ArcLight Insurance

Surrogate Health Insurance Search and Submission

Insured's Information

Insured's Full Name

First | Middle | Last

Insured's Date of Birth

Insured's Address

Street Address

Address Line 2

City | State

ZIP Code

Insured's Phone Number

Insured's Email

Insured's SSN

www.arclightinsurance.com | ***submissions@arclightinsurance.com***
Lic. #0129653 | *Phone: (310)550-6862* | *Fax: (310)550-6863*

ArcLight Insurance

Surrogate Health Insurance Search and Submission

Insurance Carrier Information

Does the insured currently have another active policy?

◯ Yes ◯ No

If yes, what is the insurance carrier name?

In which state is the policy active?

Is this policy obtained through an employer or group plan?
(This could be through either the insured's, the insured's spouse's, or the insured's parent's work).

◯ Yes ◯ No

Please list the name(s) and address(es) for any doctors or medical facilities that you would like the new plan to cover:

Note: 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).

ArcLight Insurance

Surrogate Health Insurance Search and Submission

Send billing information to:

Agency Name (if applicable)

Full Name

First

Last

Email

Phone Number

Please review the following terms of agreement:

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 $465. 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 $300 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

First

Last

Signature

Date

www.arclightinsurance.com — submissions@arclightinsurance.com
Lic. #0129653 — Phone: (310)550-6862 — Fax: (310)550-6863

Additional Comments

www.arclightinsurance.com | ***submissions@arclightinsurance.com***
Lic. #0129653 | *Phone: (310)550-6862* | *Fax: (310)550-6863*