

APPLICATION FOR HIV INDEMNITY PROTECTION INSURANCE

Employer: _____ Employee: _____ Date Hired: _____
Occupation: _____ Date of Birth: ____/____/____ Sex: ____ Annual Salary: _____
Home Address: _____
Phone Number: (Business) _____ (Home) _____ Coverage Amount selected: _____

1. For the last 90 consecutive days have you been regularly performing the duties of your occupation on a full-time basis at your usual place of employment or business? Yes No If no, please explain: _____
2. Has there been a substantial change of 10 or more pounds in your weight in the past year? Yes No
If yes, explain: _____
3. Have you consulted or been attended by a physician within the past 5 years for other than routine physical examinations, in any way curtailed your duties or altered the manner in which they were performed because of advice you received from a physician, or using any kind of medically prescribed medication or ever been told you have any disease or disorder of the lungs, bowels, nervous system, cancer or tumor, mental disorder, blood or immune disorder or chronic infection, drug or alcohol dependent, or Venereal Disease or acute mononucleosis like infection?
 Yes No If yes, explain: _____
4. During the past 5 years have you or your spouse/partner been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or being HIV Seropositive?
 Yes No
5. Have you, including routine Blood Donation purposes, ever to your knowledge been tested, received Medical Advice, Counseling or Treatment for or in connection with HIV infection or ARC? Yes No. If the Answer to the question is Yes, please give full details of the circumstances in which the test or advice was sought and full details of the result. _____
6. Have you or your spouse/partner ever had a blood transfusion? Yes No. If yes, when? Date: _____

ALL DETAILS TO ABOVE ANSWERS SHOULD INCLUDE Name of Condition, Date Occurred, Duration
I hereby authorize the necessary salary deduction for the contributions required for this coverage. _____

Signature of Employee: _____ Date: _____

AGREEMENT

I understand that the insurance applied for shall become effective on the date specified by ACE American Insurance Company (the "Company") only if this application is accepted by the Company and the first premium is paid during the lifetime of the insured. I represent that to the best of my knowledge and belief all statements and answers recorded on this application are true and complete **and that to the best of my knowledge I am HIV Negative on the date of this application.**

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or employer that has any health related records or knowledge of me or my dependents, to give to the Company or its reinsurers, all such information to use to determine eligibility for insurance or for benefits under an existing policy. This authorization shall be valid for 26 months, and a copy shall be as valid as the original. I may receive a copy upon request. I have received and read the Disclosure Notice below.

Signature of Employee: _____ Date _____

I DO NOT WANT THIS COVERAGE: Signature of Employee: _____ Date _____

INSURANCE COMPANY VALIDATION	Covered <input type="checkbox"/>	Not Covered <input type="checkbox"/>
Validation by _____	Date _____	

IMPORTANT: Detach and Retain the Disclosure Notice

DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. ACE American Insurance Company or its reinsurers, may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. ACE American Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.
INFORMATION PROCEDURES - We may need to obtain information about you from doctors or others. When necessary, we may disclose information about you to others without specific authorization. You have a right to access and correction with respect to personal information gathered. Details on these procedures will be furnished on request.