

BEITLER SERVICES, INC.
SURROGATE CONTRACTUAL EXPENSE LIABILITY INSURANCE
SURROGATE MATERNITY DISCOUNT PLAN
Part I of III

INTENDED PARENT(S) APPLICATION FOR ENROLLMENT

INTENDED PARENT(S): (Persons applying on behalf of their Surrogate and assuming financial responsibility.)

Intended Parent (1): _____ ID#: _____ - _____ - _____

Intended Parent (2): _____ ID#: _____ - _____ - _____

Address: _____
(Street) (City) (State) (Zip)

Telephone: _____ Email: _____

NAME SURROGATE: _____
(Print Legal Name of Surrogate)

IF APPLICABLE, PLEASE COMPLETE SURROGACY AGENCY INFORMATION:

SURROGACY AGENCY: _____
(Name)

Address: _____
(Street) (City) (State) (Zip)

Telephone: _____ Email: _____

I (We) as the above named Intended Parents, hereinafter referred to as IP, hereon understand and agree as follows: IP understands and agrees by virtue of contractual agreement to be responsible (unless otherwise agreed) for all maternity, pregnancy and childbirth related medical bills incurred by the above named Surrogate. IP agrees to permit the duly authorized appointed Plan Administrator, hereinafter referred to as Beitler Services, to debit certified funds deposited by the IP, as instructed by Insurance Design Administrators TPA for Beitler Services, into the designated Bank of America Certified Member Services Account for the purpose of payment remittance of negotiated usual, customary and allowable medical bills by a method satisfactory to selected approved pre-certified Medical Service Providers and/or Facilities. IP acknowledges and understands that approval of the negotiated discounts are predicated on the negotiated discounted usual, customary and allowable medical bills being satisfied by the sufficient amount of funds transferred and available on deposit by the IP in the designated Bank of America Certified Member Services Account. IP understands and agrees that it is solely their obligation to be certain that the sufficient amount of funds are transferred and available on deposit to satisfy all negotiated usual customary and allowable medical bills. If there is an insufficient amount of funds available, IP understands that the approved negotiated discount may be waived and the IP may be responsible for payment of the entire amount of the original usual and customary medical bills. The agreed cost for enrollment in the Beitler Services, Surrogate Maternity Discount Plan is a non-refundable enrollment fee of \$1,000. The fee is required to be deposited by the Member IP into the designated Bank of America Certified Member Services Account in addition to the conditional agreed amount of certified funds, as instructed by Beitler Services, to be used for payment of Member IP surrogate s negotiated usual, customary and allowable synchronization, maternity and childbirth related medical bills. Member enrollment is for the above Named Surrogate only and is not assignable to any other party. Beitler Services, undertakes to provide both the IP and their Surrogate with best service available to administer and manage IP selected medical Providers. IP agree to instruct and require that their surrogate fully cooperate and follow the understood procedures of the authorized third party administrator, Insurance Design Administrators, Inc. TPA for Beitler Services and to only use, unless a medical emergency, selected network or pre-certified Physicians and Hospitals coordinated by Beitler Services.

Signed this _____ Day of _____, 20 _____

Intended Parent (1): _____
(Signature)

Intended Parent (2): _____
(Signature)

BEITLER SERVICES, INC.
SURROGATE CONTRACTUAL EXPENSE LIABILITY INSURANCE
SURROGATE MATERNITY DISCOUNT PLAN

MEDICAL INTAKE FORM QUESTIONNAIRE

Dear Applicant (Intended Parents 'IP'): Based on your answer to the questions below, your assigned Beitler Services Case Manager will work with you and on your behalf to coordinate, negotiate and pre-certify selected Medical providers available for your Surrogates' maternity and childbirth care.

Applicant (1): _____ Applicant (2): _____

Name of Surrogate (please print): _____

Applicant Address: _____
(Street) (City) (State) (Zip)

Telephone: _____ Email: _____

Please provide top three Physician and Hospital choices: _____

How involved will the surrogate be in the choices you make for the Physician, Hospital, or other diagnostic providers? Please indicate either, _____ Not at all -or- _____ Joint Decision.

Your coordinated selected Physician limits your selection of Hospitals to those in which the Physician has admitting privileges. Do you prefer to select the Hospital first then have your Case Manager provide you with a list of admitting Physicians at that particular Hospital: Yes No Please comment:

Please note below any special requests and/or considerations that you would like your Case Manager to know as pertains to the maternity and childbirth coordination, negotiation and pre-certification of Providers.

Name of Applicant's Insurance Carrier for medical care of the Newborn: _____

Policy #: _____ Insurance Carrier Address: _____

Date: ____ / ____ / ____ **Signature:** _____ **Signature:** _____
Applicant Applicant

Underwriters or their authorized Administrator and/or any of their employees do not provide medical advice and are not responsible for any medical care obtained from a network or non-network provider of services.

UNDERWRITER AGENT: BEITLER SERVICES INC.

PRODUCER: PGI COMMERCIAL LLC. CALIFORNIA LICENSE # OE67776

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

5 Marine View Plaza Suite 201 Hoboken, NJ 07030 TEL: 201-714-9595 FAX: 201-714-966

BEITLER SERVICES, INC.
SURROGATE CONTRACTUAL EXPENSE LIABILITY INSURANCE
SURROGATE MATERNITY DISCOUNT PLAN
Part II of III

SURROGATE APPLICATION FOR ENROLLMENT

Surrogate Name (please print): _____

Telephone: _____ Email: _____

Address: _____
(Street) (City) (State) (Zip)

SS#: _____ - _____ - _____ Surrogate Date of Birth: _____ / _____ / _____

Expected Start Date of Medication for synchronization: _____ / _____ / _____

Does Surrogate have medical Insurance, social assistance and/or any other type of medical benefits?

If so, Individual or Group: _____ Company: _____

Policy No.: _____ Coverage Period: _____

Intended Parent 'IP' (1): _____
(Print 'IP' Name)

Intended Parent 'IP' (2): _____
(Print 'IP' Name)

I as above Named Surrogate agree to permit Underwriters, Coverholder or their authorized Plan Administrator 'Beitler Services' access to my medical records for the purpose of reviewing and negotiating all related medical costs incurred during my contractual term as Surrogate for 'IP' including but not limited to any information required for negotiation with selected approved Physicians, Hospitals and/or other Providers of services and/or facilities. I agree to only use, unless a medical emergency, selected approved Network Providers and/or pre-certified Physician and Hospital and/or other Medical Services coordinated by 'Beitler Services'. I understand that the above Intended Parents or their duly authorized representative will discuss and provide me with the necessary contact details of the authorized pre-certified selected Physician, Hospital and/or other Providers or services and/or facilities for rendering of all required maternity, pregnancy and childbirth related medical care. I agree to provide any reasonable additional information as needed and/or requested by Underwriters, Coverholder or their authorized appointed Plan Administrator. I understand that Underwriters, Coverholder and/or their authorized Plan Administrator and/or any of their respective employees do not provide medical advice, are not responsible for the quality of any medical care received and assume no responsibility for the outcome of the Surrogacy relationship.

Signed this _____ Day of _____, 20 _____

By {Surrogate}: _____
(Signature)

UNDERWRITER AGENT: BEITLER SERVICES INC.

PRODUCER: PGI COMMERCIAL LLC. CALIFORNIA LICENSE # OE67776

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SMD-01-04/10 [CALIF.]

BEITLER SERVICES, INC.
SURROGATE CONTRACTUAL EXPENSE LIABILITY INSURANCE
SURROGATE MATERNITY DISCOUNT PLAN

APPLICATION FORM

Surrogate Name: _____ Date of Birth: _____
(Please Print)

Address: _____
(Street) (City) (State) (Zip)

Telephone: _____ Email: _____

Date of Most Recent Delivery: ____ / ____ / _____. Named Surrogate hereon further confirms that Most Recent Pregnancy and all previous pregnancies were healthy, without any known medical complications and by vaginal childbirth.

If not, please explain:

Surrogate Medical Questionnaire (please answer all questions and if necessary provide additional explanation).

1. I, hereon as the undersigned, confirm that I recently received a complete psychological and physical examination by a board certified medical physician. 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.
2. Have you ever been diagnosed with diabetes? (Yes or No) or Gestational Diabetes? (Yes or No).
3. Have you ever been diagnosed with high blood pressure or Pregnancy Induced Hypertension? (Yes or No)
4. Have you experienced any complications with any of your prior pregnancies? (Yes or No). If Yes, please explain:

5. Have you experienced pre-term labor? (Yes or No). If Yes, please explain: _

6. Have you ever been hospitalized for any condition other than Maternity / Childbirth? (Yes or No). If Yes, for what condition and when? Please include all surgeries. _

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7. Please provide a complete list of medications both prescribed and non-prescribed that you have taken in the past 10 years:
8. Have you been a gestational carrier in the past?_ (Yes or No). For how many of your pregnancies? _

9. Total Number of Prior Pregnancies for Each Category:

Full Term	Less than 37 Weeks	C-Section	Vaginal	Stillbirth	Multiple Births	Abortion	Miscarriage	D & C With Miscarriage	Ectopic/Molar

10. Pregnancy Details (Complete for Each Pregnancy):

Sex of Baby	Month/Year of Delivery	# of Weeks Delivered	Babies Weight	Mother's Weight at Delivery	Hours of Labor	Delivery Type	Describe Any OB/Neonatal Problems	Delivering Doctor/Hospital

Name of Intended Parents: _____

(PLEASE PRINT)

I as above named Surrogate agree to permit Underwriters, Coverholder and/or their authorized Administrator hereinafter referred to as "Beitler Services, Inc." with the required access to my personal medical records during the understood contracted term as Surrogate on behalf of the above Named Intended Parents 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. Surrogate agrees to fully cooperate and follow the understood procedures of "Beitler Services, Inc.". Surrogate agrees, unless a medical emergency, to use only 'IP' member selected approved network and/or pre-certified Physicians and Facilities coordinated by "Beitler Services, Inc.". The authorized administrator "Beitler Services, Inc." will provide the Surrogate with the necessary information for coordinating all required medical care and services with selected medical Providers. 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, "Beitler Services, Inc." nor any of their employees and/or their appointed administrators are a party to 'IP' contract with their Surrogate and as such, Surrogate understands that Underwriters, Coverholder, "Beitler Services, Inc." their employees and/or appointed administrators assume no responsibility for the outcome of the Surrogacy relationship. Moreover, Surrogate understands that Underwriters, Coverholder, "Beitler Services, Inc." and/or any of their employees are not responsible for the quality of medical care received.

Surrogate: _____
(Signature)

(Date)

BEITLER SERVICES, INC.
SURROGATE CONTRACTUAL EXPENSE LIABILITY INSURANCE
SURROGATE MATERNITY DISCOUNT PLAN
Part III of III

MEDICAL AUTHORIZATION
(NOT VALID IF SUBMITTED OVER 90 DAYS)

TODAY'S DATE: ____ / ____ / ____

SURROGATE 'PATIENT' NAME: _____
(PLEASE PRINT)

SURROGATE 'PATIENT' DATE OF BIRTH: ____ / ____ / ____

I am a board certified physician in obstetrics, gynecology and/or specialist with qualifications in infertility medicine and reproductive endocrinology. I hereby further confirm that to date the above named surrogate 'patient' has experienced a normal healthy maternity without any adverse medical conditions and has no known or existing and/or prior medical conditions that may be cause for concern of any medical complications related to maternity and childbirth.

I have examined, reviewed her prior obstetrical and gynecological history, and currently care for the above named surrogate 'patient' and find her to be in continued excellent physical condition and general health, except as noted below:

ADVERSE FINDINGS:

SURROGATE 'PATIENT' REQUIRED BIOMETRIC INFORMATION:

WEIGHT: _____ GLUCOSE LEVEL AT FASTING: _____

HEIGHT: _____ BLOOD PRESSURE: _____ / _____

EXPECTED START DATE FOR SYNCHRONIZATION: ____ / ____ / ____

DATE OF MOST RECENT DELIVERY: ____ / ____ / ____ . Named Surrogate hereon further confirms that Most Recent Pregnancy and all previous pregnancies were healthy, without any known medical complications and by vaginal childbirth. If not, please explain:

Please check the appropriate box:

I recommend the above named surrogate to act as a gestational carrier.

I decline to recommend the above named surrogate to act as a gestational carrier.

_____, MD _____, MD
(NAME OF EXAMINING DOCTOR, PLEASE PRINT) (NAME EXAMINING DOCTOR, PLEASE PRINT)

(NAME OF MEDICAL FACILITY OR PRACTICE)

(TELEPHONE NUMBER)

(STREET ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

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BEITLER SERVICES, INC.
SURROGATE CONTRACTUAL EXPENSE LIABILITY INSURANCE POLICY
SURROGATE MATERNITY DISCOUNT PLAN

MEDICAL CONFIRMATION OF PREGNANCY
(NO COVERAGE GIVEN- NOT VALID IF SUBMITTED OVER 10 DAYS)

Today's Date: _____ / _____ / _____

Name of Surrogate/Patient: _____
NAME (PLEASE PRINT)

DOB (Surrogate): _____ / _____ / _____ SS ID No.: _____ / _____ / _____

I am a board certified physician in obstetrics and gynecology and/or specialist with qualifications in infertility medicine and reproductive endocrinology. I confirm that the above named Surrogate to date has experienced a normal healthy maternity without any prior adverse medical conditions and/or existing conditions that may be cause for concern of any medical complications. I am the presiding physician responsible for the care of the above named Surrogate and confirm that the named Surrogate has successfully, without any prior adverse medical conditions and/or existing conditions, completed synchronization (i.e. gestational cycle medications), embryo transfer implantation procedure and is confirmed pregnant following ultrasound.

I find the named Surrogate to be in continued excellent physical condition and general health, except as noted below:

<p>Adverse Findings:</p> <p style="text-align: center;"><i>Information written in this box may not be copied or duplicated</i></p>
--

Named Surrogate/Patient, Ultrasound Confirmed Date of Pregnancy: _____ / _____ / _____

VAG UTZ: Ultrasound Confirmed Number of Fetuses: _____

Surrogate Required Biometric Information:

Weight: _____

Glucose Level: _____

Height: _____

Blood Pressure: _____ / _____

_____, MD
NAME OF EXAMINING DOCTOR (PLEASE PRINT)

_____, MD
SIGNATURE OF EXAMINING DOCTOR

NAME OF MEDICAL FACILITY OR PRACTICE

_____-_____-_____
TELEPHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

UNDERWRITING AGENT: BEITLER SERVICES, INC.

A PHOTOGRAPHIC COPY OR FASCIMILE OF THIS DOCUMENT SHALL BE CONSIDERED AS VALID AS IF THE ORIGINAL.

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