

PART 1 - MEDICAL HISTORY

LICENSED AGENT NAME (PRINT)	SOLUTION #	DRIVERS LICENSE NUMBER / STATE	POLICY NUMBER
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PROPOSED INSURED OR ANNUITANT (PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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<p>1. a. Name and address of your personal physician? _____ b. Date and reason last consulted? _____ c. What treatment was given or medication prescribed? _____</p> <p>2. In the past 10 years have you been treated for or had any indication of:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;">Yes</td> <td style="width:5%; text-align:center;">No</td> </tr> <tr> <td>a. Chest pain, angina, heart murmur, heart attack, stroke, or other disorders of the heart or blood vessels?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Nervous or mental disorders, epilepsy or paralysis?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>c. 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Syphilis, gonorrhea or genital herpes?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>3. In the past 10 years have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or immune deficiency related disorders?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>4. In the past 5 years have you been treated for or had any indication of:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;">Yes</td> <td style="width:5%; text-align:center;">No</td> </tr> <tr> <td>a. 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Arthritis or disorder of the muscles or bones, including the back, spine or joints?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>5. Are you now under observation or receiving treatment for any mental, physical or nervous condition?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>6. Other than above, have you within the last 3 years:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;">a. Had any checkup or examination, or been a patient in a hospital, clinic or sanitarium?</td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>b. 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In the past 3 years have you been postponed, rated or declined for life, health, accident, or sickness insurance?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>9. Do you smoke cigarettes now? If yes, how long? _____ years; number of packs per day? _____</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>10. a. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>b. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table> <p>11. Females only: Have you ever had any disorder of menstruation, pregnancy or of the female organs or the breasts?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;"></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> <td style="width:5%; text-align:center;"><input type="checkbox"/></td> </tr> </table>		Yes	No	a. Chest pain, angina, heart murmur, heart attack, stroke, or other disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	b. Nervous or mental disorders, epilepsy or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	c. Diabetes or elevated sugar in blood or urine?	<input type="checkbox"/>	<input type="checkbox"/>	d. Alcoholism or alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	e. Drug dependency involving narcotics, depressants, stimulants, hallucinogenics or marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	f. 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For question 7, list each name, relationship, condition, and age at death (if applicable).</p>
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I HEREBY DECLARE that to the best of my knowledge and belief, the statements and answers in this Application are full, complete, and true. These statements and answers are to be considered as the basis for any insurance written hereon. Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ this _____ day of _____, _____
City and State

X _____ X _____
Signature of Witness Signature of Proposed Insured

PRIMERICA LIFE INSURANCE COMPANY

EXECUTIVE OFFICE: 3120 Breckinridge Boulevard • Duluth, Georgia 30099-0001 • (770) 381-1000

NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, Primerica Life Insurance Company, (Primerica Life) has requested that you elect to provide samples of your blood and/or other body fluids such as saliva, for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw samples and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. You may be requested to provide a sample of your body fluids (e.g. saliva) for testing for evidence of HIV antibodies and foreign substances such as continine and cocaine. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders other than HIV.

TESTING CONSIDERATIONS

For HIV testing and analysis, you have the option of choosing to provide samples of blood or saliva. Saliva testing is a highly accurate alternative to blood testing, and requires no blood extraction or needles. Blood testing is, however, more accurate.

Many public health organizations have recommended that before taking an HIV related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Please see the back of this form for information about the availability of counseling in your area.

MEANING OF A POSITIVE TEST RESULT

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significant increased risk for 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.

Positive HIV antibody or antigen test results or other significant blood or body fluid abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary. Other Insurers to whom you may apply in the future may require an HIV related test if they find that a nonspecific blood disorder has been reported.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose a generic code which signifies only a blood test abnormality, to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the blood test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. If your HIV blood test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The results of a saliva test will be kept confidential and will not be reported to any third party, except for a person designated by you to receive such results. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting positive test results:

Name: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

CONSENT

I have read and I understand this NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING. I voluntarily consent to the withdrawal of blood from me by needle and/or the withdrawal of a body fluid sample, and the testing of that blood and/or body fluid as described above, and the disclosure of the test results as described above, including disclosure to the person, if any, indicated above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my physician or health care provider for further information and counseling if the HIV test result is abnormal. If I elected body fluid testing, I acknowledge that: 1) the agent has discussed, and I have received the information about providing a body fluid specimen, the collection device and HIV/AIDS; 2) I have read and understand this information, including that I may elect a blood or a body fluid collection method of test; and 3) I understand that I am responsible to avail myself for any necessary retesting, and if I choose not to do so, I authorize the Company to consider my inaction as my request to withdraw my application for insurance.

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 of Birth: ____ ____ ____

State of Residency: _____

Proposed Insured's Social Security Number: ____-____-____

Policy Number: _____

Date Signed by Proposed Insured: ____ ____ ____
(or Parent/Guardian)

Signature of Proposed Insured (or Parent/Guardian)



HIV