CONSENT TO BLOOD (AND OTHER BODY FLUIDS) TESTING DISCLOSURE AUTHORIZATION

ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO
Retail Life Customer Service: PO Box 5075, Minot, ND 58702-5075

ReliaStar Life Insurance Company, Minneapolis, MN
Employee Benefits Customer Service: PO Box 20, Minneapolis, MN 55440

A member of the Voya® family of companies

PURPOSE OF THIS FORM

To evaluate your eligibility for insurance, we request 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 these test results.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood of most people with AIDS and AIDS - related complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion) or from an infected mother to her new born infant. The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRETESTING CONSIDERATION

Many public health organizations have recommended that a person seek counseling to become informed concerning the implications of such tests before taking an AIDS-related blood 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. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. 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 or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, or that an increased premium may be charged.

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 need 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 test 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.

CONFIDENTIALITY OF TEST RESULTS *(Continued)*

Your test results will not be released or disclosed to any party (other than the company and related parties identified above, to whom you hereby authorize disclosure) unless:

(a) You expressly authorize their release in writing; or

(b) A public health reporting law requires disclosure; or

(c) A court order requires disclosure.

Disclosures under (b) and (c) may be made without your consent.

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 are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results means, you are asked to list your private physician so that the Insurer can have him or her tell you the test results and explain its meaning.

Name of physician for reporting a possible test result _____

Address _____

City _____ State _____ ZIP _____

If you do not wish to know the results of the test, initial here: _____. 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 will require you to name a physician at that time in order to receive the information. In some states positive results may only be disclosed to the physician you designate to receive the results. If you want to know the results of the test but do not at present have a private physician, initial here: _____. If state law permits, the result will be sent to you at the address provided by registered mail with delivery restricted to you only.

INFORMED CONSENT

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid, the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the company for life insurance will be declined.

I know that I have the right to get a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO TESTING AND DISCLOSURE AUTHORIZATION.

Proposed Insured Name _____

➤ Proposed Insured Signature _____ Date _____

State of Residence of Proposed Insured _____

Examiner Name _____

➤ Examiner Signature _____ Date _____