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SURROGATE APPLICATION
SECTION I – PROPOSED INSURED

PROPOSED INSURED (SURROGATE):			
First Name:	Middle:	Last Name:	
Street Address:	City:	State:	Zip:
Telephone:	Email:	SS#:	Date of Birth:

Named Intended Parent (1) herein (Part I): _____

Named Intended Parent (2) herein (Part I): _____

Surrogacy Agency (If Applicable): _____

SURROGATE APPLICATION
SECTION II – MEDICAL QUESTIONNAIRE PART 1

TODAY'S DATE: _____

Proposed Insured (Surrogate) Full Name:	List All Previous Names for Proposed Insured (Surrogate):		
Height:	Weight:	Body Mass Index (BMI): ***Leave Blank If Unknown***	Date Of Birth:

Are you a US Citizen? Select

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS:

1. I, **As Proposed Insured** confirm I have been examined and evaluated by the board certified physician listed below, certified in obstetrics and gynecology and / or specialist with qualifications in infertility medicine and reproductive endocrinology: Select
2. Exam Date: _____
3. **If you answered no:** Please explain your plan for completing your IVF Doctor examination and screening:

   _____
4. Date of Most Recent Childbirth: _____
5. If there is a medical problem with the pregnancy or the child you will be (are) carrying as a surrogate and the prospective parents want to consider an abortion or reduction, would you allow them to make that decision based on the advice of the doctors involved and the intended parents personal beliefs? Select
6. **If you answered no:** Please explain:

   _____

Name of Medical Doctor:	Telephone Number of Medical Doctor:
Name of Medical Facility or Practice:	

Street Address:	City:	State:	Zip:

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SURROGATE APPLICATION
SECTION III – PREGNANCY HISTORY

PLEASE LISTALL PREGNANCIES INCLUDING ABORTION, LIVE BIRTH, MISCARRIAGES, OR STILLBORN:

Pregnancy History:

1. How many total pregnancies have you had? 0
2. Are any of your past pregnancies more than 7 years ago? Select One
3. **If Yes:** How many pregnancies have you had that are more than 7 years ago (**Medical Records not required**)? 0

Medical Records Request: As part of the application process and Underwriting Review, you will need to obtain copies of your **OB/Prenatal Records** and **Delivery Records** for your past pregnancies. We will **not** request your medical records for your past pregnancies more than 7 years ago.

Pregnancy History In Order of Most Current to Oldest: If more than 6, please contact New Life Agency, for additional pregnancy history page(s).

Pregnancy #1	**Year:**	**Months trying to Conceive:**	**Date of Delivery:**	**Birth Weight:**	**Weeks of Gestation at Delivery:**
Pregnancy Resulted In: Choose One	**Delivery Method:** Choose One	**Number of Fetus(es):**	**Pregnancy For:** Choose One		
Complications: None	**Complications Explanation (If Applicable):**				

Pregnancy #2	**Year:**	**Months trying to Conceive:**	**Date of Delivery:**	**Birth Weight:**	**Weeks of Gestation at Delivery:**
Pregnancy Resulted In: Choose One	**Delivery Method:** Choose One	**Number of Fetus(es):**	**Pregnancy For:** Choose One		
Complications: None	**Complications Explanation (If Applicable):**				

Pregnancy #3	**Year:**	**Months trying to Conceive:**	**Date of Delivery:**	**Birth Weight:**	**Weeks of Gestation at Delivery:**
Pregnancy Resulted In: Choose One	**Delivery Method:** Choose One	**Number of Fetus(es):**	**Pregnancy For:** Choose One		
Complications: None	**Complications Explanation (If Applicable):**				

Pregnancy #4	**Year:**	**Months trying to Conceive:**	**Date of Delivery:**	**Birth Weight:**	**Weeks of Gestation at Delivery:**
Pregnancy Resulted In: Choose One	**Delivery Method:** Choose One	**Number of Fetus(es):**	**Pregnancy For:** Choose One		
Complications: None	**Complications Explanation (If Applicable):**				

Pregnancy #5	**Year:**	**Months trying to Conceive:**	**Date of Delivery:**	**Birth Weight:**	**Weeks of Gestation at Delivery:**
Pregnancy Resulted In: Choose One	**Delivery Method:** Choose One	**Number of Fetus(es):**	**Pregnancy For:** Choose One		
Complications: None	**Complications Explanation (If Applicable):**				

Pregnancy #6	**Year:**	**Months trying to Conceive:**	**Date of Delivery:**	**Birth Weight:**	**Weeks of Gestation at Delivery:**
Pregnancy Resulted In: Choose One	**Delivery Method:** Choose One	**Number of Fetus(es):**	**Pregnancy For:** Choose One		
Complications: None	**Complications Explanation (If Applicable):**				

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SURROGATE APPLICATION
SECTION IV – MEDICAL QUESTIONNAIRE PART 2

MEDICAL QUESTION	ANSWER	FURTHER CLARIFICATION REQUIRED ONLY IF ANSWERED YES TO ANY OF THE MEDICAL QUESTIONS
1. Are you currently pregnant?	Select	**When is your Expected Due Date?**
2. Have you experienced any complications with your current pregnancy?	Select	**Explain:**
3. Have any of your births been C-Section?	Select	**How many and explain:**
4. Are you planning on an automatic C-Section?	Select	**Explain:**
5. Have you ever undergone any fertility treatment to become pregnant?	Select	**Explain:**
6. Have you experienced pre-term labor in the past?	Select	**Explain and did the pre-term labor result in early delivery?**
7. Have you ever been hospitalized	Select	**What was the reason and length of time for your hospitalization?**
8. Have you ever been hospitalized on bed rest from a complication of pregnancy?	Select	**What was the reason and length of time for your bed rest?**
9. Have you ever been ordered in-home bed rest by a physician for complications of pregnancy?	Select	**What was the reason and length of time for your bed rest?**
10. Have you ever had morning sickness with any prior pregnancies?	Select	**Would you say that it was mild, moderate, or severe?**
11. Have you ever been diagnosed with hyperemia?	Select	**Explain:**
12. Have you ever had postpartum depression?	Select	**Explain:**
13. Have you had pregnancy induced hypertension?	Select	**Explain:**
14. Have you ever been diagnosed with gestational diabetes?	Select	**Explain:**
15. Have you had placental abruption?	Select	**Explain:**
16. Have you had placenta previa or placenta accreta?	Select	**Explain:**
17. Have you had preeclampsia or toxemia?	Select	**Explain:**
18. Have you ever had a positive beta strep culture of the vagina or cervix?	Select	**Explain:**
19. Do you have a menstrual cycle every month?	Select	**How many days are between each cycle?**
20. Have you ever had abnormal result on a pap smear?	Select	**What was the treatment and explain:**
21. Have any deliveries been pre-term?	Select	**Explain:**
22. Do you have special requests for OB care?	Select	**Explain:**
23. Have you been diagnosed or treated for hemorrhoids?	Select	**Explain:**
24. Have you been diagnosed or treated for Varicose Veins?	Select	**Explain:**

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SURROGATE APPLICATION
SECTION IV – MEDICAL QUESTIONNAIRE PART 2
[CONTINUED]

25. Have you been diagnosed or treated for genital warts/sores?	Select	**Explain:**
26. Have you been diagnosed or treated for Ovarian Cysts?	Select	**Explain:**
27. Have you been diagnosed or treated for pelvic inflammatory disease?	Select	**Explain:**
28. Have you been diagnosed or treated for uterine fibroids?	Select	**Explain:**
29. Have you been diagnosed or treated for gonorrhea?	Select	**Explain:**
30. Have you been diagnosed or treated for syphilis?	Select	**Explain:**
31. Have you been diagnosed or treated for chlamydia?	Select	**Explain:**
32. Have you been diagnosed or treated for hepatitis B?	Select	**Explain:**
33. Have you been diagnosed or treated for hepatitis C?	Select	**Explain:**
34. Have you been diagnosed or treated for cervical problems?	Select	**Explain:**

SURROGATE APPLICATION
SECTION V – MEDICAL HISTORY QUESTIONNAIRE PART 3

MEDICAL QUESTION	ANSWER	FURTHER CLARIFICATION REQUIRED ONLY IF ANSWERED YES TO ANY OF THE MEDICAL QUESTIONS
1. Have you ever been admitted to the hospital for an overnight stay?	Select	**How many and explain?**
2. Have you ever had a surgery?	Select	**Explain:**
3. Have you ever experienced or been treated for any complications involving major organs?	Select	**Explain: (Examples; heart, liver, lungs, kidneys, etc.)**
4. Have you ever had alcoholism, drug dependency or substance abuse?	Select	**Explain:**
5. Are you currently taking any medications?	Select	**Explain; list all medications, how long did you take them and for what conditions:**
6. Have you ever been prescribed psychiatric medications?	Select	**Explain; list all medications, how long did you take them and for what conditions:**
7. Have you been prescribed any medication in the last year?	Select	**Explain; list all medications, how long did you take them and for what conditions:**
8. Have you ever been on any long term medication therapy other than birth control?	Select	**Explain; list all medications, how long did you take them and for what conditions:**
9. Do you have immune system disorders such as lupus, Raynaud's, adrenal disorder, pituitary disorder, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or Epstein-Barr/chronic fatigue syndrome?	Select	**Explain: (list all immune system disorders applicable)**
10. Are you under treatment for AIDS/ARC with AZT, HIVID or Pentamidine therapy?	Select	**Explain; list all medications, how long did you take them and for what conditions:**

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SURROGATE APPLICATION
SECTION V – MEDICAL HISTORY QUESTIONNAIRE PART 3
[CONTINUED]

11. Do you have any medical problems not mentioned on this application in the past or currently?	Select	**Explain;**
12. Do you drink alcoholic beverages?	Select	**Explain:**
13. Have you taken any illegal drug in the past?	Select	**Explain: (Give what year and how long you were taking the illegal drug)**
14. Have you taken any prescription drug which you did not have a current, valid prescription?	Select	**Explain: (Give what year and how long you were taking the prescription drug)**
15. Do you smoke or use tobacco in any form now or in the past?	Select	**Explain:**
16. Does your partner smoke cigarettes?	Select	**Explain: (Give locations where they smoke)**
17. Are you currently sexually active?	Select	**NO EXPLANATION REQUIRED**
18. Are you exposed to any second hand smoke at work, home, etc.?	Select	**Explain:**
19. Have you or your partner had a tattoo and or body piercing (other than ear) within the last 12 months? **Please note: It is critical to not have any new tattoos or piercings until completion of the surrogacy.**	Select	**Explain:**
20. Have you had TB or been exposed to TB?	Select	**Explain:**
21. Have you had a Hepatitis B Vaccination?	Select	**Explain: (Provide year of last vaccination)**
22. Have you had any problems with your heart or circulatory, such as: chest pain, angina, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, valve replacement, pacemaker, deliberator, blood clot, phlebitis, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, Raynaud's?	Select	**Explain:**
23. Have you had any problems with your brain or nerves such as: frequent and or severe headaches, migraines, seizures, epilepsy, dizziness, weakness fainting, numbness / tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, sleep apnea, narcolepsy, used a sleep monitoring device?	Select	**Explain:**
24. Have you had any problems with your lungs or respiratory such as allergies, infections, sinusitis, asthma bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, shortness of breath, spitting or coughing up blood?	Select	**Explain:**
25. Have you had any problems with your digestive system such as tonsillitis infection of the mouth/throat, jaw/chewing problems, gastric reflux, ulcers, hernia, colitis, intestinal problems, diarrhea rectal problems/bleeding polyps, hemorrhoids, gallbladder, pancreatic, liver disease, cirrhosis, hepatitis, jaundice, unexplained weight loss?	Select	**Explain:**
26. Have you had any problems with your urinary system such as kidney, bladder, urinary tract infections, stones, urinary incontinence, and blood in urine?	Select	**Explain:**

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SURROGATE APPLICATION
SECTION V – MEDICAL HISTORY QUESTIONNAIRE PART 3
[CONTINUED]

27. Have you had any problems with your female reproductive system such as breast disorder/cysts, lump, breast implants, fibroid tumors endometriosis, pelvic pain, menstruation disorder, abnormal/absent menstrual bleeding, uterine fibroids, ovarian cysts, infertility?	Select	**Explain:**
28. Have you had any problems with your musculoskeletal such as bone joint and/or muscle pain, injury or disorder of join /tendon/ ligament/disc, weakness of back/spine/joint amputation, physical handicap, polio, arthritis, gout, sprain/strain, prostheses, joint replacement, hardware, internal fixations (i.e. pins, plates, screws), fractures, Temporomandibular joint?	Select	**Explain:**
29. Have you had any problems with your endocrine/metabolic such as diabetes, thyroid, anemia, or adrenal?	Select	**Explain:**
30. Have you been diagnosed or treated for back or neck problems?	Select	**Explain:**
31. Have you been diagnosed or treated for cancer?	Select	**Explain:**
32. Have you been diagnosed or treated for asthma?	Select	**Explain:**
33. Have you been diagnosed or treated for migraine headaches?	Select	**Explain:**
34. Have you been diagnosed or treated for thyroid problems?	Select	**Explain:**
35. Have you been diagnosed or treated for seizures?	Select	**Explain:**
36. Have you been diagnosed or treated for diabetes?	Select	**Explain:**
37. Have you been diagnosed or treated for anemia?	Select	**Explain:**
38. Have you been diagnosed or treated for high cholesterol?	Select	**Explain:**
39. Have you been diagnosed or treated for eating disorders?	Select	**Explain:**
40. Have you been diagnosed or treated for schizophrenia?	Select	**Explain:**
41. Have you been diagnosed or treated for suicide/attempted suicide?	Select	**Explain:**
42. Have you been diagnosed or treated for depression?	Select	**Explain:**
43. Have you been diagnosed or treated for nervous breakdown(s)?	Select	**Explain:**
44. Have you been diagnosed or treated for congenital heart defect?	Select	**Explain:**
45. Have you been diagnosed or treated for head injuries?	Select	**Explain:**
46. Have you ever been declined for health insurance?	Select	**Explain:**
47. Have you ever been declined for life insurance?	Select	**Explain:**

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SURROGATE APPLICATION
SECTION VI

MEDICAL COVERAGE APPLICATION AUTHORIZATION, UNDERSTANDINGS AND CONDITIONS

Statement: I as the Proposed Insured (Surrogate), declare that all information given on this Medical Questionnaire is true and complete and that nothing which might influence Insurers has been withheld. I understand that I have a duty to disclose circumstances material to the insurance, or a change to the information supplied prior to attachment of the proposed insurance. I understand that failure to provide such information may render the insurance invalid.

I, as the Proposed Insured (Surrogate), hereby agree to authorize any licensed physician, medical practitioner, hospital, clinic, third party administrator or other medically related facility, insurance company or other organization, institution or person, that has records or knowledge of me or my health, to release any such information to New Life Agency, Inc Cover holders or its representatives or the Intended Parent(s) designated above herein Part I of this application.

I, as the Proposed Insured (Surrogate), agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that Pre-Existing Conditions are not covered. Should the insurance be effected the date will ONLY be in force for 90 days from effected date and if exhausted a new application must be completed and must go through proper underwriting procedures not guaranteed to be effected.

NOTICE: THIS FORM CONTAINS PRIVATE AND CONFIDENTIAL MEDICAL INFORMATION AND MUST BE RETURNED DIRECTLY TO NEW LIFE AGENCY, INC.

By signing this statement, I the Proposed Insured (Surrogate) verify that I have read the Application Authorization, Understandings and Conditions listed above and that all of the information completed on the following application is true and correct. I acknowledged receipt of a copy of this notice.

A photographic facsimile copy of this authorization and/or the electronic signature shall be considered valid as original document and/or signature.

Signed This Date: _____

Proposed Insured (Surrogate): _____

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SURROGATE APPLICATION
SECTION VII

IN-NETWORK MEDICAL PROVIDER(S) INFORMATION:			
PLEASE STATE BELOW YOUR CHOICE OF OBSTETRICIAN AND ANTICIPATED DELIVERY HOSPITAL YOU WILL UTILIZE DURING YOUR PREGNANCY. IN-NETWORK PROVIDERS WILL NEED TO BE UTILIZED DURING YOUR PREGNANCY. OUR MEMBER SERVICES DIVISION WILL CONFIRM YOUR CHOICES BELOW AT TIME OF ENROLLMENT OR AT CONFIRMATION OF PREGNANCY.			
DESIRED OR CURRENT OBSTETRICIAN:			
Name of Medical Doctor:	Telephone Number of Medical Doctor:		
Name of Medical Facility or Practice:			
Street Address:	City:	State:	Zip:
ANTICIPATED DELIVERY HOSPITAL:			
Name of Medical Facility:	Telephone Number of Medical Facility:		
Street Address:	City:	State:	Zip:
CURRENT MEDICAL COVERAGE: (If Applicable)			
Name of Insurance Company:	Name of Plan Type: (HMO or PPO)		
Member ID: (If Available)	Who is covered under your plan: (Self, Husband, or Family)		
Monthly or Annual Premium:	Deductible Per Year:		

SURROGATE APPLICATION
SECTION VIII

MEDICAL RECORDS RELEASE and IN-NETWORK PROVIDER(S) ACKNOWLEDGEMENT

I, as the Proposed Insured (Surrogate), hereby agree to authorize any licensed physician, medical practitioner, hospital, clinic, third party administrator or other medically related facility, insurance company or other organization, institution or person, that has records or knowledge of me or my health, to release any such information to New Life Agency, Inc Cover holders or its representatives or the Intended Parent(s) designated above herein Part I of this application.

The same authorized entities may have access to my medical records for the purpose of mitigating any cost possible during my term as a Surrogate and twenty-four months after my delivery including but not limited to negotiation with my doctors and other providers of services including medical care facilities for the purpose of their consideration, review and / or processing of claims for medical expense. I agree to provide any information as needed and / or requested by Underwriters, New Life Agency, Inc. or their authorized Administrator(s).

I, as the Proposed Insured (Surrogate), agree to use In-Network Providers or PPO Network doctors and medical service providers that are part of New Life Agency, Inc. network of approved providers, whenever possible. The Company and/or authorized Administrator on behalf of the Intended Parent(s) designated above herein Part I of this application, will provide me with a toll free number, for my convenience and if necessary, to access the Company's authorized Administrator's office during normal business hours, to obtain any required information needed to use network doctors and/or facilities.

I, as the Proposed Insured (Surrogate), understand that Underwriters, New Life Agency, Inc. or their authorized Administrator and/or any of their employees do not provide medical advice and are not responsible for any medical care obtained from a network or non-network provider of services. Moreover, I understand that the Company, New Life Agency, Inc., Administrator, and /or any of their employees are not responsible for the quality of medical care received.

By signing this statement, I the Proposed Insured (Surrogate) verify that I have read the Application Authorization, Understandings and Conditions listed above and that all of the information completed on the following application is true and correct. I acknowledged receipt of a copy of this notice.

A photographic facsimile copy of this authorization and/or the electronic signature shall be considered valid as original document and/or signature.

Signed This Date: _____

Proposed Insured (Surrogate): _____

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SURROGATE APPLICATION
SECTION IX
SURROGATE ACCIDENTAL DEATH INSURANCE®

PROPOSED INSURED(SURROGATE) BENEFICIARY INFORMATION			
First Name:	Middle:	Last Name:	
Street Address:	City:	State:	Zip:
Beneficiary's Relationship to Proposed Insured : (i.e. Husband, Child, or Other Family Member)	Telephone:		

This coverage applies only to the Insured AND Intended Parent(s) in respect of death that occurs only to the Insured as a result of:

1) Carrying or giving birth for the Intended Parent(s) named herein.

ACCIDENTAL DEATH: If carrying or giving birth for the Intended Parent(s) named herein results Death within the effective date of the certificate, the Underwriters will pay 100% of the maximum sum insured designated to the beneficiaries below:

1) Insureds' Beneficiary(s) Equally: US $250,000

2) Intended Parent(s): US $100,000

A photographic facsimile copy of this authorization and/or the electronic signature shall be considered valid as original document and/or signature.

Signed This Date: _____

Proposed Insured (Surrogate): _____

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SURROGATE APPLICATION
SECTION XI

AUTHORIZATION TO RELEASE PERSONAL INFORMATION – HIPPAA COMPLIANT

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me to provide to **New Life Agency, Inc.** or to any agency authorized by New Life Agency, Inc. to collect any and all such information by means of U.S. Post , fax or e-mail. **INITIAL HERE:** _____

I UNDERSTAND that the information in my health record may include information relating to sexually transmitted disease(s) (STD's), AIDS or HIV. It also may include information about behavioral or mental health services and treatment for alcohol and drug abuse. **INITIAL HERE:** _____

I AUTHORIZE New Life Agency, Inc. to communicate with me or my representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, or additional coverage's from New Life agency, Inc.. **INITIAL HERE:** _____

I UNDERSTAND the purpose of this Authorization is to allow New Life Agency, Inc. to determine eligibility and claim payment for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by New Life Agency, Inc. to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize. **INITIAL HERE:** _____

I KNOW that I may request to receive a copy of this Authorization. **INITIAL HERE:** _____

I UNDERSTAND that I may revoke this Authorization, except to the extent that New Life Agency, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to New Life Agency, Inc. Any such revocation may also have an impact upon my Underwriting or claims processing. **INITIAL HERE:** _____

I UNDERSTAND that I can obtain a complete copy of New Life Agency, Inc. Privacy Policy either on New Life Agency, Inc. website or by contacting them directly and asking for a copy. **INITIAL HERE:** _____

I AGREE this Authorization shall be valid for two years from the date shown below. **INITIAL HERE:** _____

PATIENT INFORMATION:				
First Name:	Middle:	Last Name:		
Street Address:	City:	State:	Zip:	
SS#:	Date of Birth:			

A photographic facsimile copy of this authorization and/or the electronic signature shall be considered valid as original document and/or signature.

Signed This Date: _____

Patient Signature: _____

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SURROGATE APPLICATION
SECTION XII

NOTICE

1. **THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.**
2. **THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
3. **THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
4. **CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEBSITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
5. **FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-928-4357.**
6. **IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

PRIVACY POLICY STATEMENT

New Life Agency, Inc. Lloyd's Coverholder

New Life Agency, Inc. Lloyd's Coverholder wants you to understand how we protect the confidentiality of non-public personal information we collect about you.

Information We Collect

We collect non-public information about you from numerous sources including, but not limited to:
a) Information we receive from you on applications and other forms;
b) Information about your transactions with our affiliates, others or us;
c) Information we receive from consumer-reporting agencies; and d) Financial and medical sources.

Information We Disclose

We do not disclose any non-public information about you to anyone except as necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud, investigation, regulatory reporting, etc.).

Right to access or correct your personal information

You have a right to request access to or correction of your personal information in our possession.

Confidentiality and Security

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your nonpublic personal information.

Contacting Us

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at:

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Rancho Mirage, CA 92270
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Fax (877) 952-5589