

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

The United States Life Insurance Company in the City of New York, 28 Liberty Street, 45th Floor, New York, NY 10005-1400

HIV Test Informed Consent Form

Background

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your blood, urine, and/or oral fluid for testing and analysis. One of the tests is to determine the presence of antibodies to the HIV Virus. This test is actually a series of tests performed upon your blood, urine, and/or oral fluid by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Disclosure Of Test Results

All test results will be treated confidentially. The results of the test will be reported to the Insurer named above. The results also may be reported to its affiliates, reinsurers, or contractors in connection with insurance you have or for which you have applied.

In addition, if your HIV antibody test is abnormal (positive), the Insurer may request an additional sample as necessary. If the Insurer is a member of MIB, LLC (MIB) and you choose to decline that request, the Insurer will report to MIB a generic code which specifies only that a test has been ordered and not received. If the final test result for HIV antibodies is other than normal, a generic code signifying a nonspecific blood abnormality may be made known to MIB as described in the notice given you at the time of application. MIB is a membership organization of life and health insurance companies which operates as an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or make a claim for benefits to such a company, MIB, upon request, will supply the information in its file to that member. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

Positive Test Results. While positive test results do not necessarily mean that you have AIDS, they do mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with HIV and infectious to others. You should seek medical follow-up with your personal health care provider. The Insurer will contact you for the name of the health care provider to whom you may want your test results disclosed.

Test Accuracy. HIV test results are not 100% accurate. Possible errors include:

- (a) **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behaviors. Retesting should be done to help confirm the validity of a positive test.
- (b) **False negatives:** The test gives a negative result, even though you are infected with HIV. This is most likely to happen in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Risks From Having The Tests

A positive test result may cause you significant anxiety. It also will adversely affect your insurance application and may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

You Have The Right To Ask Questions And Obtain Further Information

If you have any questions relating to AIDS, the HIV test and the consequences of being tested or not being tested, you are entitled to answers to those questions by the person offering the test or other knowledgeable person before you agree to testing.



**HIV Testing and Consent
Maine Version**

Examiner _____

Other Sources Of Information

For more information about AIDS and the HIV test, you may call the Maine Bureau of Health at (207) 287-3747. You may also call the Maine AIDS Hotline at 1-800-851-AIDS.

Consent

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of blood from me by needle, the testing of my blood, urine, and/or oral fluid for HIV antibodies, and the disclosure of the test results described above.

Signature of Proposed Insured

X

Date signed _____

Proposed Insured's name (printed) _____

Date of Birth _____

State of Residence _____

Signature of Person Obtaining Consent

X

Date signed _____

Submit this page with the application



Election or Waiver of Pre-Test and Post-Test Counseling

Professional or Voluntary Pre-Test counseling is available to all proposed insureds who have been requested to undergo blood tests for HIV antibodies. HIV has been identified as the causative agent of AIDS (Acquired Immunodeficiency Syndrome). Counseling shall be provided by a Professional or Qualified Voluntary counselor selected by the proposed insured. If such counseling is sought, the Company will pay up to \$30 (thirty) for one counseling session.

PRE-TEST COUNSELING

I intend to seek pre-test counseling. (Testing will not be conducted until counseling has been received.)

Proposed Insured _____ **Date** _____

I wish to waive pre-test counseling. By signing below, I certify that:

I have been advised of the availability of pre-test counseling, and of the obligation of the Company to pay up to \$30.00 (thirty) for one (1) session of such pre-test counseling. Before signing this waiver, I read and signed an informed consent form for an HIV blood test, and that form was read aloud to me.

I voluntarily waive pre-test counseling, and neither the Company nor its agent or representative required or encouraged me to sign this waiver.

Proposed Insured _____ **Date** _____

Witness _____

CERTIFICATION OF PRE-TEST COUNSELING

Pursuant to Rule Chapter 490, it is hereby certified that the counselor whose signature appears below is qualified to provide either Professional or Voluntary counseling as defined in 5 M.R.S.A., Section 19204-A, Subsection 1.

It is further certified that counseling was provided to the proposed insured whose signature appears below.

Signature of Proposed Insured

X

Signature of Counselor

X

Date signed _____ **Date signed** _____

NOTE TO AGENT: NO TESTING IS TO BE DONE UNTIL EITHER THE WAIVER OR THE CERTIFICATION IS SIGNED.

POST-TEST COUNSELING

I wish to receive post-test counseling.

Proposed Insured _____ **Date** _____

I wish to waive post-test counseling. By signing below, I certify that:

I have been advised of the availability of post-test counseling, and of the obligation of the Company to pay up to \$30.000 (thirty) dollars for one (1) session of such post-test counseling.

I voluntarily waive post-test counseling, and neither the Company nor its agent or representative required or encouraged me to sign this waiver. I understand that if the test results are positive or indeterminant, this waiver will be void and I will be given another opportunity to receive counseling.

Proposed Insured _____ **Date** _____

Witness _____

This page is optional. If completed, submit with the application.

