



g. Kidney disease, renal colic, kidney stones, syphilis, any disorder of the bladder, prostate or other genitor-urinary organs?	<input type="checkbox"/>	<input type="checkbox"/>
h. Diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
i. Cancer, cyst or any other tumor or skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
j. Been diagnosed as having, or been treated, by a member of the medical profession, for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
k. Any disorder of the breast, uterus, ovaries, cervix or fallopian tubes?	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).

Item#:	Date:	Details:

4. Have you WITHIN the LAST 5 Years:	YES	NO
a. Had or been treated for any disease, injury or had an operation not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
Consulted a physician, psychiatrist or other practitioner for a general exam or any other reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been a patient in any hospital or sanitarium for any reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
5. CURRENTLY:	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you drink alcohol? If YES, please indicate how often _____ How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you experience any symptoms, disorder or have a condition that may impair your health or require an operation?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you take any medication for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
d. Are you pregnant? (If YES, give expected delivery date and pre-pregnancy weight)	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you currently use tobacco products (including cigarettes, cigars, dip, snuff, chewing tobacco and nicotine patches or gum)? <input type="checkbox"/> Yes <input type="checkbox"/> No Which statement best describes your use of tobacco products. <input type="checkbox"/> Not within the last 4 years <input type="checkbox"/> Not within last 12 months <input type="checkbox"/> Never		

f. **Current occupation:** \_\_\_\_\_

During the last 3 years, have you engaged in a hazardous occupation (such as: underground mining, high-rise construction, offshore drilling, iron work, tunnel/subway construction, explosive handling, etc.)?  Yes  No  
If yes, please provide details for the past three years:

Date: \_\_\_\_\_ Project/Duties: \_\_\_\_\_

Date: \_\_\_\_\_ Project/Duties: \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_

g. **Avocation Question:**  
**Do you participate in any hazardous activities?** (Such as: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of motorized racing)?  Yes  No  
If yes, please provide details:

Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).

<u>Item #:</u>	<u>Date:</u>	<u>Details:</u>
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<b>6. Please indicate applicant's build and family history below:</b>		<b>Please provide the complete name and address of your primary care physician:</b> Name: _____ Address: _____ Telephone: _____
Height	_____ ft. _____ in. (HGT & WGT without shoes)	
Weight	_____ lbs. Pulse at REST _____	

Did you measure: YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>7. Blood Pressure</b> (Take three, 10 minutes apart and record all three)
Did you weigh: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Has applicant gained or lost within the last year? +/- _____ lbs. Reason for loss or gain: _____	

Systolic:	(1.)	(2.)	(3.)
Diastolic:	(1.)	(2.)	(3.)

Family History	AGE	Living State of Health	AGE	Not Living Cause of Death
Father				
Mother				
Brothers Number ( )				
Sisters Number ( )				

**8. Examiner Questions:**

a. Have you reason to believe or suspect that the proposed insured is under the influence of alcohol or narcotics?  
 Yes  No

b. Are you forwarding a specimen to the lab?  
 Yes  No

c. Which of the following did you use to identify the proposed?  
 Drivers license with picture  Other picture ID  
**Please indicate below what the other picture ID is:**  
\_\_\_\_\_

I hereby declare that all statements and answers as written or printed herein are full, complete and true to the best of my knowledge and belief. I agree that they are to be considered the basis of any insurance issued hereon and no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the company's rights or requirements, or to make or alter any contract.

I hereby expressly waive, to such extent as may be lawful, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has previously attended or examined me from disclosing any knowledge or information thereby acquired, and I expressly authorize such physician or other person to make such disclosures.

**The following fraud statement is applicable to disability insurance only:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Full Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Signature of Proposed Insured: \_\_\_\_\_ Dated: \_\_\_\_\_

Witnessed by Examiner: \_\_\_\_\_ Dated: \_\_\_\_\_

**HARTFORD LIFE INSURANCE COMPANIES**  
**Individual Life Operations**  
**P.O. Box 59179**  
**Minneapolis, MN 55459-0179**  
**Telephone Number: (800) 541-6757**



## **HIV TEST INFORMED CONSENT FORM**

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

### **Human Immunodeficiency Virus (HIV)**

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against 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 new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

### **PRE-TESTING CONSIDERATION:**

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

### **DISCLOSURE OF TEST RESULTS:**

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

**HIV TEST  
INFORMED CONSENT FORM (Cont'd)**

**TEST RESULTS:**

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be 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.

**OTHER SOURCES OF INFORMATION:**

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

**CONSENT FOR HIV TESTING:**

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

**NOTIFICATION OF POSITIVE TEST RESULT**

In the event of a positive test result:

\_\_\_\_\_ Send the result to me at:

\_\_\_\_\_  
(Address)

\_\_\_\_\_ I authorize The Hartford Life Insurance Companies to send the result to another person:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_ I authorize The Hartford Life Insurance Companies to send the result to the following physician or health care provider:

\_\_\_\_\_  
(Physician's Name)

\_\_\_\_\_  
(Address)

**AUTHORIZATION**

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian, if any

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person obtaining consent

\_\_\_\_\_  
Date

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER