Police and Firemen's Insurance Association

Notice and Consent Form for Aids Virus (HIV) Antibody/Antigen Testing

Insurer Name and Address: Police and Firemen's Insurance Association
101 E. 116th Street, Carmel, Indiana 46032

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 the test results.

PRE-TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an AIDS virus (HIV) antibody/antigen 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 on this form. Results of the tests will not otherwise be disclosed, except as required by law.

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 antibody/antigen test results will adversely affect your application for insurance. This means that your application can be declined.

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.

In the event of a positive HIV test result, I authorize Police and Firemen's Insurance Association to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes.

Physician's Name	Physician's Address
Proposed Insured's Name (Printed)	Date
Signature of Proposed Insured or Parent/Guardian	Date

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