HIV Testing Notice and Consent
New York Version

The United States Life Insurance Company in the City of New York
Administrative Office • P.O. Box 90503 • Amarillo, TX 79105-4003
A member of American International Group, Inc. (AIG)

Examiner _____

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The Tests. To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of a body fluid for testing and analysis. The testing will be performed by a licensed laboratory. Tests may be performed on this sample to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure which is extremely reliable.

Pre-Testing Considerations. Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

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 the Insurer's employees who have the responsibility to make underwriting decisions on behalf of the Insurer, the Insurer's affiliates, reinsurers, or legal counsel who need such information to effectively represent the Insurer in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific test abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. 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. You are also requested to designate the person to whom positive or indeterminate test results are to be reported.

1) a) ☐ Your physician or health care provider
   b) ☐ Other

Name of physician, health care provider or other designee for reporting a possible positive or indeterminate test result:

_____

Address: _____

2) ☐ Yourself

The result will be sent to you at the address provided, by registered mail with delivery restricted to you only.

Meaning of Test Results. The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred with the previous 3-6 months.

If your antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needs, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible. You may also wish to consider having further testing done by an independent testing facility. Positive HIV antibody test results will adversely affect your insurance application.

The New York Department of Health may be contacted for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services. The Department of Health's statewide toll-free number is 1-800-541-AIDS.

A negative test result means no antibodies to the HIV virus were found. Because of various incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

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 testing of my blood and the disclosure of the test results as described above. I understand that this consent shall be valid for six months following the date shown below.

Proposed Insured's Signature

X _____

Proposed Insured's Name (Printed) _____ **State of Residence** _____

Proposed Insured's signed on (date) _____ **Birth Date** _____

Submit this form with the application

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