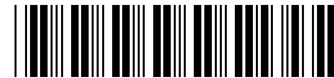


Insurer Name and Address:

GENWORTH LIFE INSURANCE COMPANY OF NEW YORK

666 Third Avenue, 9th Floor, New York, NY 10017
Mail to: Service Center, P.O. Box 10717, Lynchburg, VA 24506-0717

AUTHORIZATION AND INFORMED CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or oral fluid (saliva) for testing and analysis. In order to adequately perform all testing procedures, it may be necessary for you to provide more than one sample of your blood and/or oral fluid (saliva).

The consent you give by signing this form authorizes the Insurer to withdraw blood from you and/or obtain a sample of your oral fluid (saliva), and order laboratory tests. This consent for testing only pertains to your present application for insurance.

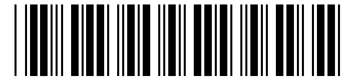
Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, or other physical conditions.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact the individual designated by you. You may identify this individual in the space provided on this form. This individual may be you, a physician, or other designee, at your discretion. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. If your test results are positive, you may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.



I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing.
My consent for testing shall be valid for six (6) months from the date of the authorized signature below.
I voluntarily consent to provide an oral fluid (saliva) sample and/or to the withdrawal of blood from me, the testing of that oral fluid (saliva) and/or blood, and the disclosure of the test results as described.

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.

______________________________	______________
Proposed Insured (Please Print)	Date of Birth

Name and address of designated recipient of other than normal test results (Designee may be a physician, yourself, or other party at your discretion):

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______________________________	______________	______________
Signature of Proposed Insured or Other Authorized Person	Date	State of Residence

For further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services, you may call the New York Department of Health's statewide toll free

AIDS HOTLINE telephone number:
1-800-541-AIDS