

PRIMERICA LIFE INSURANCE COMPANY

EXECUTIVE OFFICES: 3120 Breckinridge Boulevard • Duluth, Georgia 30099-0001 • (770) 381-1000

NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING

To help evaluate your insurability, Primerica Life Insurance Company has requested that you elect to provide samples of your blood and/or other body fluids for testing and analysis. Depending on your age, your medical history and the amount or the type of insurance applied for, you may be asked to provide a sample of blood and/or body fluids, such as saliva, for testing and analysis. All tests will be performed by a licensed laboratory. By signing and dating this form, you agree that the testing and analysis may be performed on your blood and/or other body fluid samples.

The tests to be performed will include a test to try to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test performed is actually a series of tests designed to determine the presence of these antibodies or antigens. If you have been infected with the HIV virus, which causes AIDS, your body may have produced HIV antibodies which try to get rid of the infection.

You may be requested to provide a sample of your body fluids (e.g., saliva) for testing for evidence of HIV antibodies and foreign substances such as cotinine and cocaine. You may be requested to provide a sample of your blood for testing for evidence of HIV antibodies, and for other testing such as determining blood cholesterol and related lipids (fats) and screening for diabetes, liver and kidney disorders.

TESTING CONSIDERATIONS:

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

MEANING OF A POSITIVE TEST RESULT:

Either HIV test is reliable. A blood test is more reliable than a body fluid test. You may elect which sample you prefer to provide for initial testing. In some instances, the test results may be abnormal ("positive") for persons who are not infected with the virus. Additionally, the test results may occasionally be normal ("negative") in persons who are infected with HIV, especially when the infection has occurred within the previous 6 months.

While abnormal HIV test results do not mean you have AIDS, they could mean you have a significantly increased risk of developing AIDS or AIDS-related conditions and you should consider further independent testing. Federal authorities say that persons who are HIV positive should be considered to be infected with the AIDS virus and capable of infecting others. An abnormal test result or other significant blood or body fluid abnormalities may 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.

DISCLOSURE OF POSITIVE TEST RESULTS:

All test results will be treated confidentially. The results of the test will be reported by the laboratory to the Insurer. The test results will be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who need such information to effectively advise the Insurer with regard to your application for insurance. The results also may be reported to the Insurer's affiliates or reinsurers in connection with insurance you have applied for. In addition, if you are refused insurance because your HIV test is abnormal, a generic code signifying non-specific blood abnormality will be reported to the Medical Information Bureau, Inc. (MB). Test results will not otherwise be disclosed, except as required by law or as authorized by you.

NOTIFICATION OF TEST RESULTS:

If your HIV test results are normal, no notification will be sent to you. If your HIV tests are abnormal, the Insurer will contact you, your legal guardian, or another person authorized by you.

If you wish to preauthorize another person for notification of abnormal test results, please provide the name and address below. We encourage you to authorize a physician or other health care provider for the purpose of discussing test results.

NAME, ADDRESS AND PHONE # OF PHYSICIAN OR HEALTH CARE PROVIDER (Please Print):

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

INFORMED CONSENT:

I have read and I understand this NOTICE AND CONSENT FOR BLOOD AND BODY FLUID TESTING. I voluntarily consent to the withdrawal of blood from me by needle and/or the withdrawal of a body fluid sample, and the testing of that blood and/or body fluid as described above, and the disclosure of the test results as described above, including disclosure to the person, if any, indicated above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my physician or health care provider for further information and counseling if the HIV test result is abnormal. If I elected body fluid testing, I acknowledge that: 1) the agent has discussed, and I have received the information about providing a body fluid specimen, the collection device and HIV/AIDS; 2) I have read and understand this information, including that I may elect a blood or a body fluid collection method of test; and 3) I understand that I am responsible to avail myself for any necessary retesting, and if I choose not to do so, I authorize the Company to consider my inaction as my request to withdraw my application for insurance. 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.

Name of Proposed Insured: _____

Birth Date: _____

Social Security Number of Proposed Insured: _____

Application or Policy Number: _____

Date signed by Proposed Insured: _____
(or Parent/Guardian)

Signature of Proposed Insured: _____
(or Parent/Guardian)

