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Informed Consent for an HIV-Related Test

Sec. 19a-586-1. Definitions

As used in Sections 19a-586-1 to 19a-586-3, inclusive:

- (a) "Commissioner" means the Insurance Commissioner;
- (b) "AIDS" means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;
- (c) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS; and
- (d) "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection.

(Effective December 21, 1992)

Sec. 19a-586-2. Written informed consent required

(a) Any insurer or health care center that requests an applicant for insurance coverage to take an HIV-related test shall obtain the applicant's written informed consent for such test at the time of application for such insurance. No such test may be conducted unless the insurer or health care center has first obtained such consent.

(b) The informed consent form used by insurers and health care centers shall be in the standardized format described in Sec. 19a-586-3, provided any insurer or health care center may use a form which does not conform to said section if, prior to using it, (1) the alternate form is filed with the Commissioner and (2) the insurer or health care center certifies to the Commissioner that the form includes all the information contained in the standard form and is not inaccurate, misleading or inconsistent with any applicable statute or regulation. The certification shall be filed in such form and manner as is prescribed by the Commissioner, and shall be signed by an officer of the insurer or health care center.

(Effective December 21, 1992)

Sec. 19a-586-3. Standardized informed consent form

The standard form to be used by insurers in obtaining applicants' informed consent pursuant to Sec. 19a-586-2, which in the case of use by a health care center as defined in Sec. 38a-175 of the General Statutes, all references to "insurer" shall be changed to "health care center," is as follows:

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Insurer: (Name and Address)

Examiner: (Name and Address)

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). 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 newborn infant.

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. 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. Should you desire

more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

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 such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

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.

The organizations described in the last two paragraphs 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 you. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

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. 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.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Name _____ Address _____

Zip Code _____

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

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

Date of Birth

Signature of Proposed Insured
or Parent/Guardian

State of Residence

Date

(Effective December 21, 1992)