



|  |                          |                          |
|--|--------------------------|--------------------------|
| g. Kidney disease, renal colic, kidney stones, syphilis, any disorder of the bladder, prostate or other genitor-urinary organs?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Diabetes, thyroid or other endocrine disorders?   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cancer, cyst or any other tumor or skin disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Been diagnosed as having, or been treated, by a member of the medical profession, for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Any disorder of the breast, uterus, ovaries, cervix or fallopian tubes?   | <input type="checkbox"/> | <input type="checkbox"/> |

Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).

| Item#: | Date: | Details: |
|--------|-------|----------|
|        |       |          |

**4. Have you WITHIN the LAST 5 Years:**

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| a. Had or been treated for any disease, injury or had an operation not already mentioned?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Consulted a physician, psychiatrist or other practitioner for a general exam or any other reason not already mentioned? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been a patient in any hospital or sanitarium for any reason not already mentioned?                                   | <input type="checkbox"/> | <input type="checkbox"/> |

**5. CURRENTLY:**

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| a. Do you drink alcohol? If YES, please indicate how often _____ How Much? _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you experience any symptoms, disorder or have a condition that may impair your health or require an operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you take any medication for any reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Are you pregnant? (If YES, give expected delivery date and pre-pregnancy weight)                                  | <input type="checkbox"/> | <input type="checkbox"/> |

e. Do you currently use tobacco products (including cigarettes, cigars, dip, snuff, chewing tobacco and nicotine patches or gum)?  
 Yes  No  
 Which statement best describes your use of tobacco products.  
 Not within the last 4 years  Not within last 12 months  Never

f. **Current occupation:** \_\_\_\_\_

During the last 3 years, have you engaged in a hazardous occupation (such as: underground mining, high-rise construction, offshore drilling, iron work, tunnel/subway construction, explosive handling, etc.)?  Yes  No  
 If yes, please provide details for the past three years:

Date: \_\_\_\_\_ Project/Duties: \_\_\_\_\_

Date: \_\_\_\_\_ Project/Duties: \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_

g. **Avocation Question:**  
**Do you participate in any hazardous activities?** (Such as: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of motorized racing)?  Yes  No  
 If yes, please provide details:

|   |  |                               |   |                                  |
|---|--|-------------------------------|---|----------------------------------|
| <b>Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).</b>                  |  |                               |   |                                  |
| <u>Item #:</u>  | <u>Date:</u>                                     | <u>Details:</u>               |   |                                  |
| <b>6. Please indicate applicant's build and family history below:</b>   |  |                               | <b>Please provide the complete name and address of your primary care physician:</b> |                                  |
| Height  | _____ ft. _____ in.<br>(HGT & WGT without shoes) |                               | Name: _____   |                                  |
| Weight  | _____ lbs.<br>Pulse at REST _____                |                               | Address: _____  |                                  |
| Did you measure: YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                               | 7. <b>Blood Pressure</b><br>(Take three, 10 minutes apart and record all three)     |                                  |
| Did you weigh: YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                               | _____   |                                  |
| Has applicant gained or lost within the last year? +/- _____ lbs.   |  |                               | Systolic: (1). (2). (3).  |                                  |
| Reason for loss or gain:<br>_____   |  |                               | Diastolic: (1). (2). (3).   |                                  |
| <b>Family History</b>   | <b>AGE</b>                                       | <b>Living State of Health</b> | <b>AGE</b>  | <b>Not Living Cause of Death</b> |
| Father  |  |                               |   |                                  |
| Mother  |  |                               |   |                                  |
| Brothers Number<br>( )  |  |                               |   |                                  |
| Sisters Number<br>( )   |  |                               |   |                                  |
| <b>8. Examiner Questions:</b>   |  |                               |   |                                  |
| a. Have you reason to believe or suspect that the proposed insured is under the influence of alcohol or narcotics?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                               |   |                                  |
| b. Are you forwarding a specimen to the lab?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                               |   |                                  |
| c. Which of the following did you use to identify the proposed?<br><input type="checkbox"/> Drivers license with picture <input type="checkbox"/> Other picture ID<br><b>Please indicate below what the other picture ID is:</b><br>_____ |  |                               |   |                                  |

I hereby declare that all statements and answers as written or printed herein are full, complete and true to the best of my knowledge and belief. I agree that they are to be considered the basis of any insurance issued hereon and no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the company's rights or requirements, or to make or alter any contract.

I hereby expressly waive, to such extent as may be lawful, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has previously attended or examined me from disclosing any knowledge or information thereby acquired, and I expressly authorize such physician or other person to make such disclosures.

**The following fraud statement is applicable to disability insurance only:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Full Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Signature of Proposed Insured: \_\_\_\_\_ Dated: \_\_\_\_\_

Witnessed by Examiner: \_\_\_\_\_ Dated: \_\_\_\_\_

**HARTFORD LIFE INSURANCE COMPANIES**  
Individual Life Operations  
P.O. Box 64271  
St. Paul, Minnesota 55164-0271  
Telephone Number: (800) 246-4819



## **NOTICE AND CONSENT FOR HIV-RELATED TESTING**

To evaluate your insurability, the company with whom you are applying for insurance 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 a 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 changes 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 company with whom you are applying for insurance. The test results may be disclosed as required by law or may be disclosed to employees of the company with whom you are applying for insurance who have the responsibility to make underwriting decisions on behalf of the company with whom you are applying for insurance or to outside legal counsel who needs such information to effectively represent the company with whom you are applying for insurance 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 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.

(over)

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**Notification of Test Result:**

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the company with whom you are applying for insurance as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the company with whom you are applying for insurance can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result

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

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the company with whom you are applying for insurance may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

**Consent:**

I have read and I understand this Notice and Consent For HIV-Related Testing. I voluntarily consent to the collection of a sample 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.

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

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

WHITE-HOME OFFICE

CANARY-PROPOSED INSURED

PINK-AGENT/EXAMINER