Health Insurance Request Form

1. Insured's Full Name:
2. Insured's DOB:
3. Insured's Full Resident Address:
4. Insured's Full Mailing Address (if different from resident address):
5. Insured's SSN: DO NOT FILL IN HERE – Call us with this info
   (in order to adhere to HIPAA laws please call us with this info after sending us this form)
6. Insured's Primary Phone #:
7. Insured's Email Address:
8. Does the insured currently have another active policy?
   a. If so, please list the name of the carrier:
   b. In what state is this policy active? **Other**
   c. Is this other plan a group plan? (through either the insureds, or the insured's spouse's work)
9. Please list the names and address for any doctors or medical facilities that you would like your new plan to cover:

Send billing information to:

Name:

Email:

Phone Number:

By submitting this request, you are authorizing ArcLight Insurance to search for and obtain a health insurance policy on behalf of the insured listed above. It is agreed that the requesting party will be charged a fee of $400. This fee is for the search and placement for a suitable "surrogacy friendly" policy and also to confirm that said policy will be accepted by the doctors and/or medical facilities listed above. Additionally, this fee will include an insurance verification letter (of the same policy that we obtain) at no additional cost. Once the policy is processed by the carrier we will draft a review letter which will then be sent to the requesting party/agency. If this request is subsequently cancelled on the same day as it is sent to us there will not be any fees that are due. However, if this request is ever cancelled, from the following day or later, but before we submit the application for insurance, then the search fee of $200 will still be due. By signing this form, you agree to the above fees.

_____	_____	_____
Name: (please print)	Signature	Date