

Full Name of Person Examined (Last)	(First)	(Middle)	Place of Birth	Date of Birth	Occupation
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1. a. Name and address of your personal physician (If none,  Check) \_\_\_\_\_
- b. Date and reason last consulted? \_\_\_\_\_
- c. What treatment not listed below, was given or medication prescribed? \_\_\_\_\_

2. Have you ever been treated for or ever had any known indication of:
 

	Yes	No
a. Disorder of eyes, ears, nose, or throat? .....	<input type="radio"/>	<input type="radio"/>
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disorder? .....	<input type="radio"/>	<input type="radio"/>
c. Shortness of breath, persistent hoarseness or cough, spitting blood, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ..	<input type="radio"/>	<input type="radio"/>
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? .....	<input type="radio"/>	<input type="radio"/>
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? .....	<input type="radio"/>	<input type="radio"/>
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? .....	<input type="radio"/>	<input type="radio"/>
g. Diabetes, thyroid or other endocrine disorders? .....	<input type="radio"/>	<input type="radio"/>
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints? .....	<input type="radio"/>	<input type="radio"/>
i. Deformity, lameness or amputation? .....	<input type="radio"/>	<input type="radio"/>
j. Disorder of skin, lymph glands, cyst, tumor, or cancer? .....	<input type="radio"/>	<input type="radio"/>
k. Allergies, anemia, hemophilia, leukemia and other blood disorders? .....	<input type="radio"/>	<input type="radio"/>
3. Are you now under observation or taking treatment? .....
4. Have you had any change in weight in the past year? .....
5. Other than above, have you within the past 5 years:
  - a. Had any mental or physical disorder not listed above? .....
  - b. Had a checkup, consultation, illness, injury, surgery? .....
  - c. Been a patient in a hospital, clinic, sanatorium, or other medical facility? .....
  - d. Had electrocardiogram, X-ray, other diagnostic test? .....
  - e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? .....
6. Have you ever used barbiturates, narcotics, excitants or hallucinogens or ever sought treatment or been arrested for their use? .....
7. Have you ever sought help or treatment for alcohol use? .....
8. a. Have you ever had any disorder of menstruation, pregnancy or of the reproductive organs or breasts? .....
- b. To the best of your knowledge and belief, are you now pregnant? .....
9. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? .....
10. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability? .....
11. To the best of your knowledge and belief has any proposed insured:
  - a. Used tobacco within past 12 months? .....
  - b. Used tobacco within past 36 months? .....
  - c. Ever used tobacco products? .....

*Tobacco products means cigarettes, cigars, snuff/dip/chew, pipe*
12. Family History: (Father, Mother, Brothers, Sisters) Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? .....

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

(For additional comments, use back side)

a.	Age if Living?	Age at Death?	Cause of Death?	b.	Number Living?	Number Dead?	Age if Living?	Age at Death?	Cause of Death?
Father				Brothers					
Mother				Sisters					

The foregoing statements are full, complete, and true to the best of my knowledge and belief. Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_

(X) \_\_\_\_\_  
Signature of person examined

Witness (X) \_\_\_\_\_

Signature of Examiner \_\_\_\_\_ Degree \_\_\_\_\_

PARAMEDICAL ORGANIZATION (Please stamp or type below)



**PROVIDENT  
LIFE AND ACCIDENT  
INSURANCE COMPANY**

1 FOUNTAIN SQUARE  
CHATTANOOGA TN 37402-1338

CALIFORNIA

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

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood testing and analysis. All tests will be performed by a licensed laboratory.

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. In order to ensure a reliable result, we require that three tests be done on the blood specimen. The first is referred to as the ELISA test. If this shows the presence of antibodies, we repeat the same test. If it is again positive, we perform a different test known as the Western Blot test. This is a more specific test and if it is also positive, we can conclude the specimen does show antibodies to the AIDS virus. These tests are extremely reliable. The HIV antigen test directly identifies AIDS viral particles. Other tests which may be performed include determinations of the presence of medications, blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

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 test results to others such as its affiliates, reinsurers, employees or contractors. The persons or 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.

If your HIV test results are normal, no routine notification will be sent. If the HIV test results are other than normal, the Insurer will contact you or the person you have designated below to receive such 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.

Positive HIV antibody or antigen test results or other significant blood 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.

I have read and I understand this Notice and Consent For Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. 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. I understand that I will receive a copy of the current Red Cross Brochure, concerning AIDS at the time the blood is drawn and a list of counseling resources available. 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.

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AUTHORIZATION

In the event of a positive test, I authorize the Insurer to send the results of this test:

- Directly to me, the Proposed Insured.  
 To my personal physician (print name and address): \_\_\_\_\_  
\_\_\_\_\_  
 To other designated person (print name and address): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Insured Parent/Guardian