

**Woodmen Accident and Life Company**

1526 K Street • Box 82288  
Lincoln, Nebraska 68501-2288  
Telephone Toll-Free: (800) 869-0355

**Assurity Life Insurance Company**

1526 K Street • Box 82533  
Lincoln, Nebraska 68501-2533  
Telephone Toll-Free: (800) 869-0355

## **CALIFORNIA HIV ANTIBODY TEST INFORMATION FORM**

**ABOUT AIDS.** Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 - 50% chance of developing AIDS over the next 10 years.

**ABOUT THE TEST.** Please read the important information below before you consent to testing:

**Purpose:** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

**Positive Test Results:** If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

**Accuracy:** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

- a. **False Positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
- b. **False Negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

**Side Effects:** A positive test result may cause you significant anxiety. A positive test result may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

**Disclosure of Results:** A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you through your physician, or communicated to you directly.

**Confidentiality:** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

**Prevention:** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

**Information:** Further information about HIV testing and AIDS can be obtained by contacting your physician, your county health department, or your State Health Department.

# **AIDS COUNSELING RESOURCES**

## **San Francisco AIDS Foundation**

25 Van Ness Avenue  
Suite 660  
San Francisco, CA 94102  
(415) 864-5855

## **Sacramento AIDS Foundation**

1900 K Street  
Suite 201  
Sacramento, CA 95814  
(916) 448-2437

## **Central Valley AIDS Team**

P.O. Box 4640  
Fresno, CA 93744  
(209) 264-2436

## **AIDS Project Los Angeles**

3670 Wilshire Blvd.  
Suite 300  
Los Angeles, CA 90010  
(213) 380-2000

## **AIDS Services Foundation of Orange County**

1685-A Babcock Street  
Costa Mesa, CA 92627  
(714) 646-0411

## **San Diego AIDS Project**

3777 Fourth Avenue  
San Diego, CA 92103  
(619) 543-0300

## **AIDS Project – East Bay**

400 40th Street  
Suite 20  
Oakland, CA 94609  
(415) 420-8181

## **ARIS Project**

595 Millich Drive  
Suite 104  
Campbell, CA 95008  
(408) 370-3272

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## CALIFORNIA INFORMED CONSENT TO HIV ANTIBODY TEST

I have received and reviewed the information about AIDS, the HIV antibody test, AIDS antibody test results and AIDS Counseling Resources prior to executing this consent. I understand that I have the right to pre-test counseling prior to a test for the HIV antibody. I have had the opportunity to ask questions about the HIV antibody test and the testing procedure.

I authorize Woodmen Accident and Life Company (the "Parent Company") or Assurity Life Insurance Company (the "Subsidiary Company") and its designated medical facilities and examiners to withdraw blood from me by needle from a vein, and any testing laboratory authorized by the Parent Company or the Subsidiary Company to perform blood and urine tests as may be necessary to underwrite my application for insurance coverage. These tests may include but are not limited to tests for infection by the AIDS virus, cholesterol and related blood lipids, diabetes, hepatitis, liver or kidney disorders, immune disorders or the presence of medications, drugs, nicotine or their metabolites.

In the event of Positive Test Results for infection by the AIDS virus, I designate the following to whom positive test results are to be reported (*select one*):

My Physician named directly below at the listed address:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

I request that Positive Test Results be reported directly to me.

I understand that information regarding Positive Test Results will not be disclosed directly to me except on my specific request as indicated above, and only after a renewed opportunity to name a physician to whom results should be released. I understand that I should seek appropriate counseling in the event of Positive Test Results, and agree to seek medical follow-up in that event.

This authorization will be valid for a period of six (6) months following the date the form is signed by me. 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.

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Month, Date and Year

\_\_\_\_\_  
Signature of Proposed Insured (or Parent/Guardian)

\_\_\_\_\_  
Signature of Witness (Agent's Signature)