



 NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
 NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
 NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Examiner's Report – Part II

First Name _____ Middle Name _____ Last Name _____ Male Female Date of Birth (mm/dd/yyyy) _____

Social Security No. or Tax ID No. Exempt Applied for _____ Policy No./Tracking No. _____

1. Primary physician or health care provider information: None Name _____
 Address _____ Phone number (____) _____ - _____
 Date of last visit: ____/____/____ Reason for visit : _____
 Treatment or medication provided: (Provide details and/or name and dosage) _____

2. List all prescribed medications taken on a regular basis in the last 12 months: (Include dosage and frequency) _____

3. In the last ten (10) years, has the proposed insured had, been told he/she has, or been treated for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? Yes No
 - b. Elevated blood sugar or diabetes? Yes No
 - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? Yes No
 - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? Yes No
 - e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? Yes No
 - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia, thrombocytopenia or hemophilia? Yes No
 - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder (excluding any disorder related to HIV antibody, T-cell counts, AIDS or ARC)? Yes No
 - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? Yes No
 - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? Yes No
 - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? Yes No
 - k. Any psychiatric or mental health condition (including counseling or hospitalization)? Yes No
 - l. Drug or alcohol use, or used cocaine or other controlled substances, or been counseled or hospitalized for drug or alcohol use? Yes No

4. In the last ten (10) years, has the proposed insured been diagnosed or treated by a medical doctor for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)? Yes No

5. In the last two (2) years, other than as already stated, has the proposed insured:
- a. Had any surgery or been recommended to have surgery? Yes No
 - b. Had any diagnostic tests or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy but excluding any test relating to the HIV antibody, sero-positivity or HIV virus) Yes No
 - c. Been unable to work, unable to attend school or been disabled for 30 days or more? Yes No

6. Among proposed insured's natural parents, brothers or sisters, is there any history of angina, heart disorder or stroke? (If "Yes", please provide relationship, age of onset and subsequent history in details below.) Yes No

7. Has proposed insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.) Yes No

8. Height ____ft. ____in. Weight ____lbs.

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use another form.

| Ques. No. | Reason – Include diagnosis, treatment, medication, surgery and outcomes | Onset | | Recovery | | Doctors, Hospitals and Medical Facilities Info |
|-----------|---|-------|------|----------|------|--|
| | | Mo. | Year | Mo. | Year | |
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THE UNDERSIGNED DECLARE THAT, to the best of their knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true.

Dated at _____ on ____/____/____
 (City, State) (mm/dd/yyyy)

Signature of person examined

Witnessed by _____

Signature of Parent or Guardian, if person examined is under age 14 years and 6 months

Insured

- NEW YORK LIFE INSURANCE COMPANY**
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(A Delaware Corporation)
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- NYLIFE INSURANCE COMPANY OF ARIZONA**
(Not licensed in all states)
4343 Scottsdale Road, Suite 220 Scottsdale, AZ 85251



INFORMATION STATEMENT

For

Human Immunodeficiency Virus (HIV) Related Tests

Vermont law requires that the agent read this entire statement to you aloud, subject to penalties to the agent and the Insurer.

To determine your insurability, the Insurer may request a sample of your blood, urine or oral mucosal transudate (OMT) for testing and analysis. One of the tests will be to determine the presence or absence of antibodies to the HIV Virus. HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome).

The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antibody test is extremely reliable. If the blood, urine or oral mucosal transudate (OMT) sample is reactive within specific limits, then it is considered positive for the HIV antibody.

While positive HIV antibody test results would not mean that you have AIDS, they would mean that you would be at seriously increased risk of developing AIDS or AIDS- related conditions. Presence of antibodies in blood, urine or oral mucosal transudate (OMT) means that the person has been infected with the HIV virus. It is still possible that the person will not develop AIDS or AIDS-related conditions.

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 are immune to the virus.

You may consult, at your expense, with a personal physician or counselor or the state health department, or you may choose to obtain an anonymous test at your expense, before deciding whether to consent to testing. Such testing will not affect the status of any application or policy.

Public health officials recommend those persons who test positive for the HIV antibodies should seek counseling to become informed about the implications of the test result.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you should consult your own physician or own health care provider. Further information relative to AIDS and testing can be obtained from the Vermont AIDS Hotline at 1-800-882-2437 or at the Center for Disease Control and Prevention at 1-800-458-5231.

(over)

The Insurer will pay for this test. Neither you nor your health care provider will be billed.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The results also may be reported to its affiliates, reinsurers, medical personnel, laboratories, and insurance support organizations in connection with insurance for which you have applied. In addition, if your HIV antibody test is positive or indeterminate, a code for a nonspecific test abnormality will be made known to the Medical Information Bureau. No other disclosures will be made, except as may be required by law or as authorized by you. Please be aware that any HIV positive test result from a test performed pursuant to subdivision (20) shall be reported to the Vermont Department of Health by a unique identifier code pursuant to 18 V.S.A. Section 1001.

If a test is indeterminate, you may request in writing to be retested after 6 but no later than 8 months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any underwriting decision granting a substandard classification or exclusion based on your prior HIV-related test results will be reversed.

If you are denied insurance because you tested positive, you may request, once within three years, in writing, that the Insurer retest you. If a new test is approved by the Vermont Insurance Commissioner, you may also request retesting. If the retest is negative, the Insurer may not deny you coverage based on the initial test.

Before drawing your blood or obtaining a sample of your urine or oral mucosal transudate (OMT), you will be asked for your written informed consent.

* * * * *

**ACKNOWLEDGEMENT AND CONSENT
FOR HIV-RELATED TESTS**

I have listened to the undersigned agent read aloud this printed information statement to me. I acknowledge that I have heard and understood this material, and that I have received a copy of this information statement.

Agent

Name of Proposed Insured

Date

Signature of Proposed Insured

NOTIFICATION OF TEST RESULT

If your test results are positive or indeterminate, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician, health care provider or another person to whom the Insurer may report the test results and who may explain their meaning.

Physician or other person to whom test results may be reported:

Name: _____

Address: _____

If your test results are negative, we will send the results to you unless you ask us to send them to the physician or other person named above by checking here.

Informed Consent

I have read and I understand this Information Statement for HIV-Related Tests. Notification of Test Results, and Informed Consent form. If blood testing is required, I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. If oral mucosal transudate (OMT) testing is required, I voluntarily submit a sample of my oral mucosal transudate (OMT), and consent to the sample and the disclosure of the test results as described above. I also voluntarily submit the sample of my urine and consent to the testing of urine and the disclosure of the test results as described above.

Name of Proposed Insured

Signature of Proposed Insured Date

Birth Date

State of Residence

Medical Professional Drawing Blood