

NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer indicated on Page 2 of 2 of this form (the Insurer) has requested that you provide a sample of your blood, oral fluid or urine for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw a blood sample, collect oral fluid or urine samples, and order laboratory tests only in regard to your present application for insurance. In order to perform all testing procedures, it may be necessary for you to provide more than one of these body fluid samples.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV test that we perform is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable, utilizing two ELISA tests followed by a Western Blot test to confirm positive results. Testing will proceed according to the following protocol:

1. If the initial ELISA test is negative, a negative finding will be reported to the Insurer.
2. If the initial ELISA test is positive, it will be repeated.
 - (A) If the second ELISA test is also positive, a Western Blot test will be performed to confirm the positive results of the two ELISA tests.
 - (B) If the second ELISA test is negative, a third ELISA test will be performed. If the third ELISA test is positive, a Western Blot test will be performed to confirm the previous positive results. If the third ELISA test is negative, a negative result will be reported to the Insurer.
3. Only if at least two ELISA tests and a Western Blot test are all positive will the result be reported as a positive.

Other tests to determine blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and any other condition affecting your insurability may be performed.

Positive HIV antibody or antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions.

Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact a licensed physician designated by you. You may identify the physician in the space provided on this form. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

All test results and medical information will be treated confidentially. There will be no disclosure of testing results, or medical information, except as required by law or as authorized by you.

You authorize, in connection with insurance you have or have applied for with the Insurer, the disclosure of test results to others involved solely in the underwriting process such as Insurer's affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test result for HIV antibodies/antigens is other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If the test result is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. Test results may be maintained in a file or a data bank.

Positive HIV antibody or antigen test results or other significant test result abnormalities will 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.

I have read and I understand this Notice and Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of a blood sample from me, the collection of oral fluid or urine samples, the testing of those samples, and the disclosure of the test results as described.

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.

Proposed Insured (Please Print) _____
Date of Birth

Name and address of designated Physician:

Signature of Proposed Insured or Parent/Guardian _____
Date _____
State of Residence

- | | |
|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> First Colony Life Insurance Company
P.O. Box 320
Lynchburg, VA 24505-0320 | <input type="checkbox"/> Federal Home Life Insurance Company
Administrative Office, P.O. Box 466
Lynchburg, VA 24505-0466 |
| <input type="checkbox"/> GE Life and Annuity Assurance Company
P.O. Box 27601
Richmond, VA 23261-7601 | <input type="checkbox"/> General Electric Capital Assurance Company
Administrative Office, P.O. Box 461
Lynchburg, VA 24505-0461 |