X ExamOne® A Quest Diagnostics Subsidiary

0072830197

LAB COMPANY CODE

5040

INSURANCE COMPANY INFORMATION

INSURANCE COMPANY FULL NAME

REGIONAL OR HOME OFFICE CITY | STATE

REFERENCE / POLICY / MEMBER NUMBER

AGENT NAME

AGENT ADDRESS

AGENT CITY | STATE | ZIP CODE

☐ INDIVIDUAL ☐ GROUP

☐ LIFE ☐ DISABILITY ☐ HEALTH / MEDICAL ☐ LONG-TERM CARE

W

AMOUNT OF INSURANCE APPLIED FOR $, ,

AGENT CODE

PHONE NUMBER - -

LAB USE ONLY

CONTROL NUMBER

PROPOSED INSURED INFORMATION

LAST NAME

FIRST NAME | M.I. | GENDER ☐ Male ☐ Female

DATE OF BIRTH (Month / Day / Year) | SOCIAL SECURITY NUMBER - -

STREET ADDRESS

CITY | STATE | ZIP CODE

DRIVERS LICENSE NUMBER | STATE | PICTURE VERIFIED ☐ Yes ☐ No

DATE & TIME OF LAST FOOD/DRINK (Month / Day / Hour : Minute) ☐ AM ☐ PM | URINE TEMP °F | CURRENT MENSES ☐ Yes ☐ No

1. Do you use tobacco in any form? ☐ Yes ☐ No
2. If yes, what type of product(s) have you used? ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Smokeless
3. If no, how long since you last used any form of tobacco or nicotine? ☐☐☐ Months ☐ Never
4. Are you currently using any type of nicotine delivery system (gum, patch, nasal spray, etc.)? ☐ Yes ☐ No

HEIGHT (Feet / Inches) K

Initialed by Proposed Insured

WEIGHT (Lbs)

PULSE | IRREG.

1st BLOOD PRESSURE (Systolic / Diastolic)

2nd BLOOD PRESSURE (Systolic / Diastolic)

3rd BLOOD PRESSURE (Systolic / Diastolic)

In the past 5 years have you had a moving violation or has your driver's license been restricted, suspended or revoked? ☐ Yes ☐ No

Are you currently taking ANY prescription drugs, vitamins or over-the-counter medications? If yes, list: ☐ Yes ☐ No

COMMENTS:

HISTORY OF:

High Blood Pressure ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

SPECIAL TEST REQUEST

☐ A1C ☐ CBC ☐ CDT ☐ Full Drug ☐ Hepatitis ☐ PSA ☐ Microalbumin

Other

EXAMINING COMPANY

☐ ExamOne ☐ APPS ☐ EMSI ☐ Portamedic ☐ Other

EXAMINER NAME

BRANCH NUMBER | GLOBAL ID

PHONE NUMBER - - | STATE Z

Prior to allowing my blood, urine and/or oral fluid specimen(s) to be collected, I, the Proposed Insured, have read and do understand the Notice and Consent that appears on the reverse side of this form and the information and/or Subject Information Brochure on HIV/AIDS that was given to me by the Examiner. I voluntarily consent to the testing of my blood, urine and/or oral fluid specimen(s) and to the disclosure of the test results as described on the reverse side of this form. If HIV testing is requested by the insurer, I authorize HIV testing on my specimen(s). I also authorize the release of the test results and other information about me (including but not limited to medical information) for disclosure as described on the reverse side of this form. If a blood specimen(s) was drawn, I did voluntarily consent to the withdrawal of blood from me by needle or lancet. I further acknowledge receipt of a copy of this form signed by me.

I, the Proposed Insured, verify that the enclosed contents of this/these vial(s) is/are indeed my blood, urine and/or oral fluid specimen(s). I verify that my oral fluid specimen, if collected, was placed into a vial which was sealed with tamper-evident tape that I have dated and initialed. I further verify that my urine specimen, if collected, was collected into vial(s), one of which was sealed with tamper-evident tape that I have dated and initialed.

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 / Legal Guardian**

Month / Day / Year / Hour : Minute ☐ AM ☐ PM

I verify that the enclosed specimen(s) was/were properly collected. I further verify that this/these specimen(s) is/are in fact the specimen(s) collected from the Proposed Insured named on this ID form and that the proper barcode label has been placed by me on the specimen vial(s) for the Proposed Insured named on this ID form.

X

Signature of **Examiner**

LAB COPY

5040 Y

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