

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. _____

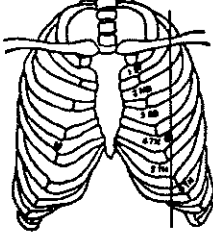
4. Heart:
 a. Are there physical findings of cyanosis, dyspnea, edema, arteriosclerosis,
 peripheral vascular or other cardiovascular disorder? Yes No
 b. Is murmur present? Yes No (If yes, complete 4c)

c. Murmur is:

<input type="checkbox"/> Systolic	<input type="checkbox"/> Apical	<input type="checkbox"/> Soft (Gr. 1-2)
<input type="checkbox"/> Constant	<input type="checkbox"/> Transmitted	<input type="checkbox"/> Presystolic
<input type="checkbox"/> Basal	<input type="checkbox"/> Mod. (Gr. 3-4)	<input type="checkbox"/> Diastolic
<input type="checkbox"/> Sternal	<input type="checkbox"/> Loud (Gr. 5-6)	<input type="checkbox"/> Inconstant
<input type="checkbox"/> Localized	<input type="checkbox"/> Absent	<input type="checkbox"/> Unchanged
<input type="checkbox"/> Increased	<input type="checkbox"/> Other	<input type="checkbox"/> Decreased

After exercise: Unchanged Increased Other

Show Location Of:

Apex by _____	LOOK ↓	
Area of murmur by _____		
Point of greatest intensity by _____		
Transmission by _____		

Your impression? _____

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.)	<input type="checkbox"/>	<input type="checkbox"/>	
b. Skin (incl. scars); lymph nodes; blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Nervous system (include reflexes, gait)?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Genitourinary system (include prostate)?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are there any hernias?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you any pertinent information not brought out above?	<input type="checkbox"/>	<input type="checkbox"/>	

8. Urinalysis: SPECIFIC GRAVITY	ALBUMIN	SUGAR	To which lab was this specimen sent?
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I certify that I made this examination on the _____ day of _____ Year _____

Examiner's signature: _____ Address _____
 City _____
 Examiner's name (print) _____ State _____ Zip Code _____



WISCONSIN NOTICE AND CONSENT FOR HUMAN IMMUNODEFICIENCY TESTING

To evaluate your insurability, USAA Life Insurance Company/USAA Life Insurance Company of New York (Insurer) requests that you be tested to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions may be based on the test results. A licensed laboratory will perform one or more tests approved by the Wisconsin Commissioner of Insurance. Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats), cotinine, cocaine, and screening for liver or kidney disorders, diabetes, and immune disorders.

PRETESTING CONSIDERATION

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provider, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous counseling and testing site and from obtaining the results of such a test. For further information on these options, contact the Wisconsin AIDSline at 1-800-334-2437.

MEANING OF POSITIVE TEST RESULTS

This is not a test for AIDS. It is a test for HIV and shows whether you have been infected by the virus. A positive test result may have an effect on your ability to obtain insurance. A positive test result does not mean that you have AIDS, but it does mean that you are at seriously increased risk of developing problems with your immune system. HIV tests are very sensitive and specific. Errors are rare but they can occur. If your test result is positive, you may wish to consider further independent testing from your physician, a public health clinic, or an anonymous HIV counseling and testing site. HIV testing may be arranged by calling the Wisconsin AIDSline at 1-800-334-2437.

NOTIFICATION OF TEST RESULTS

If your HIV test result is negative, no routine notification will be sent to you. If your HIV test result is other than normal, the Insurer will contact you and ask 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 test results.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The laboratory that does the testing will report the result to the Insurer. If necessary to process your application, the Insurer may disclose your test result to another entity such as a contractor, affiliate, or reinsurer. If your HIV test is positive, the Insurer may report it to the Medical Information Bureau (MIB, Inc.), as described in the notice given to you at the time of application. If your HIV test is negative, no report about it will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.

CONSENT

I have read and I understand this notice and consent for HIV testing. I voluntarily consent to this testing, and the disclosure of the test result as described above. A photocopy or facsimile of this form will be as valid as the original.

Name of Proposed Insured or Parent/Guardian

USAA Number

Signature of Proposed Insured or Parent/Guardian

Date

Please return a completed copy of this form and retain a copy for your records.

USAA LIFE INSURANCE COMPANY 9800 Fredericksburg Road San Antonio, Texas 78288
USAA LIFE INSURANCE COMPANY of NEW YORK Service Center 9800 Fredericksburg Road San Antonio, Texas 78288



THE IMPLICATIONS OF TESTING POSITIVE FOR HIV

A positive test result is not a diagnosis of AIDS. A positive test means that you have HIV infection. Like people with other chronic medical problems, people with HIV infection have a spectrum of conditions, ranging from no symptoms to very serious ones. Over time, most people with HIV infection progress along the spectrum toward more serious symptoms. **However, both improved medical management and many options for self-care now provide new hope for people with HIV infection.** Anti-viral drug therapy and preventive antibiotics can delay progression of HIV infection and postpone or modify complications.

It is extremely important to find a knowledgeable, experienced, and supportive health care provider to work with you in evaluating and managing your HIV infection. If you do not know whom to see, consult your local AIDS service organization for a recommendation or call the Wisconsin AIDSline to obtain a referral. **In Wisconsin, call 1-800-334-2437. In Milwaukee, call (414) 273-2437.**

Your health care provider can perform periodic examinations and arrange for appropriate tests to help you decide what treatments and interventions you may want to use. Many people with HIV infection are being successfully treated with anti-viral drugs such as zidovudine (AZT) to slow the progress of the infection. Depending on the results of certain tests of your immune system, you may also benefit from therapies to prevent some infections. People with HIV infection also need regular tuberculosis (TB) screening and certain vaccinations. You and your health care provider can work out a schedule of follow-up visits appropriate for you.

You may also want to utilize some self-care options and nonmedical therapies. A nutritious diet, regular exercise, restful sleep, stress reduction, and spiritual peace (which are important for everyone) are even more helpful for many people with HIV infection. Some people with HIV infection find strength in meditation, massage, and specialized diets. If you are HIV positive, it is healthier to avoid alcohol and recreational drugs because they may damage your immune system.

A positive test result may mean that you have to make changes in certain areas of your life. It is much easier to make these adjustments with the help and support of others. There are support groups and counselors at most AIDS service organizations. You might seek support from your partner or trusted friends, family, clergy, or health professionals.

Counseling can help you put things in perspective. Some people who test positive find that counseling assists them in handling social and intimate relationships, dealing with fear, and promoting self-esteem. Professional counseling can help lessen the effects of the numerous issues that you may face.

You have a responsibility to yourself and to others to avoid transmitting the virus. Counselors can help you sort out your feelings about intimate relationships and help you learn about HIV risk-reduction methods. Not only should you avoid infecting others, but you should also avoid getting reinfected. Getting reinfected may help speed up the process of the HIV infection you already have.

Being HIV positive means taking the right steps to maintain your health. Dealing with the fear is healthier than avoiding the knowledge of HIV infection.

For more information on HIV antibody testing and HIV related services, contact the Wisconsin AIDSline at 1-800-334-2437.

(Based on information contained in the brochure THE HIV ANTIBODY TEST, produced by the American College Health Association.)

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RESOURCES FOR PERSONS WITH POSITIVE HIV TEST

The Wisconsin AIDSline provides accurate, timely information on AIDS/HIV to people throughout Wisconsin. It offers confidential answers to your questions on the implications of a positive HIV antibody test. The Wisconsin AIDSline also provides a comprehensive listing of HIV-related medical and social services, such as dental and physician care, home care, legal aid, pastoral care, support groups, and counseling and information on Wisconsin's AIDS service organizations. To contact the Wisconsin AIDSline, call 1-800-334-2437. In Milwaukee, call (414) 273-2437.

AIDS Service Organizations (ASOs) provide direct support services to people living with AIDS and HIV infection. Services include medical referral, financial assistance, legal counsel, emotional support, referral for pastoral care, assistance with daily living needs, support groups, and comprehensive care management. Call, visit or write the ASO near you:

EAU CLAIRE	EAU CLAIRE CITY-COUNTY HEALTH DEPARTMENT 720 Second Avenue Eau Claire, WI 54703 (715) 839-4718 or (715) 839-4995	Counties served: Barron, Burnett, Buffalo, Chippewa, Clarke, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St. Croix, Washburn
GREEN BAY	CENTER PROJECT, INC. (CPI) 824 South Broadway (P.O. Box 1062) Green Bay, WI 54305 (414) 437-7400 or (414) 733-2067	Counties served: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Outagamie, Shawano
KENOSHA	SOUTHEAST WISCONSIN AIDS PROJECT (SEWAP) 6927 39th Avenue (P.O. Box 0173) Kenosha, WI 53141 (414) 657-6644 or 1-800-924-6601	Counties served: Kenosha, Racine, Walworth
LA CROSSE	LA CROSSE COUNTY HEALTH DEPARTMENT 300 North 4th Street La Crosse, WI 54601 (608) 785-9872	Counties served: Jackson, La Crosse, Monroe, Trempealeau
MADISON	MADISON AIDS SUPPORT NETWORK (MASN) 303 Lathrop Street (P.O.Box 731) Madison, WI 53701-0731 (608) 238-MASN (6276)	Counties served: Adams, Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Jefferson, Juneau, Lafayette, Richland, Rock, Sauk, Vernon
MILWAUKEE	MILWAUKEE AIDS PROJECT (MAP) 315 West Court Street (P.O. Box 92505) Milwaukee, WI 53212 (414) 273-1991	Counties served: Milwaukee, Ozaukee, Washington, Waukesha
RHINELANDER	ONEIDA COUNTY NURSING SERVICE Courthouse P.O. Box 400 Rhineland, WI 54501 (715) 369-6111	Counties served: Ashland, Bayfield, Douglas, Florence, Forest, Oneida, Price, Sawyer, Vilas
WAUSAU	CENTRAL WI AIDS NETWORK (CWAN) Marathon County Health Department Lakeview Professional Plaza 1200 Lake View Drive, Room 200 Wausau, WI 54401-6797 (715) 848-9060	Countries served: Langlade, Lincoln, Marathon, Portage, Taylor, Wood
WINNEBAGO	EAST CENTRAL AIDS/HIV ORGANIZATION (ECHO) Winnebago County Public Health 725 Butler Avenue (P.O. Box 68) Winnebago, WI 54985 (414) 235-5100 or (414) 725-2653	Counties served: Calumet, Fond du Lac, Marquette, Sheboygan, Waupaca, Waushara, Winnebago

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 required) (only if marked)

Notary signature: _____ Notary Required
(Only if required) (only if marked)