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16 674 308

PAPERWORK ONLY - NOT FOR TUBES

SECURITY SEAL
Initials Proposed Insured _____
Date / / _____



Lab Company Code _____ Type of Kit Shipped
Blood/Urine Urine Only DBS

Additional Tests - Complete only if instructed by Insurance Company.
Full Drug CDT PSA A1C Hep Panel
CBC Microalbumin Other _____

Insurance Company Name _____
Home Office City _____ State _____
Regional Office City _____ State _____
Agent Name/Code _____
Agency Name/Code _____ Agency City _____ State _____

Individual Group
Life Health/Medical Disability
Long Term Care Critical Illness
Amount of Insurance _____, _____, _____
Policy/Ref. Number _____ State _____

Examining Company Name
 Portamedic APPS EMSI ExamOne Other _____
Examiner Name/Code _____
Examiner City _____

Branch No. _____ Order No. _____
Examiner Phone No. _____
State _____ Zip Code _____

Proposed Insured Last Name _____
Proposed Insured First Name _____ Middle Initial _____
Proposed Insured Address _____ City _____ State _____
Zip Code _____ Driver's License No. _____ State _____
Social Security No. _____ Date of Birth _____ Gender _____ Current Menses _____
Hours Since _____ Date & Time Last Food and Drink _____ AM PM Urine Temperature _____ °F
Date & Time Specimen Collected _____ AM PM Date & Time Blood Centrifuged _____ AM PM
Tobacco Use? Yes _____ No _____ If "yes", check: Cigarettes _____ Cigar _____ Pipe _____ Smokeless _____
Are you currently using any type of nicotine delivery system? (patch, gum, etc...) Yes _____ No _____
Medications? Is the proposed insured currently taking ANY prescriptions, vitamins, or over-the-counter medications? Yes _____ No _____
If "yes", list: _____

I have read and understand the notice and consent for testing, which appears on the reverse side of this form. I voluntarily consent to the collection of specimen(s) from me, which may include blood, urine or oral fluids, the testing of specimen(s) I provide, and disclosure of the test results as described on the reverse side, as well as any other medical information provided by me. If HIV testing is requested by the insurer, I authorize HIV testing on my specimen(s), whether blood, urine or oral fluid and have read and understood the subject information brochure on HIV/AIDS that was given to me by the examiner.
I verify that the enclosed is my body fluid specimen(s), that the proper bar code label is affixed to each specimen container, that the urine container(s) have been sealed with tamper evident tape and initialed and dated by me. I acknowledge receipt of this form signed by me. No attempt by the proposed insured to modify or amend this form will change its terms or in any way be binding upon the insurance company or any of its agents or contractors.
X _____
Signature of Proposed Insured Date

Examiner Comments:

I, the Examiner, verify that the enclosed specimen(s) was collected by me from the proposed insured on the date noted above, and that the container(s) was labeled with the proper bar code label(s) showing the accession number indicated above.

Signature of Examiner Date

Body Measurements (Do Not Complete Unless Instructed By The Insurance Company)
Height Feet Inches Weight lbs Blood Pressure 1st / 2nd / 3rd /
Pulse Rate 1st Irregularity/Minute 2nd Irregularity/Minute
LAB COPY K1122 Rev. 07/2