PACIFIC LIFE INSURANCE COMPANY
Life Insurance Operations Center
P.O. Box 6390 • Newport Beach, CA 92658-6390
(800) 347-7787

HIV CONSENT FORM - CALIFORNIA

HIV ANTIBODY TESTING CONSENT FORM

To evaluate your insurability, the insurer may request a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. This test is a three-step protocol (ELISA, ELISA AND WESTERN BLOT). A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. A test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, the County Department of Health, the State Department of Health Services, local medical societies, or alternative test sites can provide you with further information on the medical implications of a positive test.

A positive HIV antibody test will result in your application for insurance being declined.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may 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 needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should contact the AIDS Counseling Resource Office in your area. These offices are listed below:

San Francisco AIDS Foundation, 25 Van Ness Ave., Suite 660, San Francisco, California 94102, (415) 864-5855

Sacramento AIDS Foundation, 1900 K Street, Suite 201, Sacramento, California 95814, (916) 448-2437

Central Valley AIDS Team, P. O. Box 4640, Fresno, California 93744, (209) 264-2436

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

AIDS Services Foundation of Orange County, 1685-A Babcock St., Costa Mesa, California 92627, (714) 646-0411

San Diego AIDS Project, 3777 Fourth Ave., San Diego, California 92103, (619) 543-0300

AIDS Project - East Bay, 400 40th Street, Suite 20, Oakland, California 94609, (415) 420-8181

ARIS Project, 595 Millich Drive, Suite 104, Campbell, California 95008, (408) 370-3272

If your test results are negative, no routine notification will be sent to you. The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. You should request that your results be sent to your private physician so that he can interpret them for you. If you do not have a personal physician and you wish to receive the results directly, we strongly urge you to contact one of the AIDS Counseling offices listed above, or the County Department of Health.

In the event of a positive or indeterminate test result, I authorize disclosure to my personal physician:

PHYSICIAN'S INFORMATION	**Name: First**	**MI**	**Last**	
	Address			
	City		**State**	**Zip Code**

INFORMED CONSENT

I have read and understand this information. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, 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 form. A photocopy is as valid as the original. For my information, I have been given the brochure "The Truth About HIV and AIDS" information obtained by the American Red Cross.

Print Proposed Insured's Name: First MI Last	
Proposed Insured or Parent/Guardian's Signature	**Date**

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.