UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN
PART I of IV (GENERAL INFORMATION)

Person that has contractually agreed to be impregnated, carry and give birth for the Applicant, Intended Parent(s), please PRINT all requested information clearly, thank you:

Name of Surrogate: ____
(PLEASE PRINT FULL LEGAL NAME)

Telephone: ______________________________**Email:** ______________________________

____
(Street Address)

____
(City) (State) (Postal Code)

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

Name of Intended Parents: ____
(CONTRACTED WITH SURROGATE, PLEASE PRINT NAME)

SURROGACY AGENCY:

Name of Surrogacy Agency: ____

____
(Street Address)

____
(City) (State) (Postal Code)

IVF MEDICAL INFORMATION:

Name of IVF Clinic: ________________________________ ______________________________

Telephone: ____________________________________

IVF TREATMENT AND PROCEDURE SCHEDULE:

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

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

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN

PART I of IV (GENERAL INFORMATION, Continued)

OTHER INSURANCE INFORMATION, MATERNITY;

Please place an 'X' in this box if you 'AGREE' to use your Personal Health Insurance for payment of any maternity medical expenses from the contracted surrogacy relationship;

If You have placed an 'X' in the box above then You, as the Surrogate for the proposed Applicant, Intended Parent(s) named in Part I of this application and hereon as the undersigned, have authorized the use of Your personal health insurance maternity coverage for the contracted surrogacy relationship; WE therefore REQUIRE that You please provide below Your personal health insurance maternity coverage information:

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

Plan Address: ____

Policy #: ______________________________ Medical Record Number: __________________________

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

Applicant, Intended Parent(s) may request Plan Application Form to be underwritten to include the 'Contractual Performance Indemnity Extension; this coverage extension indemnifies Applicant, Intended Parent(s) for their 'Contractual Financial Obligation' up to the Schedule Limit of Indemnity ($250,000) 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.

Please provide the name of your designated primary beneficiary for payment of contractual financial obligation:

____ ______________________________
(Name of Surrogate's Primary Beneficiary) **(Relationship to Surrogate)**

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN

PART I of IV (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.

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN

PART II of IV (MEDICAL QUESTIONNAIRE); NOT VALID IF SUBMITTED OVER 90 DAYS.

Today's Date: ___________/__________/________________

I, as the Surrogate for the proposed Applicant, Intended Parents named in Part I of this application and hereon as the undersigned, hereinafter referred to as 'Surrogate', confirm that I recently received a complete psychological evaluation by a qualified professional and physical examination by a board certified physician in obstetrics, gynecology and/or specialist with qualifications in infertility medicine and reproductive endocrinology. Medical examinations (including lab results) concluded that I was in good health with no adverse medical findings and an ideal candidate to act as a gestational carrier.

_________________; confirming Surrogate's understanding and affirmation of the above statement.
(Surrogate's Initials)

Please answer all questions and if necessary provide additional explanation, thank you.

1. Are you a United States Citizen? _____________ (Yes or No).
2. What was the date of your physical medical examination (including lab results) that determined you are in good health and an ideal candidate to act as a gestational carrier? __________ /________________. Please provide the name and
   Month **Year**

   Address of the Physician that conducted the physical examination: ____

   ____.
3. Are you currently pregnant? _____________ (Yes or No). If Yes, Expected Due Date: ________/________/___________.
4. What is your height? ________________? What is your weight? ___________________________.
5. How many times have you been medically confirmed as pregnant? ____________________________.
6. Please advise Month and Year of all prior pregnancies. ____

   ____ .
7. Have you been a gestational carrier in the past? _________ (Yes or No). If Yes, for how many of your prior pregnancies?

   __________________.

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN
PART II of IV (MEDICAL QUESTIONNAIRE, Continued)

8. Have you experienced any complications with any of your prior pregnancies? ________________(Yes or No). If Yes, please explain: ____
____.

9. During any of your prior pregnancies have you been on physician ordered hospitalized bed rest or at home bed rest? _____________(Yes or No). If Yes, please provide for each pregnancy, date(s), if bed rest was at hospital or at home, duration of physician ordered bed rest and medical diagnosed cause: ____
____

10. Were any of your prior pregnancies aborted, spontaneously terminated (miscarried), stillborn and /or ectopic /molar? _________ (Yes or No). If Yes, please provide date and result of each pregnancy: _________________________________
____
____.

11. What is the date of your most recent childbirth delivery? __________ /________________.
Month **Year**

12. Were any of your prior pregnancies delivered by Caesarian Section? _________ (Yes or No). If Yes, please provide date(s) of each childbirth delivery by Caesarian Section: ____
____.

13. Will contracted surrogacy pregnancy be a scheduled delivery by Caesarian Section? ________________ (Yes or No).

14. Have you experienced pre-term labor (i.e. labor before 37th week of pregnancy) during any of your prior pregnancies? ______________ (Yes or No). If Yes, please explain duration of each pre-term labor event and medical diagnosed cause of pre-term labor: ____
____

15. Were any of your prior pregnancies medically confirmed as twins and/or multiples? (Yes or No)__________________,
If Yes, please detail date, # of fetuses and outcome of each medically confirmed twin and / or multiple pregnancy:
____
____.

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN

PART II of IV (MEDICAL QUESTIONNAIRE, Continued)

16. Have you ever been diagnosed with diabetes? ___________ (Yes or No).
17. Have you ever been diagnosed with Gestational Diabetes? _________ (Yes or No).
18. Have you ever been diagnosed with high blood pressure or Pregnancy Induced Hypertension? ____________ (Yes or No).
19. Have you had Placental Abruption? _________________ (Yes or No).
20. Have you had Placenta Previa or Accreta? _________________ (Yes or No).
21. Have you had Toxemia or Preeclampsia? _________________ (Yes or No).
22. Have you ever been diagnosed with severe morning sickness, hyperemesis? _________________ (Yes or No). If Yes, please explain frequency of this diagnosis and how condition was medically treated: __________________________
____.
23. Have you been diagnosed or treated for Varicose Veins? _________________ (Yes or No).
24. Have you been diagnosed or treated for Ovarian Cysts? _________________ (Yes or No).
25. Have you been diagnosed or treated for Uterine Fibroids? _________________ (Yes or No).
26. Have you been diagnosed or treated for Pelvic Inflammatory Disease? _________________ (Yes or No).
27. Have you been diagnosed or treated for Cervical Problems? _________________ (Yes or No).
28. Have you had any diagnosed medical problems with your heart or circulatory system, 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? _______________(Yes or No). If Yes, please explain what was the condition, date and treatment outcome: _________
____
____
29. Have you had any diagnosed medical problems with your kidneys, bladder, chronic urinary tract infections, stones, urinary incontinence, blood in urine? _______________(Yes or No).
30. Have you been diagnosed or treated for Thyroid problems? _______________ (Yes or No).
31. Have you been diagnosed or treated for Anemia? _______________ (Yes or No).

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN
PART II of IV (MEDICAL QUESTIONNAIRE, Continued)

32. Have you been diagnosed or treated for Depression? _______________ (Yes or No).

33. Have you ever been hospitalized for any condition other than Maternity / Childbirth? _________________ (Yes or No).

    If Yes, please explain what was the condition and date? Also, please include any surgeries, _______________________

    ____

    ____.

34. If there is a medical problem with the pregnancy or the child you are carrying as a surrogate and the prospective parents want to consider abortion, would you allow them to make that decision based on the advice of the doctors involved and their personal beliefs? _________________(Yes or No).

35. Have you ever experienced or been treated for any complications involving major organs? _______________(Yes or No).

    If Yes, please explain what was the condition and date? Also, please include any surgeries, _______________________

    ____.

36. Please provide a complete list of prescribed and non-prescribed medications, vitamins supplements that you are currently taking? ____

    ____

    ____ .

I, as the Surrogate for the proposed Applicant Insured Intended Parents, understand and acknowledge that the information that I have represented in this Program Application Form shall form the basis of a proposed insurance contract. I, as the Surrogate for the Applicant Intended Parents, further understand and agree that any fraud, misstatement or concealment by the me 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.

By my signature below, I verify that I, as the Surrogate for the Applicant Intended Parents, fully understand the content of this application form and that all information represented herein as being true and correct.

Agreed: __________ day of ____________________________, 20______.

Surrogate: ____
(Print Full Legal Name)

Surrogate: ____
(Signature)

UNIVERSAL FAMILY INSURANCE, LLC
&
LOCKTON,
LLOYD'S COVERHOLDER AND STATE LICENSED PRODUCER
SURROGATE MATERNITY CONTRACTUAL LIABILITY INSURANCE PLAN

SURROGATE, PLAN APPLICATION FORM, NO COVERAGE GIVEN

PART III of IV (APPLICATION; TERMS, CONDITIONS AND WARRANTIES)

I, as the Surrogate for the proposed Applicant, Intended Parents agree to permit Underwriters, Coverholder and/or their authorized Administrator, hereinafter referred to as 'Universal', with the required access to my personal medical records during the understood contracted term as Surrogate and for an extended period of twenty-four months post delivery for the purpose of underwriting this application and/or negotiation of any covered incurred medical expenses with selected approved network and/or pre-certified Physicians, Hospitals and/or other Providers of maternity, pregnancy and childbirth related medical services. Authorized administrator, 'Universal', will provide the Surrogate with the necessary information for coordinating all required maternity medical care and services (i.e. Universal Plan Enrollment Materials) with selected medical Providers. Surrogate agrees to fully cooperate and follow the understood procedures of 'Universal' and as more fully defined in the Universal Plan Enrollment Materials. Surrogate agrees, unless there is a medical emergency, to use only 'IP' member selected approved Pre-Certified Physicians and Hospital Facilities coordinated by 'Universal'. Surrogate agrees to provide any medical information requested by Underwriters, Coverholder and/or their authorized Administrator and further authorizes medical Providers to release any information that is requested by Underwriters, Coverholder and/or their authorized Administrator for the purpose of consideration, review and/or processing of maternity, pregnancy and childbirth related claims for payment of any covered incurred medical expenses. Surrogate understands and agrees that any fraud, misstatement or concealment 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. Surrogate understands and acknowledges that neither Underwriters, Coverholder, 'Universal' nor any of their employees and/or their appointed administrators are a party to the Intended Parents contract with their Surrogate and as such, Surrogate understands that Underwriters, Coverholder, 'Universal' their employees and/or appointed administrators assume no responsibility for the outcome of the Surrogacy relationship. Moreover, Surrogate understands that Underwriters, Coverholder, 'Universal' and/or any of their employees are not responsible for the quality of medical care received.

Statement Warranty: Surrogate declares that all information given in the Program Application Form is true and complete and that nothing which might influence Insurers has been withheld. Surrogate understands and acknowledges as follows: that she has a duty to disclose circumstances material to the proposed insurance and any changes to the information represented herein prior to attachment of the proposed insurance. This Program Application Form shall form the basis of the insurance contract. 'Surrogate' understands and acknowledges that pre-existing conditions are not covered by the proposed insurance.

I, as the Surrogate for the proposed Applicant, Intended Parents, understand and agree to the above stated terms, conditions and warranties as of the

__________ day of ____________________________, 20______.

Surrogate: ____
(Print Full Legal Name)

Surrogate: ____
(Signature)