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?
   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:

Your preferred OB-GYN and DELIVERY HOSPITAL must be listed on this Health Insurance Request Form. If this information is not included on our form at the time of submission, we cannot guarantee that the plan(s) that we find will consider these medical providers as In-Network Providers. If this information is given to us after we apply for these plans, there will be an additional fee to conduct further research to identify the correct medical group and/or look into changing the plan (during Open Enrollment).

Health Insurance Request Form

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 **$450.** 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 canceled 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 canceled, from the following day or later, but before we submit the application for insurance, then the search fee of **$250** will still be due. By signing this form, you agree to the above fees.

To ensure timely processing, verification requests submitted within three days or fewer of the respective State's Open Enrollment deadline, will incur additional fees: $100 for submissions made three days prior, $150 for those submitted the day before, and $200 for requests sent to us on the final day of Open Enrollment. These fees are in addition to the standard verification fees and are necessary to cover the increased staffing costs required for prompt and accurate processing. These fees are non-refundable in the case of extenuating circumstances including, but not limited to, a retroactive extension of the Open Enrollment period.

______________________________	______________________________	__________________
Name: (please print)	Signature	Date