



United Home Life Insurance Company  
P.O. Box 7192 \* Indianapolis, Indiana 46207-7192

**NOTICE AND CONSENT FOR TESTING OF BIOLOGICAL SPECIMENS  
TO INCLUDE HIV (AIDS VIRUS) TESTING**

Examiner: Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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

Unless precluded by law, tests will be performed to determine the presence of HIV (the AIDS virus), its component parts, or its antibodies. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), cotinine, cocaine, 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. If a biological specimen other than blood is tested to determine the presence of HIV virus, its component parts, or its antibodies, the Insurer may at a later time request a specimen of your blood for further HIV testing. If you choose to decline that request, the results of all testing which has been performed will be provided to the physician which you have designated to receive such results. In addition, if the Insurer is a member of the MIB, Inc. and you choose to decline the request that you submit a blood specimen for further HIV testing, the Insurer will report to the MIB, Inc. a generic code which specifies only a non-specific blood test has been ordered and not received. Regardless of the number of tests requested, if the final HIV testing results (including the results of any confirmatory tests dictated by standard medical practice) 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 final HIV testing results are normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. 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.

If your HIV tests are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you to confirm the name of a physician to whom you authorize disclosure and with whom you may wish to discuss the results.

If you are a resident of Missouri and your HIV test(s) indicates confirmed infection with HIV and you have not provided the Insurer with the name of a physician to whom you authorize disclosure of test results, the Insurer will disclose test results to the Missouri Department of Health as required by law.

Positive HIV test results or other significant abnormalities detected by additional tests of biological specimens 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.

Physician \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

I have read and I understand this Notice and Consent for Testing of biological specimens, which includes HIV testing. I voluntarily consent to provide biological specimen(s) for testing, to the testing of such specimen(s) 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 information. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Proposed Insured

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date