

Question #2 (continued)

i. Any disorder of the kidney, bladder, or reproductive organs? Yes No

j. Gout, arthritis, or disorder of the muscles or bone? Yes No

k. Anemia, elevated cholesterol, or any other disorder of the blood? Yes No

l. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any other disorder of the immune system? Yes No

3. Have you ever been advised to reduce or discontinue the use of alcohol? Yes No

4. Have you ever used narcotics, barbiturates, cocaine, or other habit-forming drugs, except as prescribed by a physician? Yes No

5. **OTHER THAN AS PREVIOUSLY DESCRIBED, WITHIN THE LAST 5 YEARS HAVE YOU:**

a. Consulted with any other physician or medical practitioner (besides your Primary Care Physician)? Yes No

b. Had any electrocardiograms, x-rays, blood studies, scans, or other diagnostic tests? Yes No

6. **Family History** (Please provide details in the chart below.)

Family Members	Current Age	State of Health or Cause of Death	Age at Death
Mother			
Father			
Sisters			
Brothers			

AGREEMENT

I, the proposed insured, have read the above answers and statements and they: (a) are true and complete to the best of my knowledge and belief and (b) were correctly recorded before I signed Part II of the application. I agree that if any of the above answers and statements become untrue or incomplete prior to the time the policy applied for becomes effective, I will immediately notify TIAA-CREF Life Insurance Company ("TIAA-CREF Life"). I request the examiner to forward Part II of the Life Insurance application and the report of the examiner directly to TIAA-CREF Life. I understand TIAA-CREF Life will rely upon the information provided herein, and that such statements and answers are given as an inducement to TIAA-CREF Life to consider issuing the policy as applied for.

x _____
Signature of Proposed Insured

Date

x _____
Signature of Witness

Date

MEDICAL EXAMINER'S REPORT

Instructions to the Examiner:

This examination, once begun, is the property of the TIAA-CREF Life Insurance Company ("TIAA-CREF Life"), and must not be destroyed, suppressed, or given to the Proposed Insured. Please weigh and measure the applicant and answer all questions below. All positive findings should be explained in detail in the "Remarks" section.

SECTION A

Proposed Insured's Name: _____ Social Security #: _____

The questions which appear below are intended only as a basis for the examination. TIAA-CREF Life relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested, on a separate sheet and mail it directly to TIAA-CREF Life.

1. a. Height (in shoes) _____ ft _____ in.
b. Weight (clothed) _____ lbs.
- c. Measurements (males only)
Chest (full inspiration) _____ in.
Chest (forced expiration) _____ in.
Abdomen (at umbilicus) _____ in.
2. Blood Pressure (if above 140/90 or if proposed insured has had hypertension, provide additional readings taken at intervals.)
Initial Reading _____
Additional Readings _____
3. Pulse at Rest _____
Describe any irregularities (No. per minute, etc.)

4. Urinalysis: Specific Gravity? _____ Albumin? _____ Sugar? _____
5. Have you drawn a blood specimen and mailed it to the lab along with a urine specimen? Yes No
Indicate name of lab _____
6. a. Were you acquainted with the proposed insured prior to this examination? Yes No
b. Are you the proposed insured's Primary Care Physician? Yes No
7. How did you identify the proposed insured? Driver's License Other _____

SECTION B *(Only complete this section if examination is done by a physician)*

1. After physical examination and inquiry, did you find any abnormality of the following:
 - a. Eyes, ears, nose, mouth, pharynx? Yes No
 - b. Skin (incl. scars), thyroid, lymph nodes, veins, peripheral arteries? . . . Yes No
 - c. Brain, nervous system (include reflexes, gait, coordination, paralysis)? Yes No
 - d. Respiratory system? Yes No
 - e. Stomach, abdominal organs? Yes No
 - f. Is the liver enlarged? Yes No
 - g. Genitourinary system? Yes No
 - h. Heart or blood vessels? Yes No
(If there is a history of rheumatic fever, heart murmur, or if you found any abnormality in heart size, rhythm, or sounds, complete question #2.)

Remarks

SECTION B (continued)

Remarks

- 2** To be completed if you answered "Yes" to question **Section B, 1h**
- a.** Is there evidence of cardiac enlargement or abnormal location of the apical impulse (PMI)? Yes No
 - b.** Are there any abnormalities of the first (S1) or second (S2) heart sounds? Yes No
 - c.** Are there gallops (S3 or S4)? Yes No
 - d.** Is/are there ejection sound(s) or systolic click(s)? Yes No
 - e.** Is/are there murmur(s) present? Yes No
If "Yes" fully describe under "Remarks" section including timing (systolic or diastolic), intensity (grd. 1-6), location, transmission, or radiation.
- 3.**
- a.** Are you aware of any other additional medical history findings not referenced in the above questions: (signs, symptoms, or laboratory tests/results)? Yes No
 - b.** Does the Proposed Insured appear in any way unhealthy or older than the stated age? Yes No

SECTION C

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings. Name of Proposed Insured

Examined at _____, this ____ day of _____, 20____, at _____ am/pm

Examiner's Name (print) _____
(signature) _____

D.O. M.D. Paramedic Examiner's Phone # (____) _____ - _____

Name of Paramedical Company _____ Phone # (____) _____ - _____

Address: Street _____

City _____ State _____ Zip _____



730 Third Avenue
New York, NY 10017-3206
1-800-842-2733

TIAA-CREF Life Insurance Company

**NOTICE AND CONSENT FOR BLOOD, SALIVA AND/OR URINE TESTING
WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE**

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood, saliva and/or urine 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 blood and/or collect bodily fluids and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used 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.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULT

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/screening 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.

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 test results 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 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 non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. 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.

COST OF TESTING

The cost of any testing will be borne by the Insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Blood, Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the 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.

_____ Proposed Insured _____ Date of Birth _____

Name and Address of Designated Physician:

_____ Signature of Proposed Insured or Parent/Guardian _____ Date _____ State of Residence _____

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to [Insurer's name]. Therefore, [Insurer's name] makes no representations or warranties that this information is accurate as of the date you receive this list. Also, [Insurer's name] makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE-U.S. PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 344-7432

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM - BAKERSFIELD
(805) 861-3631

CENTRAL VALLEY AIDS TEAM - FRESNO
(209) 264-2436

AIDS PROJECT - EAST BAY - OAKLAND
(415) 420-8181

SACRAMENTO AIDS FOUNDATION-SACRAMENTO
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 846-5855

SANTA CLARA COUNTY ARIS PROJECT
Campbell
(408) 370-3272

SONOMA COUNTY AIDS INFORMATION HOTLINE
(707) 579-AIDS
Social Services - Southern California

AIDS HOTLINE - SOUTHERN CALIFORNIA
(800) 922-AIDS

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA
Social Services - Southern California
Hemophilia AIDS Information
(818) 792-6192
(714) 740-2222

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services -
Office of AIDS - Sacramento
(916) 323-7415

AIDS SVCS FOUNDATION OF ORANGE COUNTY - COSTA MESA
(714) 646-0411

AIDS PROJECT - LOS ANGELES - WEST HOLLYWOOD
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SAN DIEGO AIDS PROJECT
(619) 543-0300 - City of San Diego
(619) 945-6000 - City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252

