LOCKTON, LLOYD'S COVERHOLDER
UNIVERSAL FAMILY INSURANCE, LLC
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

INTENDED PARENTS, PLAN APPLICATION FORM, NO COVERAGE GIVEN

PART I of III (GENERAL INFORMATION)

Applicant, Intended Parent(s) applying for insurance on behalf of their Surrogate and assuming financial responsibility of maternity medical expenses; please PRINT all requested information clearly, thank you:

Name of Applicant, Intended Parent (#1): ____

SSN #: ________________________________, **IF NOT A U.S. CITIZEN THEN PLEASE COMPLETE PASSPORT INFORMATION,**

COUNTRY OF ISSUANCE: ____________________________ **PASSPORT #:**___________________________

Telephone: ____________________________________**Email:** __________________________________

Name of Applicant, Intended Parent (#2): ____

SSN #: ________________________________, **IF NOT A U.S. CITIZEN THEN PLEASE COMPLETE PASSPORT INFORMATION,**

COUNTRY OF ISSUANCE: ____________________________ **PASSPORT #:**___________________________

Telephone: ____________________________________**Email:** __________________________________

Applicant, Intended Parents:

____
(Street Address)

____
(City) (State) (Country) (Postal Code)

Name of Surrogate, contracted with Intended Parents: ____
(PLEASE PRINT SURROGATE'S LEGAL NAME)

Date of Birth: ________/_______/_________ Social Security Number: _______- ______ - ___________

____
(Street Address)

____
(City) (State) (Postal Code)

____
(Telephone) (Email)

PRIVATE AND CONFIDENTIAL
A photographic copy or facsimile of this document shall be considered as valid as if the original.

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PART I OF III (GENERAL INFORMATION, Continued)

SURROGACY AGENCY:

Name of Surrogacy Agency: ____

____
(Street Address)

____
(City) (State) (Country) (Postal Code)

____
(Telephone) (Email)

IVF MEDICAL INFORMATION:

Name of IVF Clinic: ____ ___________________________________

____
(Street Address)

____
(City) (State) (Country) (Postal Code)

____
(Email) (Telephone) (Name of Contact Person / Administrator)

IVF TREATMENT AND PROCEDURE SCHEDULE:

Start Date of Medications: _______/_________/______ Date of Embryo Transfer: ______/_____/_______

Is IVF treatment and procedure using donor eggs? YES ☐ NO ☐

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PART I OF III (GENERAL INFORMATION, Continued)

BIRTH PLAN:

Please indicate **OBGYN** maternity medical care and **DELIVERY HOSPITAL** selections:

#1 OBGYN NAME: ____ Phone Number: ________________________
(Must have admitting privileges at the selected hospital)

____
(Address) (City) (State) (Postal Code)

____
(Email) (Name of Contact Person / Administrator)

Please indicate **Hospital** maternity medical care of Surrogate:

#1 Hospital for Delivery: ____

____
(Address) (City) (State) (Postal Code)

Will this birth be a planned C-Section? YES ☐ NO ☐

Universal Family and/or their authorized representatives do not provide medical advice and is not responsible for any medical care obtained from any provider selected for maternity medical services.

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PART I OF III (GENERAL INFORMATION, Continued)
OTHER INSURANCE INFORMATION, MATERNITY;

Is Applicant, Intended Parent(s) requesting Plan Application Form to be underwritten as **PRIMARY** Coverage, (i.e. understood by Applicant, Intended Parents to supersede any other known or existing coverages**)?**

YES ☐ NO ☐

If answer to the above question is **'NO'** then Applicant, Intended Parents understand that they are requesting the Surrogate Maternity Contractual Liability Insurance Plan Application Form be underwritten as a SECONDARY BACK-UP coverage option; and therefore, WE REQUIRE that you please provide us with your Surrogate's personal health insurance maternity coverage details below:

Surrogate's Insurance Plan: ____
(Billed for Maternity Medical Services)

Plan Address: ____

Policy #: __________________ Medical Record Number: __________________

CONTRACTUAL LIABILITY, PERIOD OF INDEMNITY:

As a result of your surrogacy contractual relationship, please advise the period of time (i.e. understood term of your contractual liability) that you have agreed to assume the financial responsibility for payment of Surrogate's maternity medical expenses:

____ .

OPTIONAL COVERAGES AVAILABLE, NON-PERFORMANCE, DEATH OF SURROGATE:

Is Applicant, Intended Parent(s) requesting Plan Application Form to be underwritten to include the 'Contractual Performance Indemnity Extension'?

YES ☐ NO ☐

Coverage extension indemnifies Intended Parent(s) for both their 'Contractual Financial Obligation' and 'Ascertained Net Loss' up to the Schedule Limit(s) of Indemnity in the event of the non-performance of a Contract as a direct result of the Death of the Surrogate occurring during the Coverage Period.

INTENDED PARENTS, INSURANCE INFORMATION FOR THE NEWBORN(S):
Name of Applicant Intended Parents insurance carrier for medical care of the NEWBORN:

Insurance Plan: ______________________________ Policy #: __________________

Plan Address & Telephone: ____

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PART II OF III (APPLICATION; TERMS, CONDITIONS AND WARRANTIES):

I (We) as the Applicant, Intended Parents named in Part I of this application, hereinafter referred to as 'IP', are applying for coverage to protect my (our) contractual liability for payment of My (Our) Surrogate's maternity medical expenses. If the submitted application is accepted by Underwriters then applicant 'IP' will receive within ten (10) business days an authorized quotation on a no coverage given basis for 'IP' further consideration. 'IP' authorize Underwriters and/or their appointed representatives to obtain any information deemed as necessary to underwrite the coverage application, including but not limited to: 'IP' financial ability to satisfy the policy condition for deposit of the required agreed self insured retention amount and any information to assist in the determination of their named Surrogate's insurability. 'IP' understand that approval of this application is not to be construed as approval by Underwriters of the person the 'IP' selected as their Surrogate for any purpose whatsoever. 'IP' understand and agree that their Surrogate is required to follow insurance program administrative procedures and coverage conditions and warranties, including but not limited to, the conditional coverage warranties, requiring: (1) that all medically necessary Maternity, Pregnancy and Childbirth Delivery related medical services are coordinated and pre-certified by Universal Family Insurance, LLC, hereinafter referred to as 'Universal' (or their authorized Representative); (2) to only use selected authorized and pre-certified Physicians and Hospitals coordinated by 'Universal', unless otherwise agreed by 'Universal' and (3) that insurance policies subject to this application are underwritten with a condition and warranty requiring Member 'IP' and their Dependent 'Surrogate' enrollment and participation in the 'Universal' Maternity Financial and Complex Case Management Program(s). 'IP' understand and agree that Underwriters, Coverholder, 'Universal' and/or any of their employees are not responsible for the quality of any maternity medical care received. 'IP' understand and agree that any fraud, misstatement or concealment by the named Surrogate of any adverse medical conditions and/or known or existing and/or prior medical conditions that may be cause for a concern of any medical complications related to the maternity and childbirth will render any insurance subject to this application as null and void and all Claims thereunder to be forfeited. 'IP' understand and acknowledge that neither Underwriters, Coverholder, 'Universal' nor any of their employees and/or their appointed administrators are a party to 'IP' contract with their Surrogate and as such, assume no responsibility for the outcome of the Surrogacy relationship.

Statement Warranty: 'IP' declare that all information given in the Program Application Form is true and complete, and that nothing which might influence Insurers has been withheld. 'IP' understand that they have a duty to disclose circumstances material to the proposed insurance, or any change to the information represented herein prior to attachment of the proposed insurance. 'IP' understand and agree that Program Application Form, which shall include material information provided by their Surrogate, shall form the basis of the proposed insurance contract. 'IP' understand that pre-existing conditions are not covered by the proposed insurance contract.

I (We) **as the Applicant, Intended Parents** agree to the above stated terms, conditions and warranties as of the

__________ day of ____________________________, 20______.

Intended Parent (1): ____
(Signature)

Intended Parent (2): ____
(Signature)

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PART III of III (APPLICATION, AUTHORIZATION TO RELEASE PERSONAL INFORMATION, HIPAA COMPLIANT)

I (We) AUTHORIZE, as the Applicant, Intended Parents named in Part I of this application, 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, deemed as necessary to underwrite the coverage application, to provide to Universal Family Insurance, LLC or to any agency authorized by Universal Family Insurance, LLC to collect any and all such information by means of U.S. Post, fax or e-mail.

I (We) AUTHORIZE Universal Family Insurance, LLC to communicate with me and/or my Surrogate and/or my representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, and/or additional coverages from Universal Family Insurance, LLC.

I (We) UNDERSTAND the purpose of this Authorization is to allow Universal Family Insurance, LLC to determine eligibility and claim payment for casualty insurance or claim for benefits under a contractual liability policy. Any information obtained will not be released by Universal Family Insurance, LLC to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with the application, claim and/or as may be otherwise lawfully required or as I may further authorize.

I (We) KNOW that I may request to receive a copy of this Authorization.

I (We) UNDERSTAND that I may revoke this Authorization, except to the extent that Universal Family Insurance, LLC has acted in reliance upon this Authorization. My revocation must be submitted in writing to Universal Family Insurance, LLC. Any such revocation may also have an impact upon Underwriting or claims processing.

I (We) UNDERSTAND that I can obtain a complete copy of Universal Family Insurance, LLC Privacy Policy by contacting them directly and asking for a copy.

I (We) AGREE that a **photographic facsimile** copy of this Authorization shall be as valid as the original.

I (We) AGREE this Authorization shall be valid for two (2) years from the date shown below.

I (We) **as the Applicant, Intended Parents** agree to the above **Authorization to Release Personal Information** as of

the __________ day of ________________________, 20____.

Intended Parent (1): ____
(Signature)

Intended Parent (2): ____
(Signature)