

## MEDICAL QUESTIONNAIRE

Supplement to Application (Part II)

Policy/Order Number \_\_\_\_\_

Proposed Insured: \_\_\_\_\_

First Name                      Middle Initial                      Last Name

Date of Birth: (mo./day/yr.) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

1. a. Name and address of personal physician (If none, write "none") \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 b. Date and reason last consulted \_\_\_\_\_  
 c. What treatment was given and/or medication prescribed? \_\_\_\_\_  
 d. What tests/studies were completed? What were the results? \_\_\_\_\_
2. Have you ever been treated for or diagnosed by a member of the medical profession as having:
  - a. Allergies; disease(s) or disorder(s) of eyes, ears, nose or throat? .....  Yes  No
  - b. Dizziness, fainting, convulsion, epilepsy, headache; stroke or paralysis? .....  Yes  No
  - c. Depression, mental or nervous disorder(s), anxiety or attempted suicide? .....  Yes  No
  - d. Shortness of breath, persistent hoarseness or cough, bronchitis, pneumonia, tuberculosis, asthma, emphysema/chronic obstructive pulmonary disease (COPD), chronic respiratory disorder or sleep apnea?  Yes  No
  - e. Chest pain, palpitation(s), high blood pressure, rheumatic fever, heart murmur or valvular heart disease, heart attack or other disorder(s) of the heart or blood vessels? .....  Yes  No
  - f. Hepatitis (A,B,C or other), jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, disorder of the stomach, intestines, liver or gallbladder? .....  Yes  No
  - g. Sugar, blood, protein or other urinary abnormalities; stone(s) or other disorder of the kidney, bladder, prostate or reproductive organs? .....  Yes  No
  - h. Diabetes; thyroid or other endocrine disorder(s)? .....  Yes  No
  - i. Neuritis, sciatica, arthritis, gout, deformity, amputation, Multiple Sclerosis, Muscular Dystrophy or other disorder(s) of the muscles, bones, spine, back or joints? .....  Yes  No
  - j. Disorder(s) of skin; lupus or other connective tissue disease? .....  Yes  No
  - k. Cyst(s), polyp(s), tumor(s) or cancer? .....  Yes  No
  - l. Anemia or other disorder(s) of the blood (not including HIV) or lymph glands? .....  Yes  No
3. Have you had angioplasty, stent placement or bypass surgery? .....  Yes  No
4. Have you ever been diagnosed or treated by a member of the medical profession for an immune deficiency disorder (not including HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or sexually transmitted disease(s) (not including HIV) including gonorrhea, syphilis, genital herpes or venereal warts? .....  Yes  No
5. a. Are you now under observation or taking treatment? .....  Yes  No  
 b. Have you had any change in weight in the past year? .....  Yes  No

Please provide details of "Yes" answers. (IDENTIFY QUESTION, CIRCLE APPLICABLE ITEMS: Include diagnoses, treatment, dates, duration and names and addresses of all attending physicians and medical facilities.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL QUESTIONS & SIGNATURE ON REVERSE SIDE**

6. Other than as previously stated on this questionnaire, have you within the past five years:
- a. Had a mental or physical disorder? .....  Yes  No
  - b. Had a checkup, consultation, illness, injury or surgery? .....  Yes  No
  - c. Been evaluated in a hospital, emergency room or other medical facility? .....  Yes  No
  - d. Had an electrocardiogram, x-ray or other diagnostic test(s)? .....  Yes  No
  - e. Been advised to have any diagnostic test(s), hospitalization or surgery which was not completed? ....  Yes  No

Please provide details of "Yes" answers. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Have you:
- a. Ever requested or received short or long term disability payments because of injury or sickness? ....  Yes  No
  - b. Ever used sedatives, stimulants, narcotics or hallucinogens except as prescribed by a physician? ..  Yes  No
  - c. Ever been treated or advised to seek treatment for use of alcohol or drugs? .....  Yes  No

Please provide details of "Yes" answers. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Have you used any form of tobacco or nicotine substitute within the last 36 months? .....  Yes  No  
 If so, what form? \_\_\_\_\_ Date last used? \_\_\_\_\_  
 (Month/Year)

9. Any family history of diabetes, cancer, high blood pressure, heart or kidney disease, cerebrovascular disorder, mental illness or suicide?  Yes  No

Relationship	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers/ Sisters			

Please provide details of "Yes" answers \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Any person who knowingly presents a false statement or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.**

**I have read my answers to the above questions, and they are true and complete to the best of my knowledge and belief.**

\_\_\_\_\_  
 Signature of Proposed Insured  
 (If Under Age 16, Parent or Guardian Must Sign)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness By - Signature

**For Paramedical Examiner or Physician use only:**

- 1a. Measured Height \_\_\_\_\_ ft. \_\_\_\_\_ in.      1b. Measured Weight \_\_\_\_\_ lbs.  
 1c. Chest (full inspiration) \_\_\_\_\_ ins. Chest (forced expiration) \_\_\_\_\_ ins.  
 Abdomen (at Umbilicus) \_\_\_\_\_ ins.  
 1d. Did you measure?  Yes  No      1e. Did you weigh?  Yes  No  
 2. Blood Pressure: If first reading is over 140 systolic or 90 diastolic, take at least two additional complete readings two or three minutes apart. Record all readings.

Systolic	_____	_____	_____
Diastolic (5th phase)	_____	_____	_____

3. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate	_____	_____	_____
Irregularities per min.	_____	_____	_____

4. Was a urinalysis and/or blood chemistry profile sent to the laboratory? .....  Yes  No



CUNA Mutual Insurance Society

Administrative Office  
P.O. Box 61 • Waverly, IA 50677-0061  
Phone: 800/779-5433

## NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

To evaluate your insurability, CUNA Mutual Insurance Society has requested that you provide a sample of your blood, urine, or oral fluid for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood, urine, or oral fluid sample and that underwriting decisions may be based on the test results.

### HIV Antibody Test

The HIV antibody test is a series of tests performed by a licensed laboratory through a medically accepted procedure which is 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, urine and/or other body fluids 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, urine and/or other body fluids 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, urine and/or other body fluids 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.

### Meaning of Test Results

**Positive Test Results.** If your antibody test is positive, it does not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. 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. This is called a "false positive" result.

**Negative Test Results.** If your test is not positive, you most likely have not been infected by the virus. However, it is possible to have been infected with the virus within the past year and not have developed antibodies that cause a positive test result. It is possible to receive a "false negative" result.

### Notification of Test Results

If your HIV antibody test results are negative, no routine notification will be sent to you unless requested. If your test results are positive, a trained person should deliver that information so that you can clearly understand what the results mean. We ask that you please list your personal physician below so that we may forward the results to them if necessary.

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

### Confidentiality of Test Results

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes which are not specific to the testing of HIV antibodies. The release for disclosures discussed in this paragraph will be effective for 2½ years from the date shown below.

### CONSENT

I have read and I understand this Consent Form for HIV Antibody Testing. I voluntarily consent to the withdrawal of blood, urine, or oral fluid, the testing and 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.

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date



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\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date



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## COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to CUNA Mutual Insurance Society. Therefore, CUNA Mutual Insurance Society makes no representations or warranties that this information is accurate as of the date you receive this list. Also, CUNA Mutual Insurance Society makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

### **AIDS HOTLINE - U.S. PUBLIC HEALTH SERVICE**

(800) 342-AIDS

### **SPANISH AIDS HOTLINE**

(800) 222-SIDA

### **TTY INFORMATION**

Information and Referral for Hearing Impaired  
(213) 464-0029

### **KERN COUNTY AIDS TEAM - Bakersfield**

(805) 861-3631

### **CENTRAL VALLEY AIDS TEAM**

Fresno  
(209) 264-2436

### **AIDS PROJECT - EASY BAY - Oakland**

(415) 420-8181

### **SACRAMENTO AIDS FOUNDATION - Sacramento**

(916) 448-2437

### **SAN FRANCISCO AIDS FOUNDATION**

San Francisco  
(415) 864-5855

### **SANTA CLARA COUNTY ARIS PROJECT - Campbell**

(408) 370-3272

### **SONOMA COUNTY AIDS INFORMATION HOTLINE**

(707) 579-AIDS

### **AIDS HOTLINE - So. California**

(800) 922-AIDS

### **HEMOPHILIA FOUNDATION OF SO. CA.**

Social Services - So. California  
Hemophilia AIDS Information  
(818) 793-6192  
(714) 740-2222

### **CALIFORNIA DEPARTMENT OF HEALTH SERVICES - Statewide Services**

Office of AIDS, Sacramento  
(916) 323-7415

### **AIDS SERVICES FOUNDATION OF ORANGE COUNTY - Costa Mesa**

(714) 646-0411

### **AIDS PROJECT - LOS ANGELES**

West Hollywood  
(213) 876-8951

### **INLAND AIDS PROJECT**

Riverside/San Bernardino Counties  
(714) 784-2437

### **SAN DIEGO AIDS PROJECT**

(619) 543-0300 - City of San Diego  
(619) 945-6000 - City of Vista

### **SANTA BARBARA COUNTY AIDS INFORMATION HOTLINE**

(805) 965-2925

### **SHASTA COUNTY HELPLINE**

(916) 225-5252