CENTRIAN LIFE INSURANCE
LIFE INSURANCE APPLICATION - Part One

(10-05)

- Use black ink, print clearly and do not use white out.
- Initial any changes you make.
- The following questions relate to the Proposed Insured

Agent: ____________

Section A - Proposed Insured

1. Name of Insured (First, Middle Initial, Last Name) ☐ Male ☐ Female
2. Date of Birth month | day | year
3. Age nearest birthday
4. Place of birth (State or Country)
5. Home address: (Unit, Street, City, State, Zip Code)
6. Social Security Number
7. Driver's License No. State
8a. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
8b. Number of dependents: Ages:
9. Any other name previously known by (Including maiden name)
10. Occupation (include duties) ☐ Full Time (20 + hours) ☐ Part Time
11. Number of years with Current Employer
12. List any other occupation in last 2 years
13. Any plans to change occupation? ☐Yes ☐No (If "Yes", provide details)
14. Employer's Name and Address
15. Nature of Business
16. Tel. # Home:____-____-____ Work: ____-____-____ E-Mail :____
17. Have you ever used any form of tobacco or any other nicotine product or by-product? ☐ No ☐ Yes - Product Type:
Date last used (Month/Year): Quantity/Frequency: How long used?

Section B - Applicant

18. If the Applicant signing this form is not the Insured:
Print Applicant's Name: ____________
Relationship to Proposed Insured: ____________

Section C - Owner (*Complete only if the Owner is to be other than the Proposed Insured* • ***Owner's signature required***)

19. *Note: If Owner is a Trust, the full name and date of the Trust, and the name(s) of the Trustee(s) is required.*

Class	Name(s) (please print clearly)	Relationship to Proposed Insured	Social Security/Tax I.D. Number
1 (Primary)			
2 (Contingent)			

For first Owner listed above: Mail Address (include Zip Code):

Tel. Number: ____-____-____ E-Mail Address: ____________

Section D - Beneficiary

20. Beneficiary: State the class: 1 (Primary), 2 (Secondary), etc. Surviving beneficiaries in the lowest numbered class share equally. All decisions made by Centrian in good faith as to the identity of beneficiaries shall be conclusive as to Centrian's liability and any payment made in accordance therewith shall, to the extent thereof, discharge Centrian of its obligation for such payment.
NOTE: If the desired beneficiary designation does not conform to this format, attach a detailed explanation of the desired designation.

Class	Name(s) (please print clearly)	Relationship to Proposed Insured

If no beneficiary is designated, the proceeds will be paid to the Owner or the Owner's Estate

Note: If the Beneficiary is a Trust, the full name and date of the Trust, and the name(s) of the Trustee(s) is required.

Section E - Insurance Applied For

21. Plan of Insurance / Amount applied for
a. $
b. $
c. $

22. Additional Benefits/Riders (if available):
☐Term Insurance Rider - Plan ____________ Amount: $____
☐Child Insurance Rider (complete rider form) Amount: $ ____
☐Waiver of Premium (ages 15 to 55 only)

23. Dividend Option (If no selection or if selected option is not available, #4 will be effective.)
1 ☐ Plan of Insurance
2 ☐ Reduce amount due - any excess as: ☐#4 ☐#3 ☐#1
3 ☐ Purchase paid-up life additions
4 ☐ Accumulate at interest

Continued on next page.

CENTRIAN LIFE INSURANCE
LIFE INSURANCE APPLICATION - Part One

(10-05)

Name of Proposed Insured (print) ______________________

Section F - Premiums & Billing

24. Premium Frequency: ☐Annual ☐Semi-Annual ☐Quarterly ☐Monthly*
(Monthly is available only with Centrian's Automatic Payment Plan. EFTS form is required)
Automatic Premium Loan Provision to be effective on permanent plans unless requested otherwise here:
25. Mailing Address for all policy notices: (If other than address shown in #5 - Insured, or #19 - Owner)
Include Unit, Street, City, State & ZIP Code:

26. Are the notices for this insurance to be sent "in care of" someone other than the Owner? ☐Yes ☐No
If "Yes", complete the following:
Name of addressee: ______________________
Relationship to Insured: ______________________

Section G - Other Insurance

27. List all individual (non-group) Life Insurance in force and pending on the Insured's life, including existing Centrian insurance. (If none, state "None". If more space is needed, use Section L, "Remarks")

	Name of Insurance Company	Face Amount	Issue Year
A.			
B.			
C.			

28. How much life insurance does the proposed Insured's spouse have in force? $ ______________, Being applied for? $______________
29. Will this insurance replace or change any current life insurance or annuity, other than Centrian? ☐Yes ☐No
If "Yes" Replacement Forms must be completed in states where applicable.
30. Have you ever had an application for life or health insurance declined, postponed, modified or offered at other than regular premiums for your age? ☐Yes ☐No If "Yes", provide details in Section L.
31. EXCHANGE ONLY (A new 2 year contestable period will apply to the replacement policy.)
List the Centrian policy(ies) being exchanged:
Total Face Amount ______________ Plan(s) ______________
Policy numbers ______________ ______________ ______________ ______________
______________ ______________ ______________ ______________

The above policies are hereby tendered for endorsement or surrender in consideration for, and effective as of the date of issue of the new policy. **Submit your policy(ies) with this application.**
During the time of processing this application it is the responsibility of the Policyholder to maintain the above listed policies in force. Failure to maintain premium payments may result in a total loss of coverage.
The said endorsement or surrender will be held pending approval of this application and payment of the first full premium on the insurance herein applied for. If this application is not approved, the above policies will be returned to the policyholder without action taken thereon, except for any nonpayment of premium.

Section H - Personal History *(Please provide details to any "Yes" answers in the Section L)*

32. Are you a U. S. citizen? ______ If "No", Country of citizenship ______________ ☐ Yes ☐ No
Visa type: ______________ Expiration date: ______________, **and attach a copy of your documentation.**
33. Have you, in the last 3 years, resided or traveled, or do you intend to reside or travel outside of the United States? ☐ Yes ☐ No
34. In the last 3 years, have you had your drivers license suspended or revoked, or received any moving violations? ☐ Yes ☐ No
35. Have you ever been convicted of reckless driving, driving to endanger or driving under the influence of drugs or alcohol? ☐ Yes ☐ No
36. Have you ever been convicted of a misdemeanor (other than a traffic violation) or felony, or are you awaiting trial for a felony? (If "Yes", give details, dates and circumstances.) ☐ Yes ☐ No
37. Have you in the last 2 years engaged in, or do you intend to engage in, any hazardous activities or sports such as hang gliding, hot air ballooning, ultra light flying, mountain or rock climbing, motor vehicle or boat racing, scuba diving, sky diving or parachuting? ☐ Yes ☐ No
38 Are you, or do you intend to become, a member of the Armed Forces, including Reserves? ☐ Yes ☐ No
39 Have you ever owned, operated, been, or intend to be, licensed to operate, an airplane? ☐ Yes ☐ No
40 How many flights have you made in the last 12 months in other than a Commercial airline/airplane? __________
41 How many flights do you plan to make in the next 12 months in other than a Commercial airline/airplane? __________

Section I - Special Requests

Continued on next page.

CENTRIAN LIFE INSURANCE
LIFE INSURANCE APPLICATION - Part One

(10-05)

____
Name of Proposed Insured (print)

Section J - Financial Information

A. PERSONAL AND BUSINESS INSURANCE APPLICANTS: Complete if applying for business insurance or, if applying for personal coverage, complete if the amount applied for is at least $300,000 or if total amount of insurance in force and applied for exceeds $500,000.
Personal Finances: Current Annual Earned Income $__________ Estimated Net Worth: $__________

Within the past 5 years have you filed for bankruptcy or had any liens or judgements filed against you? ☐Yes ☐No
If "Yes", please explain in the Section L, and provide the date of discharge.

B. BUSINESS APPLICANTS ONLY:
Business finances: Total assets: $ __________ Total liabilities: $ __________ Net worth: $__________
Percentage of business you own: ________% Amount of business insurance in force on your life: $ __________
Is business insurance applied for or in force on other key members of the business? ☐Yes ☐No
Within the past 5 years has the business filed for bankruptcy or had any liens or judgements filed against it? ☐Yes ☐No
If "Yes", please explain in the Section L.

Section K - Changes (Changes made by Centrian - Not applicable in Pennsylvania and West Virginia)

Section L - Remarks (Details of "Yes" answers, etc. - Attach separate sheet if more space is required)

____
____
____
____
____
____
____

1. I hereby represent that the above answers and statements are complete, correct and true to the best of my knowledge and belief. I agree that Centrian, believing them to be complete, correct and true, shall rely and act on them. I agree to notify Centrian of any changes to the statements and answers given in any part of the application before accepting delivery of the policy.
2. **I understand that even if I have paid a premium with, or prior to the approval of, this application, I have not purchased immediate insurance coverage. I agree that the insurance applied for shall not be effective until the later of: (a) the date that the first full premium is paid or, (b) the date the application is approved by Centrian, and only then if each person to be insured is in good health and insurable within company standards on such date.**
3. **Unless I request otherwise in Section I, I agree that the issue date of the policy may be back dated to preserve a lower issue age, provided that the issue date shall be no earlier than the date I sign Part 1 of this application. Even if the issue date is back dated, I agree that no coverage is effective prior to the later of the date that the first full premium is paid or the date the application is approved by Centrian.**
4. If Centrian makes a change in Section K, it will be approved by my acceptance of the policy (not applicable in Pennsylvania).

Under penalty of perjury, I certify that: (A) the number shown is my correct taxpayer identification number and (B) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
(The Internal Revenue Service does not require your consent to any provision of this document other than certification required to avoid backup withholding.) *Cross out all of subpart (B) if you are subject to backup withholding.*

Any person who includes any false or misleading information on an application for an insurance policy is (or, may be, in Massachusetts and Vermont) subject to criminal and civil penalties.

Date ______ Signature of Proposed Insured (if age 15 or over) ______ Signature of 1st Owner in Section C, if any ______

Signed at ______ City, ______ State ______ Signature of Applicant (if other than Insured) ______

Initial Prem. Rec'd. $ __________

Agent: Does this sale involve a replacement?
☐ No ☐ Yes (Submit applicable form)

Agent Signature: ____________________ Date:__________

Agency	Agent #	Agent Email (Optional)	Rate Code
Source	Lead #		

DO NOT WRITE IN THIS SPACE

Process Date:

CENTRIAN LIFE INSURANCE
LIFE INSURANCE APPLICATION - Part One

Name of Proposed Insured (print)	Date of Birth	Social Security Number

AUTHORIZATION

(This authorization is in compliance with the HIPAA Privacy Rule.)

In order to evaluate my eligibility for insurance or in connection with a claim for insurance benefits, I hereby authorize:

- any physician, medical practitioner, health care provider, hospital or clinic,
- any state and federal governmental agency
- any criminal bureau and repository, court, registry of motor vehicles,
- any mental health practitioner,
- the Medical Information Bureau (MIB),
- any financial institution,
- any insurance company,
- any other organization or person that has records or knowledge of me or my health

to give such information, including my entire medical record and any other protected health information concerning me, to the Medical Director of Centrian Life Insurance (the Company) or, except for information obtained from MIB, to any consumer reporting agency acting on its behalf. This may include, but is not limited to, findings or records of: medical care, examinations, information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases (see below for state specific exclusions concerning disclosure of HIV related information), psychiatric or psychological care, psychotherapy, drug or alcohol/tobacco use history or previous disability or surgery.

FOR MAINE APPLICANTS, this authorization excludes the results of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact the applicant has AIDS.

FOR VERMONT APPLICANTS, this authorization excludes the release of any information relating to previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC, by the applicant's family/regular/attending medical doctor/physician/practitioner or care giver or any other person or entity which may be possessed of this information. This exclusion extends to any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB, Inc., employer, consumer reporting agencies, other insurance companies, or anyone else with respect to previous test results. The applicant is not authorizing the company to forward the results from any new test, requested of the applicant by the company, to any outside, non-affiliated company, nor to any entity not under specific contract with the company to perform underwriting services.

- By my signature below, I acknowledge that <u>any agreements I have made to restrict my protected health information do not apply to this authorization</u> and I instruct any physician, medical practitioner, health care provider, hospital, clinic or any other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers can not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.
- I further authorize the Company to release any information obtained by this authorization to MIB, to other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
- I further authorize the Company to obtain an investigative consumer report on me and I understand that I have a right to request to be interviewed in connection with the preparation of any such report and to receive a copy of any such report.
- I authorize Centrian to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application.
- All provisions of this authorization also apply to any member of my family proposed for coverage in my insurance application. A photocopy of this form shall be as valid as the original and I understand that I, or my authorized representative, may have a copy of this form upon request. The authorization is valid for 30 months (24 months if R.I. or VT. laws apply) from the date of my signature shown below. In connection with a claim for benefits, this authorization is valid no longer than the duration of the claim.
- I understand that I may revoke this authorization at any time by submitting a written request to the Company. Any written request to revoke this authorization will be effective upon receipt of same by the Company. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.
- I also understand that failure to sign this authorization statement, or subsequent revocation of this authorization by me, may impair the ability of the Company to process my application or evaluate claims, and may be a basis for denying an application or claim for benefits.
- By signing below I agree to the terms of this authorization and acknowledge that I have read and understand it.

Date: ________________ Signature of Proposed Insured: ______________________________

If Insured is under age 18,_
signature of ___Parent ___Guardian ___Other (please describe) ______________________

X ______________________________________

CENTRIAN LIFE INSURANCE
LIFE INSURANCE APPLICATION - Part Two
Completed by examiner (agent if no-medical)

(10-05)

Name of Proposed Insured (print) | Date of Brth | Social Security Number

All questions pertain to the Proposed Insured.

1. a. Who is your personal physician? (If you do not have one, so state.)
   Name: Telephone Number:
   Address: Date Last seen:
   Reason and results of visit:

   b. Was your last physical exam done by the above? ☐ Yes ☐ No
   If "No", who performed it? Name: Telephone Number:
   Address:

   c. Are you now taking, or have you been advised to take, any medications? ☐ Yes ☐ No
   If "yes", please explain:

   d. Do you have any medical consultations scheduled? ☐ Yes ☐ No
   If "yes", please explain:

   e. If you lost weight in the past year, please state how much: __________ Lbs. and the reason for the loss:

   f. If under age 15, or if applying for conversion:
   What is your height? _______ Feet, _________ Inches What is your weight? _________ Lbs

2. Family history:
   (natural parents, brothers, sisters)
   a. Have any family members had:
   - cancer
   - diabetes
   - heart disease
   - tuberculosis
   - mental illness
   - committed suicide?

   ☐ Yes ☐ No (If "Yes", identify family member, disorder and age at onset in the area provided for "Details".)

   b. Complete the following:

Family Member	Living: Age	Living: State of Health	Deceased: Age at Death	Deceased: Cause of Death
Father				
Mother				
Brothers (List individually)				
Sisters (List individually)				

ALL POSITIVE RESPONSES TO THE FOLLOWING REQUIRE FULL DETAILS IN THE AREA PROVIDED ON PAGE 2.

3. Within the past 10 years have you (A) been treated for, or (B) been diagnosed as having, any of the following: (If YES, place a check mark in the box and give details in the area provided on page 2.)

☐ nervous or mental disorder
☐ paralysis
☐ epilepsy
☐ loss of consciousness
☐ stroke
☐ recurring dizziness
☐ chronic headaches
☐ any disease of the brain or nervous system
☐ asthma
☐ pleurisy or bronchitis
☐ emphysema
☐ tuberculosis
☐ spitting blood, chronic cough, or other respiratory system ailment
☐ ulcer of stomach or duodenum
☐ colitis
☐ disease of the liver or gall bladder
☐ gallstones
☐ hepatitis
☐ pancreatitis, or other disorder of the esophagus, stomach, intestines or pancreas
☐ kidney disease or kidney stone
☐ renal colic or any disease of the urinary or genital tract (including prostate)
☐ blood, albumin, sugar or pus in the urine
☐ Diabetes
☐ venereal disease
☐ goiter
☐ hernia
☐ anemia
☐ any impairment of sight or hearing
☐ disease of the eyes, ears, nose or throat
☐ any bone or joint disease or arthritis
☐ gout
☐ backache or sciatica
☐ loss or deformity of extremity
☐ any thyroid or endocrine disorder
☐ any other disease, injury, illness or condition not specifically mentioned above

4. Within the past two years, have you suffered from, or experienced any physical or mental illness, disease, injury or condition which could reasonably have required medical advice or treatment? ☐ Yes ☐ No

Continued on next page.

CENTRIAN LIFE INSURANCE - LIFE INSURANCE APPLICATION

5. Have you ever (A) been treated for, or (B) been diagnosed as having, any of the following: (If YES, place a check mark in the box and give details in the area provided below.)

- ☐ heart attack or heart disease
- ☐ palpitations, angina or pain in the chest
- ☐ heart murmur
- ☐ rheumatic fever
- ☐ high blood pressure
- ☐ disease of the circulatory system
- ☐ any cyst, cancer or tumor
- ☐ any lymph gland disorder
- ☐ any blood disorder
- ☐ any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)
- ☐ **(not applicable in CT)** positive results indicating the presence of the Human Immunodeficiency Virus (HIV) or antibody

6. Have you ever: (Please explain "Yes" answers in "Details" area.)

a. Used narcotics, hallucinogens, barbiturates, heroin, cocaine, amphetamines, sedatives, or any other habit-forming drugs except as prescribed by a physician?	☐ Yes	☐ No
b. Been advised by a physician, psychiatrist or psychologist to quit or reduce alcohol use?	☐ Yes	☐ No
c. Been advised to seek, or received treatment or counseling for, alcohol or other drug use?	☐ Yes	☐ No
d. **(Not applicable in Connecticut)** Been advised to attend or been a member of any self-help group? (Example: Alcoholics Anonymous or Narcotics Anonymous.)	☐ Yes	☐ No
e. Been convicted of drug possession or distribution?	☐ Yes	☐ No
f. Had, or been advised to have, any surgery?	☐ Yes	☐ No
g. Been treated or been advised to have treatment in any hospital, clinic or similar institution?	☐ Yes	☐ No
h. Had any X-Rays, electrocardiograms, blood tests or any other medical tests?	☐ Yes	☐ No
i. Been disabled?	☐ Yes	☐ No
j. Attempted suicide?	☐ Yes	☐ No

7.

a. Have you ever had any disorder of menstruation, pregnancy (including toxemia) or of the reproductive organs or breasts?	☐ Yes	☐ No
b. Are you now pregnant?	☐ Yes	☐ No
c. Are uterine functions now irregular?	☐ Yes	☐ No

DETAILS: Please provide details of all 'Yes' answers. List the question number. Include diagnosis, dates, duration, full names and addresses of all attending physicians and medical facilities. Give reasons for checkup, treatment and medication.

____

____

____

____

____

____

____

In New Jersey, any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In other states, **except Virginia**, it is (or may be, **in Massachusetts**) a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

To the best of my knowledge and belief, I hereby represent that the above answers and statements are complete, correct and true. I agree that Centrian, believing them to be complete, correct and true, shall rely and act on them. I agree that they shall be a part of my application for insurance or policy change request.

I acknowledge my responsibility to update any of the information or responses I have provided on this application up to the time it is approved. I understand that my failure to do so may constitute a material misrepresentation.

I hereby represent that I am not currently suffering from an illness, disease or condition which could reasonably require medical advice, treatment or diagnosis except as specifically provided in my responses to this application.

I acknowledge receipt of the Abbreviated Notice of Information Practices.

____________________	________	____________________
Signature of Examiner (Agent if non medical - Agent #)	Date	Signature of Proposed Insured (Parent or Guardian if insured under age 15)

Name of Proposed Insured (print) ____________

Date of Birth ____________

Social Security Number ____________

CENTRIAN LIFE INSURANCE
LIFE INSURANCE APPLICATION - Part Three - Completed by examiner

Insured's Name: ______________________

Insured's Social Security Number: ______________________

EKG required: ☐ No ☐ Yes - attach to this form

How have you identified the person being examined? ☐ Drivers License ☐ Other (specify) ______________

Can the Proposed Insured speak and understand English? ☐ Yes ☐ No - Language spoken: ______________

SECTION A: Complete for ALL applicants:

51. Males only: Chest measurement: _______ in. Waist measurement: _______ in.

52. Blood Pressure: If over 138/88, repeat x 2, three minutes apart:

Systolic			
Diastolic			

53. Pulse: Rate _____ Quality _______ Irregularities/Minute _______
    (If over 90, repeat) Rate _____ Quality _______ Irregularities/Minute _______

54. Measured Height (In stocking feet): _______ ft., _______ In. Weight: _______ lbs. (weigh applicant - normal street clothes)

55. Has weight changed in last 2 years? ☐ Yes ☐ No If "Yes", - by how much? +/- __________ lbs.
    - how long has weight been stable? __________

56. Females only: Menstruating at time of exam? ☐ Yes ☐ No

57. Did you observe any indication of physical or mental impairment or abnormality not indicated in Part 2?
    ☐ Yes ☐ No If "Yes", explain:

SECTION B: Complete for PHYSICIAN'S EXAM ONLY: (Paramedic Examiner continue to Section C)

Do not write in this space

58. Is there, upon examination, any abnormality of the following:
    a. eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) ☐ Yes ☐ No
    b. skin (include scars), lymph nodes, varicose veins, or peripheral arteries? ☐ Yes ☐ No
    c. nervous system (include reflexes, gait and paralysis)? ☐ Yes ☐ No
    d. respiratory system? ☐ Yes ☐ No
    e. abdomen (describe scars)? ☐ Yes ☐ No
    f. genitourinary system? ☐ Yes ☐ No
    g. endocrine system (include thyroid)? ☐ Yes ☐ No
    h. musculoskeletal system (include spine, joints, amputations and deformities)? ☐ Yes ☐ No

59. Are there any hernias? ☐ Yes ☐ No

60. Are you aware of additional medical history? ☐ Yes ☐ No

61. For the heart, is there any:
    Enlargement? ☐ Yes ☐ No Dyspnea? ☐ Yes ☐ No
    Edema? ☐ Yes ☐ No Murmur? ☐ Yes ☐ No

Provide details to each "Yes" answer. Identify question #. Use reverse side, or attach additional sheet, if needed.

Apex by:
Murmur area by:
Point of greatest intensity by:
Transmission by:

Location:	First murmur	Second murmur
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐

State comments and observations in space to the left. Use reverse side, if needed.

SECTION C: Complete for ALL applicants:

I have personally seen the person whose name appears above and in Part 2. I am satisfied as to the identity of that person. I certify that I personally weighed and measured the proposed Insured, and that the answers in Part 2 were correctly recorded by me.

Paramed Stamp

Date: ______________ Examiner Signature: ______________________

Printed Name: ______________________ Sent to Lab : ☐ Urinalysis ☐ Blood Sample

A-73 CT

(10-05)

You have the right to delay signing this form. However, no blood sample will be taken and Centrian may not begin processing your application until the completed form is submitted.

CENTRIAN LIFE INSURANCE

WOBURN, MASSACHUSETTS

NOTICE OF AIDS VIRUS ANTIBODY TESTING AND AUTHORIZATION FOR TESTING AND DISCLOSURE

This document contains important information concerning the AIDS virus antibody test that we require you to undergo to apply for insurance with us. It also contains information about who will have access to the information we obtain.

READ THIS NOTICE VERY CAREFULLY. DO NOT SIGN IT UNLESS IT IS COMPLETELY FILLED OUT AND YOU HAVE READ AND UNDERSTOOD IT.

You have up to 21 days from the date you receive this form to decide whether to sign this authorization.

In connection with your application for insurance your blood sample will be tested for the presence of the AIDS virus (HIV) antibody. Before consenting to this test, you are urged to read the following information about AIDS, the nature of the test and our policy concerning the confidentiality of the test and other AIDS-related information. After you read this material, you will find a request for your written authorization to be tested for the AIDS virus and for subsequent disclosure of test results. You should be aware that a positive test result will result in the denial of your insurance application.

INFORMATION ABOUT AIDS - AIDS is a condition caused by the human immunodeficiency virus (HIV). In some individuals the virus reduces the body's normal defense mechanisms against certain diseases or infections. As a result, such people often develop such unusual conditions as severe pneumonia or a rare skin cancer. The symptoms of AIDS may include the following, although other causes of these symptoms are more likely: unexplained weight loss; persistent night sweats, cough, shortness of breath, diarrhea and white spots evidencing fungal infection; fever and swollen lymph nodes lasting more than one month; and raised purple spots on or under the skin or on mucous membranes.

From medical studies, it is clear that the following groups are at a high risk of contracting AIDS: past or present users of intravenous drugs; males who have had sex with more than one male since the late 1970's; recipients of blood or blood products infected by the HIV virus; and sexual partners of individuals belonging to any of the above categories.

HIV ANTIBODY TEST - The HIV antibody test is actually a series of tests designed to detect the presence of antibodies to the AIDS virus rather than detect the virus itself. Antibodies to the AIDS virus are found in the blood of most patients with AIDS and AIDS-related complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus.

Your blood sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your blood specimen will then be subjected to another, more specific technique called the Western blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA tests and a Western blot test.

POSITIVE TEST RESULTS - In general, if you receive such a positive test result, there is a high probability that you have HIV antibodies in your blood. However, there is a risk that a person who has not been exposed to the virus will be incorrectly classified by the test as having a positive test result. This is called a "false positive" result. People who are not in one of the "high risk" groups listed above who get a positive test result are much more likely to receive a "false positive" than those who are in a high risk group.

A positive test result does not mean that you have AIDS. The diagnosis of AIDS is established using a patient's history, symptoms and physical examination. A positive test result does mean, however, that you are at risk of developing AIDS or AIDS-related conditions. It also means that, without taking precautions, you may transmit the virus to other people. Therefore, the following steps are recommended to limit the spread of AIDS: (1) do not donate blood, semen or body organs; (2) limit sexual contacts and follow "safe sex" practices; (3) inform your sexual partners; (4) do not share intravenous needles; (5) notify your doctor; and (6) if you are considering having a child, carefully evaluate the risks to the fetus.

If your test results are positive, the test will be sent to the doctor you designate on this form, or if you prefer, we will mail the result directly to you no later than 45 days after your blood sample is taken. It is strongly recommended that you consult a physician or obtain counseling to learn more about the meaning of such a result.

NEGATIVE TEST RESULTS - If your test result is not positive, you most likely have not been infected by the virus. However, it is possible to receive a "false negative" result. Also, a negative test does not mean that you are immune to the virus.

COUNSELING AND ALTERNATIVE TEST SITES - You may experience increased anxiety as a result of having this test performed or receiving a positive test result. Many public health organizations recommend that before a person takes an AIDS-related test, he or she obtain counseling about the test and about AIDS. For Massachusetts residents, a source of information about AIDS and counseling is the AIDS Action Line, 1-800-235-2331. In addition, the Massachusetts Department of Public Health offers free anonymous HIV antibody testing, with pre-test and post-test counseling at its Alternative Test Sites. For additional information regarding AIDS, AIDS testing or counseling, or to obtain a free, anonymous test, individuals in the high risk categories listed above are encouraged to contact the Massachusetts Department of Public Health for an appointment. For individuals residing outside of Massachusetts, the National AIDS Hotline telephone number is 800-342-2437. Additional State AIDS Hotline telephone numbers are: Connecticut 800-203-1234, Delaware 800-422-0429, District of Columbia 202-332-2437, Maryland 800-638-6252, New Hampshire 800-752-AIDS, New Jersey 800-624-2377, North Carolina 800-342-2437, Pennsylvania 800-662-6080, Rhode Island 401-222-2223, Tennessee 800-525-AIDS, Vermont 800-882-2437, Virginia 800-533-4148 and West Virginia 800-642-8244.

CONFIDENTIALITY - We must treat all AIDS-related information (including test results) as highly confidential. We have established safeguards within our company that will protect the privacy of any AIDS-related information that is in your files. We have designated employees who are responsible for keeping this information confidential. We have designated certain personnel who will have access to AIDS-related information if they need the information in connection with an insurance transaction. Other personnel are aware that they are not permitted access to such information. We will make sure AIDS-related information that is stored in a computer data bank or other files is protected by reasonable security safeguards.

To handle your insurance business, we may need to disclose your test results or other AIDS-related information to employees, reinsurers, contractors or attorneys who need AIDS-related information for underwriting, claims or other necessary business purposes in connection with your insurance transaction. These persons and entities have been informed of their clear legal obligation to maintain the confidentiality of all AIDS-related information, including test results. Similar privacy safeguards have also been adopted by the laboratory that will perform tests on your blood sample, and by any contractor, reinsurer or attorney to whom we might grant access to AIDS-related information. If we need to disclose to anyone else information about you and AIDS, we must again ask you to provide prior written consent to such disclosure. However, AIDS-related information could be disclosed without your consent in response to a subpoena. If you believe that your right to the confidentiality of any AIDS-related information about you has been violated, you should contact your state's Department of Division of Insurance. In Connecticut: The Connecticut Insurance Department, 153 Market St., Hartford, 06103 - Tel. 860-297-3800. In Delaware: The Department of Insurance. 841 Silver Lake Blvd., Dover, 19904 - Tel. 302-739-5280. In the District of Columbia: The Department of Insurance and Securities, 810 First Street, NE, Washington, 20002 - Tel. 202-442-7811. In Maryland: Insurance Administration, 525 St. Paul Place, Baltimore, 21202 - Tel. 800-492-6116. In Massachusetts: The Massachusetts Division of Insurance, 1 South Station, Boston, 02110 - Tel. 617-521-7777. In New Hampshire: The New Hampshire Division of Insurance, 56 Old Suncook Road, Concord, 03301 - Tel. 603-271-2261. In New Jersey: The New Jersey Department of Banking and Insurance, 20 West State St., Trenton, 08625 - Tel. 609-292-5427. In North Carolina: Department of Insurance, P.O. Box 26387, Raleigh, 26711 - Tel. 919-733-2032. In Rhode Island: The Rhode Island Insurance Department, 233 Richmond St., Providence, 02903 - Tel. 401-222-2223. In Pennsylvania: The Pennsylvania Insurance Department, 1345 Strawberry Square, Harrisburg, 17120 - Tel. 717-787-5173. In Tennessee: Department of Commerce and Insurance, 500 James Robertson Parkway, Nashville, 37243 - Tel. 615-741-1670. In Vermont: The Vermont Department of Banking and Insurance, 89 Main St., Drawer 20, Montpelier, 05620 - Tel. 802-828-3301. In Virginia: The Bureaus of Insurance, P.O. Box 1157, Richmond, 23216 - Tel. 804-371-9741. In West Virginia: West Virginia Insurance Commission, P.O. Box 50540, Charleston, 25305 - Tel. 304-558-2094.

MEDICAL INFORMATION BUREAU - If your test result is positive, we will make a report indicating a non-specific abnormal blood test result to the Medical Information Bureau, Inc. (MIB). The nature of the test will not be reported; there will be no record with the MIB that you had a positive HIV antibody test. The MIB is a nonprofit organization of life insurance companies which operates an information exchange for its members. Our decision on whether or not to issue you a policy will not be sent to the MIB. If you later apply to another MIB member company for life or health insurance or submit a claim for life or disability benefits, the MIB will, upon request, provide that company with information in its file including information we have furnished. Otherwise the MIB will observe confidentiality safeguards similar to our own stated above. Upon your request, the MIB will arrange for disclosure to you of any information it has in your file. If you feel the information in the MIB's file is not correct, you may contact the MIB and seek a correction in accordance with the procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: MIB, Inc., P.O. Box 105, Essex Station, Boston MA 02112. The MIB telephone number is (617) 426-3660.

DISCLOSURE AND ACCESS TO INFORMATION - If we disclose any AIDS-related information to a person or entity who is not our employee, reinsurer, contractor, or attorney as described above, or the MIB, we will notify you in writing unless we are prohibited from doing so by law or court order. Upon your written request, we will provide you, either directly, or at your option, through a physician designated by you, with copies of any information relating to you and AIDS in our files, for the reasonable cost of photocopying those documents. If you believe any of the information in our files in incorrect, you may write to us to request that it be corrected.

AUTHORIZATION - I have read and understood this Notice of AIDS Virus Antibody Testing and Authorization for Testing and Disclosure. I understand that: if I test positive I will be denied the insurance for which I have applied; I may experience increased anxiety as a result of having this test; the people and entities described above will or may have access to the results of my test as stated above for the purposes identified on this form; I have received a copy of this form; and this authorization is valid for ninety (90) days from the date of my signature below.

I authorize the drawing and testing of my blood for HIV antibodies and the disclosure of the test results as stated in this form.

*****NOTIFICATION OF A POSITIVE TEST RESULT***** - In the event of a positive test result: (check one)

___ Please send the results to me at the residence address entered on my application for insurance.

___ Please send the results to me at the following address: ______________________

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___ I authorize Centrian Life Insurance to send the results to my physician and understand that such results may become part of my physician's permanent medical records concerning me:

Doctor's Name & Address: ______________________

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Name of proposed insured	Application #	Centrian Agent Name	Number

X______ Date	X______ Signature of Proposed Insured	X______ Signature of legal guardian, if any