type="checkbox"/> No				
13. Blood Pressure:	1 st Reading	2 nd Reading	3 rd Reading	
Systolic				
Diastolic 5 th Phase				
14. Pulse:	At Rest	After Exercise	3 Minutes Later	
Rate				
Irregularities per min. (Answer all columns)				
15. Heart: Is there any:	Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No		Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No		Edema <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Murmur 1	Murmur 2		
Murmur Location			Indicate:	
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	
Systolic	<input type="checkbox"/>	<input type="checkbox"/>		
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>		
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>		
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>		
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>		
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>	In your opinion is murmur organic or functional? _____	
After exercise:			If organic, your diagnosis. _____	
Increased	<input type="checkbox"/>	<input type="checkbox"/>		
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>		
Decreased	<input type="checkbox"/>	<input type="checkbox"/>		

Record any additional information here: it will be considered strictly confidential. Anything regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated.

16. Is there on examination any abnormality of the following: (Circle applicable item and give details.)

a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing is markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>		<input type="checkbox"/>	
c. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>		<input type="checkbox"/>	
d. Respiratory system?	<input type="checkbox"/>		<input type="checkbox"/>	
e. Abdomen (include scars)?	<input type="checkbox"/>		<input type="checkbox"/>	
f. Genitourinary system (include prostate)?	<input type="checkbox"/>		<input type="checkbox"/>	
g. Endocrine system (include spine, joints, amputation, deformities)?	<input type="checkbox"/>		<input type="checkbox"/>	
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>		<input type="checkbox"/>	

17. a. Are there any hernias? Yes No b. Any hemorrhoids? Yes No

18. Are you aware of additional medical history? Yes No
(A confidential report may be sent to the Medical Director)

Name of person who requested you to make this examination: _____
 Place examined: Your Office Proposed Insured's: Home or Office
 Date examined: _____ Time: _____ AM/PM

Signature of Medical Examiner: _____
 Address: _____
 City: _____ State: _____ Zip: _____

HOME OFFICE USE ONLY: Fee Paid \$ _____