

**Part II**

**MEDICAL HISTORY**

If medical examination is not required; questions are to be completed by Agent.  
If medical examination is required, questions are to be completed by Medical Examiner.

<b>12. PROPOSED INSURED (Print full name in black ink)</b> <small>First Name                      Middle Name                      Last Name</small>	<b>DATE OF BIRTH</b> <small>month    day    year</small>	<b>NAME OF SOLICITING AGENT</b>
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FAMILY HISTORY OF PROPOSED INSURED					
Living Family Member	Age	State of Health	Deceased Family Member	Age at Death	Cause of Death
FATHER			FATHER		
MOTHER			MOTHER		
BROTHERS & SISTERS			BROTHERS & SISTERS		

<b>14. A. Height</b> _____ ft. _____ in.	<b>B. Weight</b> _____ lbs.	<b>C. Change in weight in past 12 months. (Give reason.)</b> lbs. Loss _____ lbs. Gain _____ Reason _____
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**15.**

A. Name and address of your personal physician: \_\_\_\_\_  
(if none, so state)

B. Date and reason last consulted: \_\_\_\_\_

C. What treatment was given or medication prescribed? \_\_\_\_\_

D. Do you take other medication? If yes, details, please.  Yes  No \_\_\_\_\_

HAVE YOU EVER HAD OR BEEN TREATED FOR:	Yes	No	GIVE FULL DETAILS OF ALL YES ANSWERS Details, Dates, Doctors Names And Addresses
A. convulsions, paralysis, neuritis, nervous breakdown, dizziness, fainting spells, nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
B. high blood pressure, chest pain, shortness of breath, palpitation, heart attack, disorder of heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
C. hemorrhage, chronic hoarseness or cough, asthma, tuberculosis, disorder of respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
D. chronic indigestion, ulcer, hernia, colitis, intestinal bleeding, disorder of stomach, gall bladder, liver, digestive or abdominal organs?	<input type="checkbox"/>	<input type="checkbox"/>	
E. kidney stone, diabetes, sugar, albumin or blood in urine, disorder of kidneys, bladder, genito-urinary organs?	<input type="checkbox"/>	<input type="checkbox"/>	
F. rheumatic fever, arthritis, gout, disorder of bones, joints, or spine?	<input type="checkbox"/>	<input type="checkbox"/>	
G. impairment of vision or hearing or disease of eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
H. tumor, cancer, venereal disease, disorder of blood, skin, thyroid, breast, ovaries, or other glands?	<input type="checkbox"/>	<input type="checkbox"/>	
I. treatment or observation in any hospital or institution? (past 5 years)	<input type="checkbox"/>	<input type="checkbox"/>	
J. X-ray or electrocardiograms? (past 5 years) When, why, by whom, with what results?	<input type="checkbox"/>	<input type="checkbox"/>	
K. treatment or consultations with any physicians or practitioners, other than as stated above? (past 5 years) Give details.	<input type="checkbox"/>	<input type="checkbox"/>	
L. Is the person proposed for insurance now pregnant? (if so, how many months?)	<input type="checkbox"/>	<input type="checkbox"/>	
M. Does proposed insured smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	

**17.**

IN THE PAST TEN YEARS HAVE YOU:	Yes	No
A. had, or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
B. received treatment in connection with any item mentioned in (A.) above?	<input type="checkbox"/>	<input type="checkbox"/>

Date \_\_\_\_\_

X \_\_\_\_\_  
Signature of Agent or Examiner

X \_\_\_\_\_  
Signature of Proposed Insured (If A Minor, Parent's Signature)



# ExamOne

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

Insurer: \_\_\_\_\_

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### 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.

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#### 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

\_\_\_\_\_  
Address