

INSURANCE COMPANY INFORMATION

INSURANCE COMPANY NAME _____ REGIONAL OFFICE _____ AGENT NUMBER OR CODE _____

CITY _____ STATE _____ AGENT NAME _____

TYPE OF INSURANCE _____ AGENCY NAME _____

INDIVIDUAL LIFE DISABILITY LONG-TERM CARE
 GROUP HEALTH MAJOR MED. CRITICAL ILLNESS POLICY NUMBER _____ POLICY AMOUNT _____
 OTHER: _____ BROKERAGE

PROPOSED INSURED INFORMATION

LAST NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ GENDER _____
 M O DAY Y E A R M F

FIRST NAME _____ DRIVERS LICENSE NUMBER _____ STATE _____ PICTURE VERIFIED? _____
 YES NO

STREET ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ E-MAIL ADDRESS _____

DATE AND TIME OF LAST FOOD AND DRINK _____ AM _____
 M O DAY Y E A R HOUR MINUTE PM

DATE AND TIME SPECIMEN WAS OBTAINED _____ AM _____
 M O DAY Y E A R HOUR MINUTE PM

COLLECTED URINE TEMPERATURE _____
 FAHRENHEIT

1. DO YOU SMOKE CIGARETTES? YES NO 2. Any history of: Diabetes? YES NO High blood pressure? YES NO
 Heart disease? YES NO Protein/Albumin in urine? YES NO

a. IF NO, HOW LONG SINCE YOU LAST SMOKED CIGARETTES? MO. NEVER 3. In the past 5 years, have you had a moving violation or your driver's license restricted, suspended or revoked? YES NO

b. DO YOU USE ANY TOBACCO PRODUCTS? YES NO 4. Do you have a physician? YES NO How long since last visit? MO.

c. IF NO, HOW LONG SINCE YOU LAST USED TOBACCO PRODUCTS? MO. NEVER 5. Are you currently taking any prescription medications? YES NO If yes, please list _____

d. DO YOU USE A NICOTINE SUBSTITUTE (i.e. gum or patch)? YES NO 6. Current menses? YES NO

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*** **DO NOT COMPLETE THIS SECTION UNLESS INSTRUCTED BY THE INSURANCE COMPANY** ***

HEIGHT		WEIGHT		BLOOD PRESSURE		PULSE		MALE APPLICANT ONLY		
FT	IN	LBS		SYSTOLIC 1ST	2ND	RATE AT REST	IRREGULARITY	CHEST (Full Inspiration)	CHEST (Forced Expiration)	Abdomen, at Umbilicus
								IN	IN	IN

EXAMINER/COLLECTOR INFORMATION

EXAMINER COMPANY _____

APPS _____ EMSI _____ EXAMONE _____ PORTAMEDIC _____ Other: _____

PHONE _____ EXAMINER NAME _____

CITY _____ STATE _____ ZIP _____

SPECIAL TESTS:
 FULL DRUG _____ MICROALBUMIN _____
 A1C _____ CBC _____ CDT _____ HIV ONLY _____
 PSA _____ OTHER _____

COMMENTS _____

NOTICE CONSENT AND CHAIN-OF-CUSTODY STATEMENTS

Prior to allowing my samples to be collected, I have read and understand the notice and consent for testing that may include AIDS (HIV) antibody testing, which appears on the reverse side of this form. I voluntarily consent to the withdrawal of blood from me by needle or lancet and the testing of any blood/urine/or oral fluid I provide, by CRL! Furthermore, if this is a urine only sample and is to be tested for HIV antibodies, I have read and understand the subject information brochure entitled "Urine Testing for Antibodies to HIV-1" that was given to me by the collector. I authorize the release of the test results and other information about me (including but not limited to medication information) for disclosure as described on the reverse side of this form. I further acknowledge receipt of a copy of this form signed by me.











I, the proposed Insured, verify that the enclosed contents of these container(s) are indeed my blood/urine/or oral fluid specimens. I have verified that the barcode labels on the specimen tubes match the barcode on this consent. I verify that my urine was collected into tubes, one of which was sealed with tamper evident tape that I have dated and signed. **X**

I verify that the enclosed specimens were collected according to the specimen criteria on the instruction sheet provided by Clinical Reference Laboratory. I further verify that these specimens are in fact the specimens taken from the proposed insured named on this ID form. I have verified the barcode labels on the specimen tubes match the barcode on this consent. I have verified the tamper evident tape, which I have placed on one urine tube, matches the barcode on this consent.

Signature of Proposed Insured or Guardian _____ Date _____

Signature of Examiner/Collector _____ Date _____

LAB USE ONLY

 80 98092754 10	 80 98092754 11	 80 98092754 03	 80 98092754 02	 80 98092754 01
EXTRA LABEL  80 98092754 12	EXTRA LABEL  80 98092754 13	WHOLE BLOOD TAMPER EVIDENT TAPE		
 80 98092754 04	(PLACE OVER CAP)		 80 98092754 02	 80 98092754 01

SECURITY SEAL

PROPOSED INSURED SIGNATURE _____
 COLLECTOR INITIALS _____ DATE _____

SERUM _____ URINE _____