PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619
Birmingham, AL 35283-0619

NOTICE AND CONSENT FORM FOR TESTING TO DETERMINE EXPOSURE TO THE CAUSATIVE AGENT OF AIDS

Dear Proposed Insured:
To evaluate eligibility for insurance coverage, it is requested that a sample of blood, oral and/or urine specimen be provided for testing to determine the probable causative agents of AIDS. Before an insurer can request a specimen and perform a test, the insurer must explain the testing protocols, as established by the Director of the District of Columbia Department of Health. The insurer is also required to obtain a written consent statement from the applicant for insurance confirming that the insurer has complied with its obligations.

The signing of this form indicates that the procedure used in implementing this test has been explained and has been shown to be in full compliance with the protocol currently adopted by the Director of the Department of Health. Additionally, by signing and dating this form, it is agreed that this test may be performed and that an underwriting decision may be based on the test results.

No insurer shall request or require you to take the testing protocol without first obtaining you or your legal guardian's signature on this consent form. You have the right to decide not to be tested and not to sign this form. Once the insurance company has asked you to sign this consent form, you or your legal guardian may wait 14 days before signing this informed consent.

In the event the test result is positive, the Department of Health recommends that you or your child are immediately put in contact with an HIV (infectious disease) provider. Please see form U-462 for further information.

DISCLOSURE OF TEST RESULTS:
All information regarding the performance of the test, including the test results, will be treated confidentially. The results of the test will be reported to the insurer identified on this form; the applicant or his or her legal guardian; a physician or health care provider if designated on this form by the applicants; a court of competent jurisdiction pursuant to a lawful court order; any person or entity involved solely in the underwriting process; and any other person or entity expressly named and given separate written authorization by the applicant. Results of the test shall not be otherwise disclosed.

MEANING OF POSITIVE TEST RESULTS:
Positive test results may adversely affect your application for insurance. This means that your application may be declined, an increased premium may be charged or other changes may be necessary.

SIGNATURE AND WRITTEN CONSENT:
I have read and I understand this Notice and Consent Form. I voluntarily consent to having an AIDS test performed and disclosed as described above. I understand that I have the right to request and receive a copy of this form. A certified photocopy of this form may serve and be deemed as valid as the original.

PHYSICIAN: **and / or** **HEALTH CARE PROVIDER:**

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NOTICE OF RIGHT OF APPEAL:
We are required by law to provide you with the following information:

An applicant for insurance who tests positive under this testing protocol certified by the Director of the Department of Health may appeal to the Commissioner of the Department of Insurance, Securities and Banking to review the testing procedures and results, and may present additional medical evidence, including the result of similar tests for exposure to the probable causative agent of AIDS that the named applicant independently obtains. The Commissioner of the Department of Insurance, Securities and Banking can be reach at the following address:
810 First Street, NE, Suite 701, Washington, DC, 20002.

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Date Signature of Proposed Insured or Parent/Guardian

Original - HOME OFFICE Copy - PROPOSED INSURED