

**J. C. PENNEY LIFE INSURANCE COMPANY  
2700 WEST PLANO PARKWAY, PLANO, TEXAS 75075**

**NOTICE AND CONSENT FOR BLOOD OR OTHER BODILY FLUID TESTING WHICH WILL INCLUDE AIDS VIRUS (HIV)  
ANTIBODY/ANTIGEN TESTING  
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE**

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood or other bodily fluid 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 blood, or have you provide other bodily fluids, and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

**TESTS TO BE PERFORMED**

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum, plasma, or other bodily fluid specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

Oral fluid tests are less reliable than blood tests for purposes of determining HIV status. You have the option to choose either the authorized HIV blood tests (Western Blot or ELISA) or the oral fluid test. The cost of either test will be paid by the Insurer.

**MEANING OF POSITIVE TEST RESULT**

Positive HIV antibody/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.

Positive HIV antibody or antigen test/screening results or other significant blood, or other bodily fluid 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.

**CONFIDENTIALITY OF TEST RESULTS**

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. 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 involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood, oral fluid, or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

**COST OF TESTING**

The cost of any testing will be borne by the Insurer.

**NOTIFICATION OF TEST RESULTS**

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 your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

**TIME LIMIT**

This Consent shall be valid for a period of 30 months from the date noted below.

**CONSENT**

I have read and I understand this Notice of Consent for blood or other bodily fluid testing which will include HIV antibody/antigen testing. I voluntarily consent to the withdrawal of blood, or providing other bodily fluid, the testing of that sample, and the disclosure of the test results as described above.

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

\_\_\_\_\_ Date of Birth

Name and Address of Designated Physician:

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence