

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY TESTING

INSURER

American Life & Security Corp.

PO Box 5577 • LINCOLN NE 68505-5577

Phone: 402.489.8266 • Fax: 402.489.8295

To evaluate your eligibility for insurance coverage, it is requested by the Insurer named above that you provide a sample of your blood for testing to determine the presence of the human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be performed and that underwriting decisions will be based on the results. You may refuse to be tested; however, such refusal may be used to deny coverage or issuance of the policy.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking the AIDS related blood test a person seek counseling to become informed concerning the implications of such test. You may wish to consider counseling, at your expense, prior to being tested. To obtain information regarding counseling, you should contact your local health department.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus. A positive result does not mean that you have AIDS, but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare; however, they do occur. Your private physician, public health clinic, or an AIDS information organization may provide you with further information on the medical implications concerning a positive test result.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer and to medical personnel, laboratories, and to outside counsel who needs such information to effectively represent the Insurer in regard to your application. The results may also be disclosed to a reinsurer if the reinsurer is involved in the underwriting process. The results may be released to an insurance medical information bureau under procedures designed to assure confidentiality, including the use of general codes that also cover results for the other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity to any particular person.

NOTIFICATION OF TEST RESULT

In the event a test is positive, you authorize disclosure of the result to the following physician:

NAME: _____

ADDRESS: _____

CITY, STATE ZIP: _____

INFORMED CONSENT

I HAVE READ AND UNDERSTAND THIS NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING. I VOLUNTARILY CONSENT TO TESTING AND DISCLOSURE AS DESCRIBED ABOVE. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST AND TO RECEIVE A COPY OF THIS FORM. A PHOTOCOPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL.

Date

Signature of Proposed Insured or Parent/Guardian