





**PART III. MEDICAL EXAMINER'S REPORT**

Name of agent authorizing examination: \_\_\_\_\_

10a. Height		Weight		Males Only:		
(In Shoes)		(Clothed)		Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen at Umbilicus
ft.	in.	lbs.		in.	in.	in.

Unless authorized under Special Requirements below, any additional studies or tests made in conjunction with this examination will be at applicant's expense.

b. Is appearance unhealthy or older than stated age? Yes  No

SPECIAL REQUIREMENTS:

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic	4th phase		
	5th phase		
<hr/>			
	At Rest	After Exercise	3 Minutes Later
12. Pulse: Rate			
Irregularities per min.			

13. Heart: Is there any:

Enlargement  Yes  No  
Murmur(s)  Yes  No  
Dyspnea  Yes  No  
Edema  Yes  No

(Describe below - If more than one murmur, describe separately.)

Details of "Yes" answers. (Identify item.)

Location	1.	2.	Indicate:		
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by		X
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by		○
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by		○
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by		▶
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	For comments and your impression?		
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>			
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>			
Soft (Gr.1-2)	<input type="checkbox"/>	<input type="checkbox"/>			
Mod. (Gr.3-4)	<input type="checkbox"/>	<input type="checkbox"/>			
Loud (Gr.5-6)	<input type="checkbox"/>	<input type="checkbox"/>			
After exercise:					
Increased	<input type="checkbox"/>	<input type="checkbox"/>			
Absent	<input type="checkbox"/>	<input type="checkbox"/>			
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>			
Decreased	<input type="checkbox"/>	<input type="checkbox"/>			

14. Is there on examination any abnormality of the following: (Circle applicable items and give details.)

(a) Eyes, ears, nose, mouth, pharynx?.....	<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing impaired, indicate degree and correction.)		
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?..	<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?.....	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen? .....	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system? .....	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)? .....	<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)? .....	<input type="checkbox"/>	<input type="checkbox"/>

15. (a) Are there any hernias? Yes  No  (b) Any hemorrhoids?...

16. Are you aware of additional medical history?.....

(A confidential report may be sent to the Medical Director)

PLEASE RECORD URINALYSIS	Specific Gravity	Albumin	Sugar	Microscop
PLEASE FORWARD URINE SPECIMEN TO HOME OFFICE IF: Examinee is Diabetic, Hypertensive, or has History of Urinary Tract Disease.				

I certify that I have carefully examined \_\_\_\_\_ in private at \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_ at \_\_\_\_\_ (A.M.) (P.M.):

College of Graduation? \_\_\_\_\_ Year? \_\_\_\_\_ Examiner's Signature \_\_\_\_\_ M.D.  
Examiner's Social Security or Tax Identification # \_\_\_\_\_ Examiner's Address \_\_\_\_\_  
Street and No. City State

A Fee of \$25.00 will be paid by the Company for this Examination

NOTE TO EXAMINER: This report is to be mailed direct to the Home Office of the Company in Greenville, South Carolina 29602

**Authorization for Release of Health Information  
To Liberty Life Insurance Company ("Company")**  
(This authorization complies with the HIPAA Privacy Rule)

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

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives and reinsurers. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I also authorize any insurance company, the Medical Information Bureau, or other organization, institution, or person ("Other Persons") that has any records or knowledge of me or my health, to give to the Company, its agents, its employees, its representatives and its reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

This protected health information is to be disclosed under this Authorization so that the Company may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Liberty Life Insurance Company, PO Box 19078, Greenville, SC 29602-9078.

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization, the Company may not be able to process my application. I acknowledge that I have received a copy of this Authorization.

\_\_\_\_\_  
Proposed Insured or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's authority or relationship to Proposed Insured.

## CALIFORNIA COUNSELING RESOURCE LIST

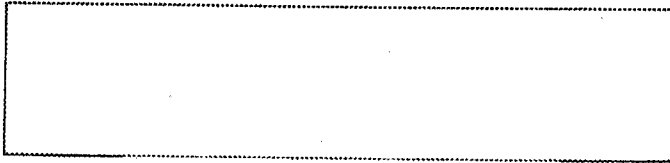
Liberty

Liberty Life Insurance Company PO Box 789 Greenville, South Carolina 29602-0789

As required by law, the following list of HIV counseling resources is being provided to you. It was compiled from publicly available information that is subject to change without notice to Liberty Life. Therefore, Liberty Life makes no representations or warranties that this information is accurate. In addition, Liberty Life makes no representations or warranties regarding the quality or nature of any services these resources may provide.

This is not a comprehensive list. We suggest that you contact your personal physician or your county health department for further information.

<b>AIDS HOTLINE</b> (Toll-free in California)	<b>1-800-367-AIDS</b>
<b>AIDS HOTLINE</b> (San Francisco area)	<b>415-863-AIDS</b>
<b>AIDS HOTLINE</b> (Toll-free TTY for the hearing impaired)	<b>1-888-225-AIDS</b>
<b>Clement Street Counseling Center</b> (San Francisco)	<b>415-221-9227</b>
<b>Comprehensive AIDS Resource Education Program and Clinic (CARE)</b> (Long Beach)	<b>800-347-9165</b>
<b>Women's HIV Care Center</b> (East Los Angeles)	<b>323-869-5421</b>
<b>Pacific Pride Foundation</b> (Santa Barbara)	<b>805-963-3636</b>
<b>Foothill AIDS Project</b> (Claremont)	<b>800-448-0858</b>
<b>North Coast AIDS Project</b> (Eureka)	<b>707-268-2132</b>
<b>Sierra Foothills AIDS Foundation</b> (Grass Valley)	<b>800-711-2437</b>
<b>Monterey County AIDS Project</b> (Salinas)	<b>800-300-4740</b>
<b>Sacramento AIDS Foundation</b> (Sacramento)	<b>916-448-2437</b>
<b>Santa Cruz AIDS Project</b> (Santa Cruz)	<b>831-427-3900</b>
<b>San Joaquin AIDS Foundation</b> (Stockton)	<b>209-476-8533</b>



INSURANCE COMPANY

**NOTICE AND CONSENT FOR BLOOD, URINE & SALIVA WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

**THE HIV ANTIBODY TEST**

To evaluate your insurability, the Insurer named above has requested that you provide a specimen sample of your blood, urine or saliva 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. A series of tests will be performed by a licensed laboratory through medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, it is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when infection occurred within the previous 3-6 months prior to the test.

**MEANING OF TEST RESULTS**

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

**COUNSELING**

Many public health organizations have recommended that before taking an AIDS-related test, a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling at your own expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have any questions or concerns, you may wish to consult your own physician or health care provider. A list of counseling resources is provided for your information.

**NOTIFICATION OF TEST RESULTS**

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the result means, you are asked to list your personal physician so that the Insurer may know whom to contact with those results.

Name of Physician: \_\_\_\_\_ Address \_\_\_\_\_

**CONFIDENTIALITY OF TEST RESULTS**

All test results are treated confidentially. The laboratory will report them only to the Insurer. The test results 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 need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to reinsurers, involved in the underwriting process. The test results may be released to an insurance medical information exchange using only general codes that include 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. No other disclosure will be made of the results except as required by law.

**CONSENT**

I have read and I understand this Notice of Aids Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and disclosure of the test results as described above.

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)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date