New Life Agency inc.
a new world of insurance
p 877.952.life(5433) f 877.952.5589 newlifeagency.com info@newlifeagency.com
41-750 Rancho Las Palmas Drive, Suite F-1 Rancho Mirage, CA 92270

INTENDED PARENT(S) APPLICATION
SECTION I - PLAN SELECTION PAGE

I (We), as the Intended Parent(s), am (are) requesting the following New Life Agency Plan(s):
Please check all that apply:

Primary Plan:

- ☐ Surrogate Maternity Care & Cycle Medical Plan® - Platinum Comprehensive
- ☐ Surrogate Maternity Care® - Platinum
- ☐ The Affordable Surrogate Maternity Care & Cycle Medical Plan® - Major Comprehensive
- ☐ The Affordable Surrogate Maternity Care® - Major
- ☐ None

Back Up Plan:

- ☐ Surrogate Maternity Care® - Platinum Back Up Plan – 3000
- ☐ The Affordable Surrogate Maternity Care® - Major Back Up Plan - 3000
- ☐ None

Newborn Plan:

- ☐ The Affordable International Newborn Care Plan® - Major
- ☐ International Newborn Care Plan® - Silver
- ☐ International Newborn Care Plan® - Gold
- ☐ International Newborn Care Plan® - Platinum
- ☐ None

Other Plan Options:

- ☐ Surrogate Accidental Death Insurance®
- ☐ IVF Cycle Complication Insurance Coverage®
- ☐ Fertility Pharmacy Care Card®
- ☐ None

Please send you're completed and signed application to New Life Agency, Inc.
Scan & Email: info@newlifeagency.com
Toll Free Fax: 877.952.5589 | Option 2

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INTENDED PARENT(S) APPLICATION

SECTION II – INTENDED PARENT INFORMATION

INTENDED PARENT(S):

Intended Parent (#1):		SSN#:		DOB:
Passport #:	Driver License #:	Passport Country:		
Street Address:	City:	State:	Zip:	Country:
Telephone:		Email:		
Intended Parent (#2):		SSN#:		DOB:
Passport #:	Driver License #:	Passport Country:		
Street Address: *(Indicate "Same As Above" If Applicable)*	City:	State:	Zip:	Country:
Telephone:		Email:		

PROPOSED INSURED (Surrogate): _____

SURROGACY AGENCY (If Applicable): _____

My (Our) Surrogate, designated above and the named Insured (Surrogate) herein (Part II), is applying for coverage to protect my (our) liability for payment of medical expenses. (We) attach the policy premium with this application. Should the Company not accept my application, I (We) will receive a total refund of the policy premium paid. I (We) authorize the Company to obtain any reports they deem necessary to underwrite coverage's, including but not limited to financial ability to pay the self-insured retention, credit, character and an evaluation of the Surrogate.

I (We) understand that approval of this application is not to be construed as approval by the Company of the person I (We) selected as Surrogate for any purpose whatsoever. I (We) agree to instruct Named Surrogate to use In-Network Providers or PPO Network doctors and medical service providers that are a part of the Surrogate Maternity Policy whenever possible from lists available in hard copy and/or internet online.

Neither the Company, New Life Agency, Inc. their employees and /or administrators are a party to my contract with the Surrogate. As such, I (We) understand that, either the Company, New Life Agency, Inc., their employees and/or administrators assume any responsibility for the outcome of the Surrogate relationship. I (We) accept that this policy is to be used in conjunction with the Surrogate Maternity Policy offered through New Life Agency, Inc. Lloyd's Coverholders.

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: _____

Intended Parent (1): _____

Intended Parent (2): _____

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INTENDED PARENT(S) APPLICATION

SECTION III – ASSUMING FINANCIAL RESPONSIBILITY

INTENDED PARENT(S): (PERSON(s) APPLYING / ASSUMING FINANCIAL RESPONSIBILITY)

Intended Parent (#1):
Intended Parent (#2):

PROPOSED INSURED (Surrogate): _____

SURROGACY AGENCY (If Applicable): _____

I (We) authorize the Company to obtain any reports they deem necessary to negotiate claims of the named Surrogate herein (Part II) as a result of surrogate pregnancy. I (We) agree to pay the negotiated usual and customary medical bills within (30) days from the date received by a method satisfactory to Medical Service Providers, Underwriters and/or their authorized representative.

I (We) understand that approval of the negotiated discounts are predicated on the negotiated discounted usual and customary medical bills being paid by the Intended Parents within (30) days directly to the medical care provider.

I (We) 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 (We) 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.

I (We) hereby agree to authorize New Life Agency, Inc. Coverholders and its third party administrator, representatives, licensed physician, medical practitioner, hospital, clinic, and other medically related facility, insurance company and other organization, institution or person, that has knowledge of my Surrogates health, to release my (our) personal information for the purpose of mitigating any cost related to the medical plan I (We) am/are applying.

If I (We) do not make certain that the negotiated discounted bills are paid within (30) days, I (We) understand that the approved negotiated discount will be waived and I (We) will be responsible for payment of the entire amount of the original, usual and customary medical bills.

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: _____

Intended Parent (1): _____

Intended Parent (2): _____

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INTENDED PARENT(S) APPLICATION
SECTION IV – MEDICAL QUESTIONNAIRE

TODAY'S DATE: _____

PROPOSED INSURED (Surrogate): _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS:

Select I (We), as the Intended Parent(s), am (are) utilizing a Board Certified Physician in Obstetrics and Gynecology and/or Specialist with qualifications in Infertility Medicine and Reproductive Endocrinology for the above stated Insured (Surrogate).

Select I (We), as the Intended Parent(s) confirm the above stated Surrogate has been examined and evaluated by the Medical Doctor listed below.
Examination Date: _____

Select A Medical Doctor has performed testing recommended by ASRM on the Surrogate and performed testing mandated on the egg/sperm donor. I (We), as the Intended Parent(s) verify the results met or did meet necessary standards to clear and proceed with the Insured (Surrogate) listed above.

Select Is your Surrogate pregnant? **If Yes**: I (We), as the Intended Parent(s) verify the Medical Doctor below has completed routine maternity care that has met necessary standards and no discovery of in-utero complications have been found. Select

Select **In-Utero and/or Pregnancy Adverse Findings:** The Medical Doctor named below has found adverse findings on the proposed Insured (Surrogate) named above: The adverse findings are:

(Note - if there were no adverse findings, please state NONE.)

Select The Medical Facility or Practice named below is administering the IVF treatments/procedures. **If No:** Complete next page – Section V.

I acknowledge receipt of the following specimen certificates for (check all applicable boxes):

☐ Maternity Specimen Certificate ☐ Newborn Specimen Certificate ☐ Accidental Death Specimen Certificate ☐ IVF Complication Specimen Certificate

Name of Medical Doctor:			Telephone Number of Medical Doctor:
Name of Medical Facility or Practice:			
Street Address:	City:	State:	Zip:

Statement: I (We) declare that all information given on this Medical Questionnaire is true and complete and that nothing which might influence Insurers has been withheld. I (We) understand that I (We) 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 (We) 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.

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

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: _____

Intended Parent (1): _____

Intended Parent (2): _____

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INTENDED PARENT(S) APPLICATION
SECTION V – CYCLE MEDICAL QUESTIONNAIRE
Please proceed to SECTION VI (next page) if this section does not apply.

TODAY'S DATE: _____

PROPOSED DONOR: (List Full Name, Donor ID Number, Frozen Cycle, or Not Applicable): _____

EGG DONOR AGENCY (If Applicable): _____

START DATE OF CYCLE (List Medication Start Date, Initial Cycle Start Date, TBD, or Not Applicable): _____

CYCLE NUMBER WITH CURRENT RECIPIENT: (i.e. 1st, 2nd, 3rd, or Not Applicable): _____

NAME OF FACILITY AND DOCTOR PHYSICALLY ADMINISTERING THE DONOR and/or IVF TREATMENT/PROCEDURES:

Name of Medical Doctor:		Telephone Number of Medical Doctor:	
Name of Medical Facility or Practice:			
Street Address:	City:	State:	Zip:

It is a condition and warranty that individual donors are donor candidates in good health; medically examined, interviewed and cleared by a Board Certified Reproductive Endocrinologist. Moreover, that participating donors do not suffer from any pre-existing conditions, illnesses or diseases; the knowledge of which would prevent the donor from being acceptable to the cycle coverage. This coverage is ONLY for complications resulting from the cycle.

The Intended Parent shall notify New Life Agency, Inc. upon any change in the stated proposed donor above and New Cycle Medical Questionnaire must be completed.

The industry professional who is administering the donor treatment must be a Board Certified Endocrinologist for minimum of (3) years for your donor to receive coverage. Any fraud, misstatement or concealment, in the statement made by or on behalf of the insured person prior to the commencement of the cycle procedures or any fraudulent claim made thereunder shall render this insurance null and void and all claims thereunder shall be forfeited.

Claim Notification: As soon as reasonably practical of any accident or illness which may give rise to a claim under this insurance, contact New Life Agency Member Services Division at:

New Life Agency, Inc. Member Services
41-750 Rancho Las Palmas Drive, Suite F-1
Rancho Mirage, CA 92270
Tel: 877-952-5443

Statement: I (We) declare that all information given on this Medical Questionnaire is true and complete and that nothing which might influence Insurers has been withheld. I (We) understand that I (We) 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 (We) 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.
A photographic facsimile copy of this authorization shall be considered valid as original.

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

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: _____

Intended Parent (1): _____

Intended Parent (2): _____

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INTENDED PARENT(S) APPLICATION
SECTION VI – ENROLLMENT FEE AGREEMENT

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.**

Enrollment Fee Agreement:

1. The parties to this Agreement are Intended Parent(s) (Client) and New Life Agency, Inc., California Department of Insurance License Number 0F13013 (Broker).

2. Client appoints Broker as client's insurance Broker of Record.

3. This Agreement shall become operative on the effective date as stated in the Sample Certificate of Coverage and shall continue in full force until terminated by either party or by expiration of policy terms.

4. Broker agrees to represent client honestly and competently.

5. The Enrollment Fee vary dependent upon insurance product plan selected. The schedule of Enrollment Fees are as follows:

- Surrogate Maternity Care & Cycle Medical Plan® - Platinum, Major - Comprehensive – **Enrollment Fee - $4,800.00**

- Surrogate Maternity Care® - Platinum - **Enrollment Fee - $1,000.00**
- Surrogate Maternity Care® - Major - **Enrollment Fee - $500.00**

- Surrogate Maternity Care® - Platinum, Major - Back Up 3000 Plan - **Enrollment Fee - $3,000.00**

- The Affordable International Newborn Care Plan® - Major - **Enrollment Fee - $500.00**
- International Newborn Care Plan® - Platinum, Gold, Silver - **Enrollment Fee - $1,000.00**

- Surrogate Accidental Death Insurance® - **No Enrollment Fee**

6. The Enrollment Fee is refundable in the event of no confirmed pregnancy for any of the Surrogate Maternity Care® Insurance options. (Platinum Comprehensive, Major Comprehensive, Platinum, and Major).

7. The Enrollment Fee is refundable in the event of no live birth for the any of the International Newborn Care Plan® options.

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: _____

Intended Parent (1): _____

Intended Parent (2): _____

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INTENDED PARENT(S) APPLICATION
SECTION VII – 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:

41-750 Rancho Las Palmas Drive, Suite F-1
Rancho Mirage, CA 92270
Tel (877) 952-5433 (LIFE)
Fax (877) 952-5589