

EXAMINATION FOR GROUP INSURANCE



DECLARATION MADE
TO EXAMINER

Employee Name: _____ Employee SSN: _____	Mailing Address Hartford Life Companies Group Medical Underwriting PO Box 2999 Hartford, CT. 06104
Policy Holder Name: _____ Policy Number: _____ (Company Name)	

1. Applicant's Full Name: (Please print-First Name, Middle Initial, Last Name)

Date Of Birth: _____ Gender: M or F (circle one)

Medical Questionnaire: All questions should be asked by the examiner (or licensed nurse assistant) to promote understanding, completeness, and accuracy of answers. The completed form should be signed and witnessed by the examiner.

2. Have you EVER:	YES	NO
a. Been arrested for drug possession, drunkenness, treated for drug addiction, alcoholism or regularly taken controlled drugs which were not prescribed by a physician or used barbiturates or amphetamines?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had your application for life, health, or accident insurance rejected, rated up, restricted, postponed or withdrawn?	<input type="checkbox"/>	<input type="checkbox"/>
c. Applied for or received any disability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been classified as 4F or been discharged from the service because of a disability?	<input type="checkbox"/>	<input type="checkbox"/>
e. Had or been advised to have any surgical operations, x-rays, heart examinations, electrocardiogram, blood or other laboratory studies?	<input type="checkbox"/>	<input type="checkbox"/>
f. Used insulin or been on a restricted diet, or had sugar or albumin in the urine?	<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.)

<u>Item #:</u>	<u>Date:</u>	

3. Have you EVER had or been treated for:	YES	NO
a. Nervous breakdown, anxiety, depression, dizziness, loss of consciousness, epilepsy, convulsions, frequent or severe headaches, or other mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. Ear discharge or impairment of hearing, speech, or sight?	<input type="checkbox"/>	<input type="checkbox"/>
c. Asthma, pleurisy, spitting of blood, tuberculosis, emphysema, chronic cough, or other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Arthritis, rheumatic fever, gout, deformity, or any disorder of the muscles, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
e. Heart trouble, heart murmur, palpitations, pain in the chest, angina pectoris, high blood pressure, cholesterol, anemia, varicose veins, or other disorder of the blood or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
f. Indigestion, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, GERD, jaundice, hepatitis or any disorder of the liver or gastrointestinal tract?	<input type="checkbox"/>	<input type="checkbox"/>
g. Kidney disease, renal colic, kidney stones, syphilis, any disorder of the bladder, prostate, or other genito-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), Aids-Related Complex (ARC) or any other immune deficiency disorder?	<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.)

<u>Item #:</u>	<u>Date:</u>	

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"/>
b. 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:	<input type="checkbox"/>	<input type="checkbox"/>
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. Have you used tobacco products in the past 12 months? (If YES, circle type) Cigarettes, Pipe, Cigar or Chewing Tobacco. Indicate how much () Per day.	<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:	

6. Please indicate applicant's build and family history below:

Height		ft.		in. (HGT & WGT without shoes)
Weight		lbs.		Pulse at REST

Did you measure? YES NO
 Did you weigh? YES NO
 Has applicant gained or lost within the last year? +/- _____ lbs.
 Reason for loss or gain. _____

Family History	AGE	Living State of Health	AGE	Not Living Cause of Death
Father				
Mother				
Brothers Number ()				
Sisters Number ()				

Please provide the complete name and address of your primary care physician:
 Name: _____
 Address: _____

7. Blood Pressure: (Take three, 10 minutes apart and record all three)

Systolic: (1.) _____	(2.) _____	(3.) _____
Diastolic: (1.) _____	(2.) _____	(3.) _____

8. Examiner Questions:

a. Have you reason to believe or suspect that the proposed insured is under the influence of alcohol or narcotics? YES NO

b. Are you forwarding a specimen to the lab? YES NO

c. Which of the following did you use to identify the proposed?
 Drivers license with picture Other picture ID
Please indicate below what the other picture ID is:

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.

Print Full Name: _____ **Social Security Number:** _____

Signature of Proposed Insured: _____ **Dated:** _____

Witnessed by Examiner: _____ **Dated:** _____



Information Statement
Information/Consent Regarding Blood Or Other Bodily Fluid Sample Testing
Important Information About Blood Or Other Bodily Fluid Sample Testing
Before consenting to testing, please read the following important information.

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood and/or other bodily fluid 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.

1. **Description of Tests to be Performed.** A blood or other bodily fluid sample is drawn for the purpose of laboratory testing to provide medical information concerning your insurability. These tests may include but are not limited to tests for: infection by the HIV virus; immune disorders; cholesterol and related blood lipids; diabetes; liver or kidney disorders; or the presence of medication, drugs, nicotine or other metabolites.

When HIV testing is performed, it will be performed according to the medical protocols required by Section 799 of the California Insurance Code.

2. **Purpose.** An HIV test is done to determine whether you may have been infected with the HIV virus. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation. If you have a positive ELISA test followed by a positive Western Blot Assay performed on the same specimen of blood or other bodily fluid sample, your life insurance application may be declined.
3. **Potential Uses.** If your HIV test results are positive, the company with whom you are applying for insurance will report a "nonspecific abnormality" of your blood or other bodily fluid sample to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many other blood or bodily fluid sample abnormalities are reported to the Bureau under the same classification.
4. **Limitations.** An HIV test is considered positive only when conducted according to the protocol specified by Section 799 of the California Insurance Code. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
 - a. False positives. The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
 - b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
5. **Meaning of the Test Results.** While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. If your blood or other bodily fluid sample is tested for HIV antibodies and if your test results are positive, the company with whom you are applying for insurance will notify the physician designated on Page 3 to whom you have authorized disclosure and with whom you may discuss the results. Positive HIV antibody test results will adversely affect your insurance application.

6. **Disclosure of Test Results.** All test results may be treated confidentially. Test results will be reported to the company with whom you are applying for insurance. The results may be reported to the company's affiliates, reinsurers, or contractors in connection with insurance you have or have applied for. In addition, if your HIV antibody

test is positive, a generic code signifying a nonspecific blood or bodily fluid sample abnormality will be reported to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

7. **Confidentiality of Test Results.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application.
8. **Notice of Available Counseling Resources.** The California Code requires that a list of counseling resources be made available, where the applicant can obtain assistance in understanding the meaning of the test and its results. There are many counseling resources in your area for you to contact. Below are samples of some of the many counseling resources:

Valley Aids Project
4341 Railroad Ave #H
Pleasanton, CA
(925) 485-3260

Aids Project Los Angeles
1313 Vine Street
Los Angeles, CA 90028
(323) 993-2300

Aids Project of The East Bay
1755 Broadway Fl 2
Oakland, CA
(510) 663-7979

Aids Project Monterey County
12 E Gabilan Street
Salinas, CA
(831) 772-8200

Aids Health Care Foundation
8631 W 3rd St.
Los Angeles, CA
(310) 657-9353

Aids Emergency Assistance
2440 3rd Avenue
San Diego, CA
(619) 544-0221

San Francisco Aids Foundation
1 6th Street
San Francisco, CA
(415) 487-3000

Being Alive
4068 Centre St.
San Diego, CA
(619) 291-1400

Aids Benefit Counselors
973 Market Street
San Francisco, CA
(415) 777-0333

Santa Monica Aids Project
2020 Santa Monica Boulevard
Santa Monica, CA 90404
(310) 652-7627

AIDS HOTLINE
Us. Public Health Service
(800) 342-AIDS
(800) 922-AIDS (Southern CA)

Sacramento Aids Foundation
2411 F Street Apt. 5
Sacramento, CA 95814
(916) 448-2437

California Department of Health Services
Statewide Services – Office of AIDS
(916) 323-7415

Spanish AIDS Hotline
(800) 222-AIDS

9. **Printed Material about HIV.** By my signature on Page 3, I acknowledge receipt of a copy of the American Red Cross pamphlet "AIDS: The Facts" (AIDS-1) before executing the following CONSENT TO BLOOD OR OTHER BODILY FLUID SAMPLE TESTING AND DISCLOSURE AUTHORIZATION.



CONSENT TO BLOOD OR OTHER BODILY FLUID SAMPLE TESTING AND DISCLOSURE AUTHORIZATION

I give my consent to the company with whom I am applying for insurance, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

1. Blood test or other bodily fluid testing for antibodies to the AIDS Virus (HIV).
2. Such other or additional blood or other bodily fluid sample tests which the company with whom I am applying for insurance may lawfully order.

My consent to this testing is freely given, based on the following understandings:

1. The purpose of the test(s) is to determine whether I am insurable for life insurance.
2. I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood or other bodily fluid sample tested and by refusing to give a blood or other bodily fluid sample. I know that if I do not take the test(s), my application to the company with whom I am applying for life insurance will be declined.
3. The test(s) for the antibodies to the AIDS virus (HIV) (or other test(s) permitted by law) will be conducted following approved test protocols.
4. I designate the following physician to receive notice of positive test results:

Physician's Name

Telephone Number

Street

City, State, Zip Code

(If no physician is designated, we will notify you directly, but we strongly urge you to designate a physician.)

I further understand that test results will not be released or disclosed to any party (other than the company with whom I am applying for insurance and related parties identified above, to whom I hereby authorize disclosure) unless:

- a. I expressly authorize their release in writing; or
- b. A public health reporting law required disclosure; or
- c. A court order required disclosure.

I understand that disclosures under 4(b) and 4(c) may be made without my consent.

5. I understand that the company with whom I am applying for insurance may report to the Medical Information Bureau (MIB) any abnormal blood or other bodily fluid sample test, but, in case of a positive HIV antibody test, the company with whom I am applying for insurance will not disclose the type of blood or other bodily fluid sample test which was abnormal. I acknowledge receipt of the company's Notice Regarding the MIB, Inc.

I acknowledge receipt of a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO BLOOD OR OTHER BODILY FLUID SAMPLE TESTING AND DISCLOSURE AUTHORIZATION.

Name of Proposed Insured

Signature of Proposed Insured

Address of Residence of Proposed Insured

Date

City, State, Zip Code

Signature of Examiner/Agent

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER