APPENDIX A

Examiner	_____	Insured	_____
Address	_____	Address	_____
	_____		_____

NOTICE AND CONSENT FOR BLOOD, URINE, OR ORAL FLUID TESTING
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, urine, or oral fluids for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed 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. This series of tests is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) 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 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. 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 you desire, you have the right to request a complete list of the parties to whom the insurer has released test information.

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You should also be aware that the person who performs the blood, urine or oral fluid testing is subject to W. Va. Code §§16-3C-3 and 16-3C-4 which authorize that they may disclose test results to certain limited individuals under certain limited circumstances [these relate primarily to (1) persons you authorize to see the test results, (2) health care providers who may come into contact with you or specimens obtained from you, (3) the United States centers for disease control, (4) a court order to release the results, and (5) identified sex partners and persons sharing needles.] These persons are required by W. Va. Code §§16-3C-3 and 16-3C-4 to keep test information confidential.

You may direct that test results be disclosed directly to you or if you prefer to your personal physician or other health care professional. It is strongly suggested that you designate a physician or health care professional to receive your test results so that they may properly explain the results to you.

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 you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. If you have not already indicated one, the Insurer may ask you at that time 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.

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 results or other significant 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.

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I wish my test results to be released to:

(Check Please)

_____ Myself only.

_____ My physician, health care provider, or other person indicated below.

_____ Both myself and my physician, health care provider or other person indicated below.

Physician, Health Care Provider, or other person.

Name: _____

Address: _____

_____

I have read and I understand this Notice and Consent For Blood, Urine or Oral Fluid Testing Which May Include AIDS Virus HIV Antibody/Antigen Testing. I voluntarily consent to give a urine or oral fluid specimen and/or to the withdrawal of blood from me, the testing of that urine and/or blood or oral fluid, and the disclosure of the test results as described.

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

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

THIS AUTHORIZATION EXPIRES AFTER 60 DAYS