



Name of Proposed Insured (please print)

Birthdate of Proposed Insured

Examiner

Name of Agent (please print)

**STATE OF ARIZONA  
NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV)  
ANTIBODY/ANTIGEN TESTING**

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

**INFORMATION ON HIV**

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. **HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.**

Persons most at risk of contracting HIV are men who have had sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

**PRE-TEST COUNSELING CONSIDERATIONS**

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department **or:**

Phoenix metropolitan area: 234-2752  
(Arizona AIDS Information Line)

Outside the Phoenix area: 1-800-334-1540  
(Arizona Department of Health Services)

**DISCLOSURE OF TEST RESULTS**

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. §20-448.01.

**MEANING OF POSITIVE TEST RESULTS**

The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS. About 50% of infected individuals have developed AIDS within 10 years after being infected with the virus.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

**CONSENT**

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

X \_\_\_\_\_ Date  
Signature of Proposed Insured  
or Parent/Guardian

**OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN**

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, ZIP

X \_\_\_\_\_ Date  
Signature of Proposed Insured  
or Parent/Guardian



INSTRUCTIONS TO THE EXAMINER:

1. Examination should be made in private.
2. Record answers in your own handwriting.
3. Proposed Insured should sign full name.
4. Mail this report direct to the Home Office.
5. Do not deliver or reveal this report to any Agent.
6. Mail urine specimen/blood kit direct to laboratory as addressed on container.

**PART 2  
MEDICAL**

*Columbus Life  
Insurance Company*

Application for Insurance



**USE BLACK INK**

400 EAST FOURTH STREET CINCINNATI, OHIO 45202-3302

Proposed Insured \_\_\_\_\_ Birth \_\_\_\_\_ Date \_\_\_\_\_  
 First Name Middle Initial Last Name Month Day Year

1. a. Name and Address of your personal physician (if none, so state) \_\_\_\_\_
- b. Date and reason last consulted? \_\_\_\_\_
- c. What treatment was given or medication prescribed? \_\_\_\_\_

	YES	NO	
<b>2. Have you ever been diagnosed as having or been treated by a member of the medical profession for:</b>			
a. Disorder of eyes, ears, nose, or throat? .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>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. Use Part 3 if additional space is needed.)</b>
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, allergies, asthma, emphysema, tuberculosis or chronic respiratory disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? .....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs? .....	<input type="checkbox"/>	<input type="checkbox"/>	
g. Diabetes; thyroid or other endocrine disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>	
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints? .....	<input type="checkbox"/>	<input type="checkbox"/>	
i. Deformity, lameness or amputation? .....	<input type="checkbox"/>	<input type="checkbox"/>	
j. Disorder of skin, lymph glands, cyst, tumor, or cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>	
k. Alcoholism or any habit-forming drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	
l. Anemia, hemophilia, or any other blood disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you now under observation or taking treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you had any change in weight in the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	
5. AIDS, ARC (AIDS-Related Complex, which may include signs and symptoms of generalized swollen lymph glands, loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause), or any other immune deficiency disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	
6. <i>Other than above</i> , have you within the past 5 years:	<input type="checkbox"/>	<input type="checkbox"/>	
a. Had any mental or physical disorder not listed above? .....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had a checkup, consultation, illness, injury, surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Had electrocardiogram, X-ray, other diagnostic test? .....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? .....	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? .....	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? .....	<input type="checkbox"/>	<input type="checkbox"/>	
9. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? .....	<input type="checkbox"/>	<input type="checkbox"/>	
10. a. Do you now use tobacco in any form? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, specify type (cigarettes, pipe, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Did you previously use tobacco and quit? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, in what month and year did you quit? .....	<input type="checkbox"/>	<input type="checkbox"/>	
c. Daily average use of tobacco (past or present)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
d. Do you now use any "stop smoking" aids? .....	<input type="checkbox"/>	<input type="checkbox"/>	

who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician, or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired, and I authorize any disclosure to such extent as may be lawful.

Signed at (City, State) \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ M.D. \_\_\_\_\_  
 (Medical Examiner)

Proposed Insured \_\_\_\_\_  
 (Signature in full of Person Examined)

**AUTHORIZATION TO OBTAIN INFORMATION**

I authorize any physician or other medical practitioner, hospital, clinic, other medical care institution, other companies or institutions, my employer, consumer reporting agency or the Medical Information Bureau, Inc., to give Columbus Life Insurance Company, or its reinsurers, information about me or my health for underwriting purposes. Except for the Medical Information Bureau reports, information may, in some cases, be obtained by authorized representatives of Columbus Life. This information may include an investigative consumer report, other insurance coverage, details of employment, or medical care including diagnosis, advice, treatment and prognosis of any physical and mental condition regarding me or any of my minor children to be insured. I further consent to the release of any drug- or alcohol-related information which may be protected by Federal Regulations.

**USE AND DISCLOSURE**

I understand that Columbus Life will use this information to determine eligibility for insurance and/or benefits. Also, Columbus Life may release this information to the Medical Information Bureau, Inc., reinsurance companies and to other insurance companies to which I may apply for insurance and/or benefits. This Authorization is valid for two and one-half years from the date shown below unless a shorter period is legally required. I understand that I have the right to receive a copy of this Authorization upon request. A photocopy of this Authorization will be as valid as the original.

**SIGN BOTH PLACES**

CL 30.7 (2/89) Signed at (City, State) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Insured (if of legal age for such signature) \_\_\_\_\_