



# HIV Consent

Issued by American National Insurance Company  
One Moody Plaza, Galveston, TX 77550-7999

- American National Insurance Company (ANICO)
- American National Life Insurance Company of Texas (ANTEX)



## **NOTICE AND CONSENT FOR BLOOD OR OTHER BODY FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

EXAMINER \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue or urine for testing and analysis. All tests will be performed by a licensed laboratory.

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 antibody test 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. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) or cotinine or cocaine and screening for liver or kidney disorders, diabetes and immune disorders.

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 solely involved in the underwriting process. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health and if the Insurer is a member of the Medical Information Bureau (MIB, Inc.), the Insurer may report the results in a generic code which signifies only non-specific test abnormalities. If your HIV test 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. The organizations described in this paragraph may maintain the test results in a file or data bank. The test results may be disclosed as required by law. 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.



If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, your designated physician or the Florida Department of Health and Rehabilitative Services will contact you. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal medical authorities have concluded 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 results or other significant test 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 of Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of blood, oral fluid from the cheek and gum tissue or urine from me, the testing of that sample and the disclosure of the test results as described above.

In the event of a positive HIV test results, I authorize American National Insurance company to send the test results to the following physician, or in the absence of such designation the Florida Department of Health and Rehabilitative Services.

\_\_\_\_\_  
(Physician's Name)

\_\_\_\_\_  
(Physician's Address)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original.

\_\_\_\_\_  
Proposed Insured

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

\_\_\_\_\_  
Date