

**KENTUCKY
NOTICE AND CONSENT FOR AIDS-RELATED MEDICAL TESTING**

Insurer Name: _____ Address: _____

PURPOSE OF THIS FORM

To evaluate your eligibility for insurance, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the human immunodeficiency virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions will be based on these test results. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related blood test, a person seek counseling to become informed concerning 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 will be treated confidentially. The results of the tests will be reported to the insurer identified above. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau, Inc. (MIB), and if the test results for HIV antibody/antigens are other than normal, the Insurer will report to the MIB a generic code which signifies only a non-specific test abnormality. The organizations described in this paragraph may maintain the test results in a file or data bank. Results of the test will not otherwise be disclosed except as required or allowed by law or authorized by you.

MEANING OF POSITIVE TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at increased risk of developing AIDS or AIDS-related conditions. The tests are tests for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus.

Positive HIV antibodies test results will adversely affect your application for insurance. This means that your application will probably be declined.

NOTIFICATION OF TEST RESULT

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Cabinet for Human Resources. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have your private physician tell you the test result and explain its meaning.

Name and address of physician for reporting positive test result: _____

CONSENT

I have read and I understand this Notice and Consent form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Name of Proposed Insured _____

Proposed Insured or Parent/Guardian _____

Address _____

Date Signed _____