



909 North Washington Street • Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com

COMMONWEALTH OF VIRGINIA
NOTICE AND CONSENT
for
HIV-RELATED TESTING

To evaluate your insurability, the insurer named above (“the Insurer”) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (“HIV”) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations: Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result: The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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 charges may be necessary.

Confidentiality of Test Results: All test results are required to 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 or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover the results of tests for

other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Positive Test Result:

In the event of a positive test result:

___ please send the result to me at:

Address: _____

___ I authorize 5 Star Life Insurance Company to send the result to my physician and understand that such results may become part of my physician's permanent medical records concerning me:

Physician's Name: _____

Physician's Address: _____

If the test indicates a positive result, but you do not designate a private physician, personal face-to-face counseling is available through the Virginia Department of Health. To obtain information regarding counseling, a person should contact their local health department. Additional information concerning AIDS or HIV infection can be obtained by calling the Virginia Health Department at (800) 533-4148.

Consent: I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means. 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.

Date: _____

Signature of Proposed Insured or Parent/Guardian

Name of Proposed Insured (Please print)

Address

Agency (Please print)

Agent (Please sign and print)