

PART B: Medical Examiner's Confidential Report

Instructions to Examiner –

This examination, once begun, is the property of the Company, and must not be destroyed, suppressed, or given to the Proposed Insured. It should be sent to the home office upon completion.

Examination must be made in private. Proposed Insured must be properly prepared for careful physical examination. Please weigh and measure the applicant. Explain all positive findings under "Remarks". If for any reason you don't care to give certain special confidential information on this form, please enter such information on a separate sheet and mail directly to the Medical Director of the Company.

The questions, which appear below, are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though such information may not be specifically requested on this form.

1. Proposed Insured		REMARKS:	
2. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other photo i.d.			
3. Height _____ ft. _____ in. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight _____ lbs. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No Any change in weight over the past 12 months? If yes, reason:			
4. Measurements (for males only) Chest: Full inspiration _____ in. Forced expiration _____ in. Abdomen: (at umbilicus) _____ in.			
5. Have you drawn a blood specimen and mailed it along with a urine specimen? Lab Name _____ If female, menses?			
6. Blood Pressure: Initial reading _____ Additional readings _____ Report all readings. If initial reading is 140/90 or higher, or if the Proposed Insured has had hypertension or marked obesity, provide two additional blood pressure readings taken at intervals.			
7. Pulse Pulse at rest _____ Describe any irregularities _____ _____			
8. a. Does the Proposed Insured appear in any way unhealthy, or older than the stated age? b. Do you know of any facts bearing upon the risks, which are not brought out by the foregoing questions? c. Did you observe any other physical attributes such as, but not limited to, amputation, large area scars, etc.? d. Was anyone else besides the Proposed Insured present at time of exam? (If Yes, who?)			
9. Are you acquainted with the Proposed Insured? If Yes, how well do you know the Proposed Insured? <input type="checkbox"/> Known well <input type="checkbox"/> Not known well <input type="checkbox"/> Relative (state relationship) _____ How long known?			

The Chesapeake Life Insurance Company

Home Office: 1331 W Memorial Road, Suite 112, Oklahoma City, OK 73114 1-800-725-7887

**NOTICE AND CONSENT FOR 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, oral fluid (saliva) and/or urine 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 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 manufacturers 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 manufacturers 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 results or other significant test 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, reinsurer, 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, oral fluid (saliva) or urine 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 Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the blood, oral fluid (saliva) and or urine sample from me, the testing of that sample, 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 or facsimile 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 Resident