Woodmen of the World/Omaha Woodmen Life Insurance Society

A Fraternal Benefit Society OMAHA, NEBRASKA

PART III - Paramedical Examination

Proposed Insured's Name for Life Insurance

First MI Last

Date of Birth Social Security No.

Certificate No. Amount Applied For

Field Representative's Name Code

TO BE COMPLETED BY THE PROPOSED INSURED

1. Name and address of your personal physician? If none, check box ☐ _____

2. A. When did you last consult a physician? If not the personal physician, include name & address _____

   B. What symptoms or complaints did you have? _____

   C. What diagnosis was made and what treatment was prescribed? _____

3. Are you now taking any medication? Yes ☐ No ☐ If Yes, give name, dosage and reason for, if different from above information _____

4. Have you had any other illness or injury not mentioned above? Yes ☐ No ☐ If Yes, give details to include diagnosis, date, duration, treatment and name of attending physician. _____

5. In the past 12 months, have you used tobacco in any form, such as cigarettes, pipe, cigars, snuff, or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? Yes ☐ No ☐
   If Yes, date last used Mo. _____ Yr. _____ Indicate form(s) used: _____ If cigarettes, how many ppd? _____
   Have you ever used cigarettes in the past? Yes ☐ No ☐ If Yes, when did you quit? _____

The foregoing answers are true and complete to the best of my knowledge.

_____ (Date) _____ (Signature of Proposed Insured)

TO BE COMPLETED BY THE EXAMINER

6. A. Height _____ B. Weight _____ C. # Lost Past Year _____
   D. Did you measure and weigh the person? _____ E. Weight Limit for your Scale _____
7. Blood Pressure: (If above 140/90 report additional readings five minutes apart)

Systolic	_____	_____	_____
Diastolic	_____	_____	_____

8. Pulse Rate: _____ Is it regular? _____ (If no, please describe) _____
9. If female, is applicant currently menstruating? Yes ☐ No ☐

⇨ Age 13 and over, forward urine specimen to lab assigned to your paramedical company.

Affix paramed address or stamp Company name here & Phone no.

I understand that tests other than those specifically requested are not authorized, and will not be paid for by the Society. I have verified the identity of this applicant.

Signature of Examiner _____ Date _____ Daytime Phone No. _____

Printed Signature _____

Address _____ City _____ State _____ Zip _____

Form 5015 R-2/2001

Woodmen of the World Life Insurance Society

Omaha, Nebraska

Notice and Consent for HIV-Related Testing

To evaluate 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 to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. 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. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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 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.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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.

_____ _____

Name of Proposed Insured | Signature of Proposed Insured or Parent/Guardian

Address: _____ Date Signed: _____