MEDICAL EXAMINER'S REPORT

This examination should be made in private. If 3rd person present, give details.

Name | USAA # | Details of "Yes" answers. (Identify item.)

D.O.B. Mo. | Day | Yr. | Contract #

Identification: ☐ Driver's License ☐ Other ______

1. HEIGHT (IN SHOES)	WEIGHT (CLOTHED)	ABDOMEN AT UMBILICUS RELAXED
FT. IN.	LBS.	IN.

Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

Weight change in past year? _________ lbs. ☐ Gain ☐ Loss

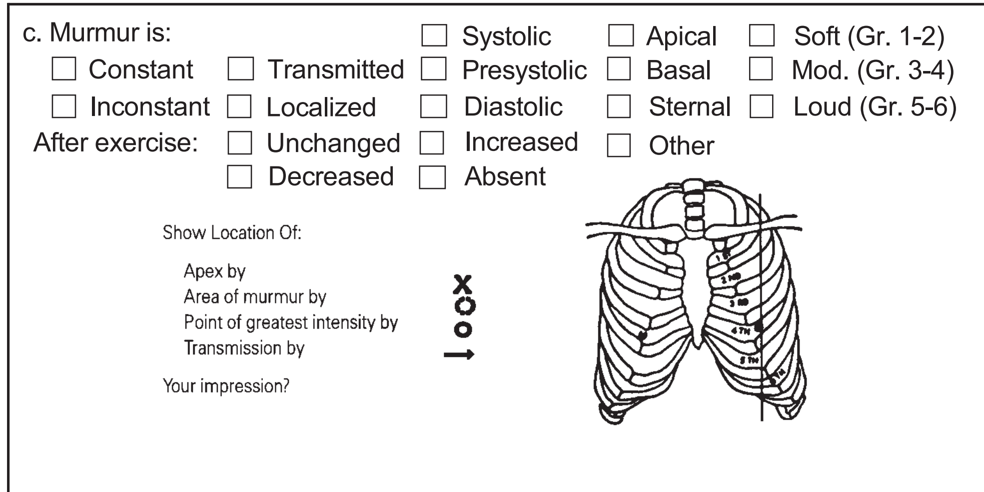
2. Blood Pressure (Record all readings)	INITIAL READING	FOLLOW UP READING IF NEEDED	If initial BP Reading exceeds 129 Systolic, or 79 Diastolic. Complete 1 Additional BP Reading.
Systolic			
Diastolic			

3. Resting Pulse:
Rate ______
Irregularities Per Min. ______

4. Heart:
a. Are there physical findings of cyanosis, dyspnea, edema, arteriosclerosis, peripheral vascular or other cardiovascular disorder? ☐ Yes ☐ No
b. Is murmur present? ☐ Yes ☐ No (If yes, complete 4c)

c. Murmur is:

☐ Constant ☐ Transmitted ☐ Systolic ☐ Apical ☐ Soft (Gr. 1-2)
☐ Inconstant ☐ Localized ☐ Presystolic ☐ Basal ☐ Mod. (Gr. 3-4)
☐ Diastolic ☐ Sternal ☐ Loud (Gr. 5-6)
After exercise: ☐ Unchanged ☐ Increased ☐ Other
☐ Decreased ☐ Absent



5. Is there on examination any abnormality of the following:
(Check applicable items and give details.)

	YES	NO
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (incl. scars); lymph nodes; blood vessels?	☐	☐
c. Nervous system (include reflexes, gait)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
6. Are there any hernias?	☐	☐
7. Have you any pertinent information not brought out above?	☐	☐

8. Urinalysis:	SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?

I certify that I made this examination on the ______ day of ______ Year ______

Examiner's signature: ______ Address ______

City ______

Examiner's name (print) ______ State ______ Zip Code ______

HIV TESTING INFORMATION STATEMENT & CONSENT FORM

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for the presence of antibodies to the HIV virus. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood, urine or oral fluids (OMT) in order to conduct the test. The insurance company will pay for this test.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Presence of antibodies in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS. A negative test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies does not mean that you are immune to the virus.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will end. You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. In addition, you may obtain an anonymous test before deciding to consent to this testing (call the Vermont AIDS Hotline for information about free testing, the number is listed below) an any delay will not affect the status of your application or policy.

You may choose to receive the test results directly or to designate in writing on the informed consent form any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health using a unique identifier code.

You have rights that include the following:

1. If a test is indeterminate, you may request in writing to be re-tested after six months, but not later than eight 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 prior decision to grant a substandard classification or exclusion based on prior HIV-related test results will be reversed;

2. If the test result of urine or oral fluids is positive or indeterminate, the insurance company must provide you with the opportunity to retest once, within 30 days following receipt of those test results. You have the option of choosing a blood, urine or oral sample for that retest.

3. If you are denied insurance because of a positive test result, you may request a retest once within the three-year period following the date of the most recent test or if an alternative test has been approved for use by the Vermont Insurance Commissioner. If such retest is negative, an insurer may not deny coverage based upon the initial test results.

It is very important to seek counseling in the event you test positive for HIV antibodies. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437 and the Centers for Disease Control and Prevention at (800) 342-2437.

You will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV antibodies.

Informed Consent

To be signed at the time when medical professional or company agent obtains sample.

This statement has been read aloud to me and I understand this ***HIV TESTING INFORMATION STATEMENT & CONSENT FORM.*** I voluntarily consent to the collection of blood, urine or OMT samples for the purpose of testing to determine if HIV antibodies are present and the disclosure of the test results as described above.

Name of Proposed Insured	Signature of Proposed Insured Date
Birth date	State of Residence
Name of Medical Professional or Company Agent Collecting Sample	Signature of Medical Professional or Company Agent

Notification of Test Results

To be completed at time of application or when a Medical Professional or company agent obtains sample.

You may choose to receive the test results directly or to designate below another person to whom the results should be sent:

PLEASE SEND MY TEST RESULTS TO:

Name

Address

City State Zip Code

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to:______________________________
Insurance Company

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:

Facility Name:______________________________

Address:______________________________ ______

____

To release any and all records and information regarding:

Patient's Name:______________________________
First Middle Last

Other Names Used:______________________________

Date of Birth:____________ Social Security Number:______________________________

Specifics to be released:______________________________

To be released to and exchanged between the insurance company first named above, and:

EMSI
P.O. Box 2505
Waco, Texas 76702-2505

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of EMSI in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

Signature of patient/guardian/personal representative: ______________________________ **Date:**______________

Legal relationship to applicant:______________________________
(Only if signed above by guardian or personal representative)

Witness signature:______________________________ ☐ **Witness Required (only if marked)**
(Only if required)

Notary signature:______________________________ ☐ **Notary Required (only of marked)**
(Only if required)

Rev. 05/14/03