



## Participation Agreement for the StemCure, Ltd., Tissue Banking Program

- This Agreement outlines the mutual consent and obligations of the client and StemCure, Ltd., hereafter referred to as StemCure. Both parties agree to fully comply with the conditions of the Agreement as described below:
- StemCure is a company that performs biomedical activities related to Cryoconservation, the preservation of human tissue samples.
- The client, for the purposes of tissue banking, acknowledges that the decision to enlist StemCure to preserve his/her genetic material was made willingly and free from any outside pressures or mental duress.

### 1. The Rights and Obligations of StemCure.

---

The rights and obligations of StemCure as they relate to the Tissue Banking Program are determined by the specificity of each particular activity: The Collection, Analysis and Cryoconservation of Tissue Samples are described in the following paragraphs:

**1.1. Tissue Sample Kit.** After completing the necessary forms, signing the participation agreement and making the initial payment, in accordance with the Payment Agreement, StemCure will send a standard Tissue Sample Kit to the address you specified in the contract. The Tissue Sample Kit contains all the components necessary for the proper collection and transportation of a biopsy sample. You will also receive a prepaid FedEx label that is to be affixed to the box containing your samples for transportation to StemCure Lab Facilities. You will also receive an instruction booklet for your doctor with a detailed explanation on how to perform a tissue sample swab for biopsy collection.

**1.2. Medical Provider Reimbursement.** After receiving and crediting your processing fee, StemCure will reimburse your doctor in the amount of \$100.00 for professional services rendered in the successful collection of the tissue sample that will allow our company to prepare your genetic material for storage.

**1.3. Laboratory Processing and Cryogenic Storage of Samples.** After receiving the genetic materials, StemCure will arrange for the processing and cryogenic storage of your tissue samples in our laboratory. The biomedical techniques of processing and storing tissue samples are conducted solely at the absolute discretion of StemCure. Our company guarantees an extremely high quality procedure that is in accordance with our unique development and tested laboratory methods. StemCure pledges to maintain all the necessary conditions for cryogenic tissue preservation during the term of the contract. StemCure reserves the right to test the tissue samples whenever they deem necessary, and also reject the processing and/or preservation of said samples if they do not meet our discerning requirements; namely, (1) poor quality of the samples; (2) lack of vitality and/or if (3) the analysis of a sample reveals any viral or other dangerous infectious diseases. In case if any collected tissue sample will be determined by StemCure as unfit for Cryoconservation due to unsuccessfully performed procedure, StemCure will notify Client as soon as practicable and the procedure of tissue sample collection may be repeated at no additional expense to the Client.

**1.4. Confidentiality.** All the personal information, analysis and tissue samples received by StemCure from our clients will be stored under the condition of strict confidentiality and cannot be used without a client's expressed agreement, even after cancellation of the present contract, except for cases where stipulated by law.

**1.5. StemCure Has the Right to Cancel the Contract.** As outlined below, in certain cases, StemCure has the right to cancel a client's contract.

**A.** In any case where according to the above-mentioned techniques and procedures and due to the reasons other than unsuccessful sample collection, as indicated in section 1.3 of this agreement, StemCure conclusively determines that it cannot process and/or store your tissue samples.

**B.** In case where a client fails to pay StemCure for services rendered within 60 days of invoice. If you fail to pay according to the "Payment Agreement " within 30 days, we will send you a reminder notice. If after receiving this reminder 30 more days pass and you fail to pay, StemCure reserves the right to cancel this agreement. In addition, client should be responsible for any fines incurred due to funds unavailability or insufficiency at the time client's account is charged, regardless of method of payment. Pursuant to this action you will receive written notice by mail about the cancellation of your contract due to failure of payment. StemCure will then have the right to use your tissue samples for any research purposes the company deems necessary and not be obligated to preserve or dispose of these genetic materials. Upon cancellation of the current agreement neither you nor StemCure will have any subsequent mutual obligations. You also understand that after such cancellation you cannot claim any refunds.

**1.6. Research & Development Initiatives.** StemCure has undertaken an important medical mission – the genetic preservation of our clients' youthful tissue samples which in turn assured his/her future health and the extension of human life. We are committed to invest as much as possible in scientific breakthroughs and developments in the application of stem cell research. The capital for R & D investments will be allocated from the proceeds of StemCure Tissue Banking Program. We pledge to expand our research activity in this area and to coordinate our efforts with other well-known research centers throughout the world.

## **2. The Rights and Obligations of the Client.**

---

**2.1. Examination and Completing the Documentation.** Client is responsible for reading, comprehending, completing, signing and returning all forms and registration documents provided by StemCure. By signing this agreement Client covenants and represents that he/she has been encouraged to consult his/her physician regarding the tissue sample collection procedure. Client further covenants and represents that to the best of his/her knowledge and belief he/she is in good health condition and has no knowledge of any health problems as of the date of the proposed procedure. This is further understood and agreed by the Client that the services offered by StemCure are not intended and in fact are not a substitute of a medical treatment. Client is strongly encouraged to consult a physician whenever such medical treatment is necessary or advisable.

**2.2. Use of Independent Professionals.** To the extent reasonably necessary to enable StemCure to perform the duties under this agreement, StemCure may from time to time retain the services of independent physicians and/or other independent professionals that StemCure may deem proper and further to engage, or retain the services of other persons or corporations to aid or assist StemCure in the proper performance of its duties. It is expressly understood and agreed by the parties to this agreement that by retaining services of such independent parties, no agent-principal or employer-employee relationship will be intended or in fact created. Thus, StemCure shall not be liable for any services provided by independent professionals or any other third parties.

**2.3. Biopsy Performance and Delivery.** The client agrees to arrange for his own (without participation from StemCure) biopsy procedure by an independent medical provider (MD, Physician) and to inform such provider about his willingness to participate in StemCure Tissue Banking Program. After successfully acquiring the tissue sample, you must properly pack the genetic materials in the box included and make sure the sample is mailed to StemCure within 12 hours from the moment of the biopsy procedure. You will also need to bring the box to your nearest FedEx Office or call 1-800-Go-Fedex to arrange for overnight delivery.

**2.4. Client's property rights.** Clients, who deposited their tissues for storage and preservation, have property rights to these tissues with the exception of cases where any decisions regarding the samples of minors are made by legal guardians. Upon reaching the age of 18 (majority), the minor whose tissue samples were deposited for storage and Cryopreservation receives all property rights to these tissue samples and becomes the only person to make future decisions related to the current agreement.

**2.5. Payment for StemCure Services.** Client is responsible for the timely payment of all services rendered by StemCure as specified in "Payment Agreement Contract".

**2.6. Client Change of Address.** Any changes in a client's postal address or telephone number must be made in writing to StemCure by certified mail, return receipt requested, within 30 days of move.

**2.7. Cancellation of the Agreement.** Client has the right to cancel their contract with StemCure in writing upon 60 days notice, providing for a cancellation date and offering instructions with regard to the transfer of tissue samples. After withdrawal of the samples from cryopreservation storage as per the client's instructions the present contract will be considered voided and StemCure will no longer bear any responsibility for the tissue samples of the client. In the event the client does not provide for and pay for the preparation and overnight shipment destination of the samples, StemCure has the right to dispose of the samples at its discretion.

**2.8. The Right to Information.** Taking into consideration the uniqueness and importance of StemCure research, and also the very high expectations that our clients demand regarding their long-term participation in StemCure Tissue Banking Program, the company feels the need to provide our clients with the right to be informed about StemCure activities. You will be kept abreast of the last 3 months that briefly describe major activities at StemCure as well as the latest scientific achievements in the world related to Stem Cell research.

### **3. Agreement in Entirety and Release from Liability.**

---

**3.1. Entire Agreement; Governing Law.** This Contract Agreement, including The Rights and Obligations of StemCure; The Rights and Obligations of the Client; Agreement in its Entirety Release from Liability; Agreement Based on the Complete Information; Healthcare Provider's Authorization for Biopsy Performance; Release From Liability and Payment Agreement represent the entire agreement between the parties. This Agreement contains the complete agreement of the parties and will supersede any and all other agreements, understandings and representations by and between the parties hereto. This agreement was written in English, which is the only language permissible to determine its interpretation. This agreement is governed by state or international laws where StemCure is registered and operates, thus excluding the effect of the conflict of laws, rules or principles.

**3.2. Force Major.** If the performance of this contract becomes impossible, restricted, prevented due to any circumstances, such as any laws and ordinances or the requirement of any governmental agency or institution, or by reasons of natural calamity and/or accidents, strikes or labor conflicts, technical breakdown of the equipment, technological breakdown of process, or acts of violence and vandalism or any other action or condition beyond the control of StemCure, the company will be excused from any of the obligations under the present Contract.

**3.3. Indemnification.** I, as a participant in the StemCure Tissue Banking Program, on behalf of myself and/or as a legal guardian of a minor, on behalf of dependent family members and heirs, hereby release and deem legally harmless StemCure and any of its affiliates, employees, contractors, subcontractors, directors, officers and agents from any litigations, claims and demands both in law and equity and agree not to institute action or suit against all these parties except if such actions result from willful or malicious conduct by StemCure. I also agree that if StemCure is found liable for willful or malicious conduct, the amount of damages that can be recovered shall be limited to the amount of money paid by me to StemCure for participation in StemCure Tissue Banking Program under the present contract.

### **4. Agreement Based on the Complete Information.**

---

It is my personal decision, without any constraints, to participate in StemCure Tissue Banking Program and to provide tissues for Cryoconservation of myself and/or the minor who I represent as a legal guardian. I understand that StemCure, at its sole discretion, can decide to reject the processing and/or preservation of my tissue samples if they do not meet certain medical requirements. In this case, I cannot claim any reimbursement for the money I already paid.

I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES CAN BE OR HAVE BEEN MADE TO ME CONCERNING THE OUTCOMES AND/OR RESULTS OF ANY OF THE PROPOSED TREATMENTS OR PROCEDURES. IN PARTICULAR, I FULLY UNDERSTAND THAT A SUCCESSFUL BIOPSY PROCEDURE, ITS TREATMENT AND CRYOGENIC STORAGE DO NOT GUARANTEE A POSITIVE THERAPEUTIC EFFECT.

Although at the same time, I agree that this procedure offers an advantage by preserving my highly viable young cell material. I understand that the only goal set by the StemCure Tissue Banking Program is to preserve my genetic material over time. Subsequently, such material can be used in StemCure Stem Cell Therapy Program or the similar programs of other companies intended for the development of healthier or more vital tissues that might be utilized in the future. I also understand that StemCure Tissue Banking and Stem Cell Therapy Programs, despite being closely related technologically, are in fact independent in law and equity. I am aware that payment for participation in StemCure Tissue Banking Program is unrelated to participation in StemCure Stem Cell Therapy Program. In order to fully participate in StemCure Stem Cell Therapy Program, I will have to complete different agreement forms and provide separate payment.

I have carefully read, understood and accepted all the provisions of this contract that include The Rights and Obligations of StemCure; The Rights and Obligations of the Client; Agreement in Entirety and Release from Liability; Agreement Based on the Complete Information; Healthcare Provider's Authorization for Biopsy Performance and Release From Liability and Payment Agreement. I have discussed all the issues related to StemCure Tissue Banking Program with my medical care provider and my attorney. All questions I have had about the program were completely answered and I am willingly making a personal decision to participate in the StemCure Tissue Banking Program. I acknowledge that all the information furnished to me by StemCure company representatives is true and unbiased. I have signed the given agreement knowingly and voluntarily.

**Parent / Legal Guardian**

\_\_\_\_\_

Name

\_\_\_\_\_

Signature

Date

**5. Healthcare Provider's Authorization for Biopsy Performance and Release from Liability.**

---

I, \_\_\_\_\_, as a parent/legal guardian of \_\_\_\_\_, authorize my healthcare provider to perform a biopsy procedure. I understand it is my healthcare provider's final decision whether or not to perform this biopsy depending on certain medical tests. I also understand that although this biopsy is a relatively simple and straightforward procedure - a detailed description can be found in the Instructions for Healthcare Providers Booklet, enclosed in the Tissue Sample Kit - complications may occur after a biopsy has been performed such as rash; inflammation at the biopsy site; certain discomfort or painful sensations. In addition, as evidenced by my signature below, I release my doctor or healthcare provider as well as the institution where the biopsy was performed, its officers, directors and employees from any liabilities surrounding my biopsy procedure that might cause any damage, harm or destruction. I understand that by signing this Release of Liability, I agree to cede any legal rights, both now and in the future, to prosecute or claim any monies from my doctor; healthcare provider; hospital or medical institution for any reason or consequence surrounding this biopsy procedure.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Healthcare Provider's Signature

\_\_\_\_\_  
Medical Institution Address

\_\_\_\_\_  
Full Name of Healthcare Provider  
(please print)

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

# PERSONAL INFORMATION FORM FOR MINORS

**All Information is Mandatory for Proper Completion**

_____	_____	_____	_____-_____-_____	_____
Last Name	Middle	First Name	Social Security Number	Date of Birth
_____		_____		
Name of Parent/Legal Guardian		Relationship to Child		
_____			_____	
Home Address			Home Telephone	
_____			_____	
City, State, Zip Code			Email Address	
_____			_____	
Parent/Legal Guardian's Employer			Work Telephone	
_____			_____	
Daytime Phone Number			Cellular Number	
_____			_____	
Kit Shipping Address (if different from Home Address)				
_____				
_____			_____	
Signature of Parent/Legal Guardian			Date	

# MEDICAL HISTORY OF CHILD

Child's Full Name: \_\_\_\_\_  
Last Middle First

\_\_\_\_\_  
Male/Female Date of Birth MM/DD/YYYY Age

## Health History of Tissue Participant:

### Questions:

1. Has the child ever had an infectious skin disease within the previous 6 months? Yes \_\_\_ No \_\_\_
2. Has the child ever had any congenital diseases? Yes \_\_\_ No \_\_\_
3. Does the child have any Genetic Disorders? Yes \_\_\_ No \_\_\_
4. Does the child have any chromosomal Disorders? Yes \_\_\_ No \_\_\_
5. Does the child have any known blood problems? Yes \_\_\_ No \_\_\_
6. Does the child have any heart problems? Yes \_\_\_ No \_\_\_
7. Does the child have diabetes? Yes \_\_\_ No \_\_\_
8. Has the child had any liver problems? Yes \_\_\_ No \_\_\_
9. Has the child ever been exposed to Hepatitis and/or Jaundice? Yes \_\_\_ No \_\_\_
10. Has the child tested positive for HIV/AIDS or other immunosuppressive disorders? Yes \_\_\_ No \_\_\_
11. Has the child had any serious respiratory infections or TB? Yes \_\_\_ No \_\_\_
12. Has the child had any serious infections, surgery or illnesses? Yes \_\_\_ No \_\_\_
13. Has the child had a transfusion or an organ/ tissue transplant? Yes \_\_\_ No \_\_\_
14. Does the child suffer from any form of Cancer? Yes \_\_\_ No \_\_\_
15. Does the child suffer from Epilepsy? Yes \_\_\_ No \_\_\_
16. Has the child ever been the victim of a stroke? Yes \_\_\_ No \_\_\_

If you have answered yes to any of the previous questions, please explain in further detail below.

---

---

---

---

17. To better gauge your health condition, on a scale from 1-10 where 1 is extremely thin, 5 is considered normal and 10 is severely obese, please indicate your weight level: 1 2 3 4 5 6 7 8 9 10

18. On a scale from 1 to 10, where 1 is very inactive and 10 is very physically fit and energetic, please indicate your level: 1 2 3 4 5 6 7 8 9 10

19. Has the child ever tried smoking? Yes \_\_\_ No \_\_\_  
If yes, how many cigarettes per day? \_\_\_\_\_

20. Has the child ever consumed alcohol? Yes \_\_\_ No \_\_\_

21. Has the child ever experimented with controlled substances? Yes \_\_\_ No \_\_\_

**Health History of Participant’s Mother and Father**

**Questions:**

	<b>Mother</b>	<b>Father</b>
1. Have you ever had any congenital diseases?	Yes ___ No ___	Yes ___ No ___
2. Do you have any Genetic Disorders?	Yes ___ No ___	Yes ___ No ___
3. Do you have any chromosomal Disorders?	Yes ___ No ___	Yes ___ No ___
4. Do you have any known blood problems?	Yes ___ No ___	Yes ___ No ___
5. Do you suffer from high blood pressure?	Yes ___ No ___	Yes ___ No ___
6. Do you have any heart problems?	Yes ___ No ___	Yes ___ No ___
7. Do you have diabetes?	Yes ___ No ___	Yes ___ No ___
8. Have you had any liver problems?	Yes ___ No ___	Yes ___ No ___
9. Do you suffer from any form of Cancer?	Yes ___ No ___	Yes ___ No ___
10. Do you suffer from Epilepsy?	Yes ___ No ___	Yes ___ No ___
11. Have you ever been the victim of a stroke?	Yes ___ No ___	Yes ___ No ___
12. Do you have Alzheimer’s or Parkinson’s disease?	Yes ___ No ___	Yes ___ No ___
13. Before childbirth, have you ever used intravenous drugs or consume large quantities of alcohol?	Yes ___ No ___	Yes ___ No ___

If you have answered yes to any of the previous questions, please explain in further detail below.

---



---



---

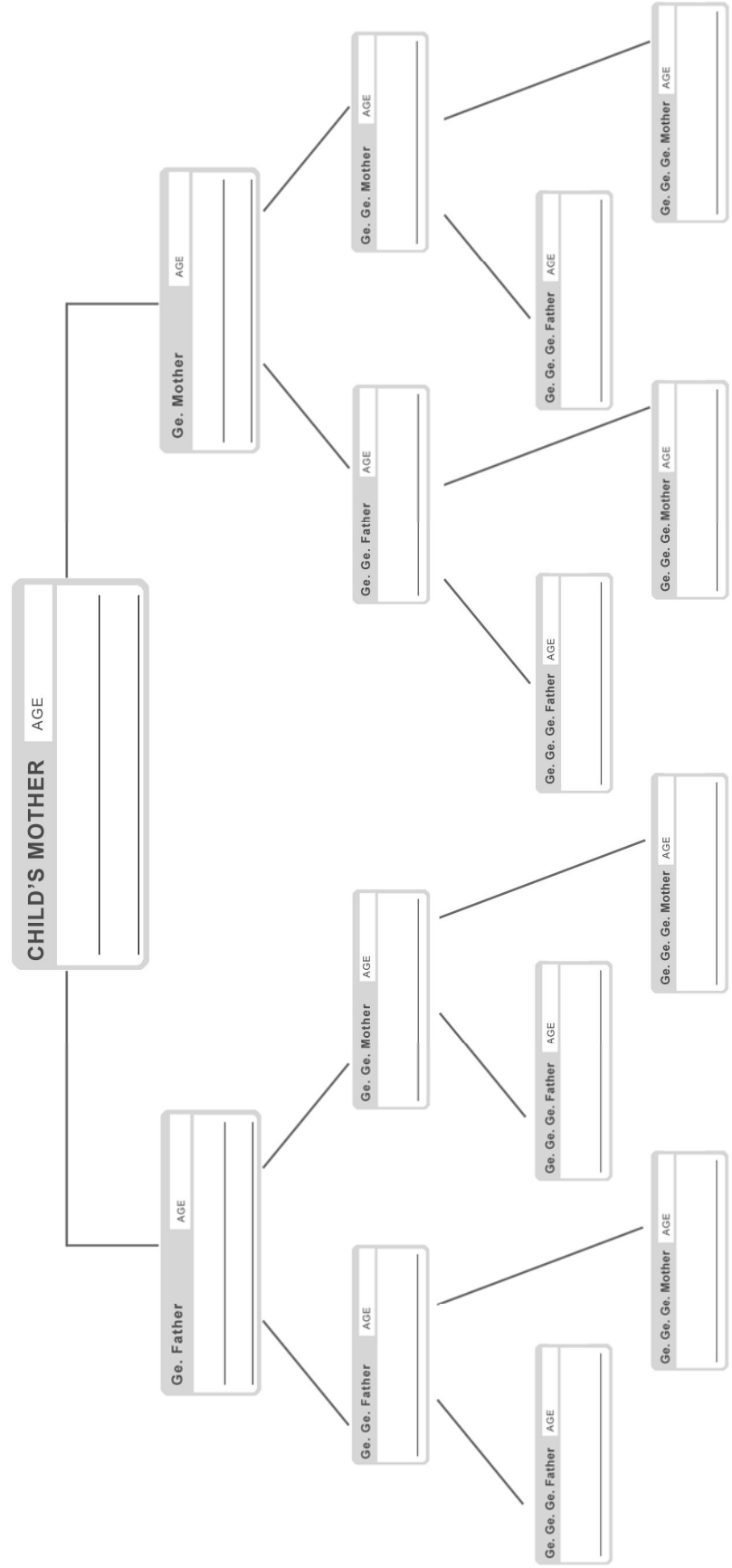


---

	<b>Mother</b>	<b>Father</b>
14. To better gauge the hereditary nature of your child’s health condition, on a scale from 1-10 where 1 is extremely thin, 5 is considered normal and 10 is severely obese, please indicate your weight level.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

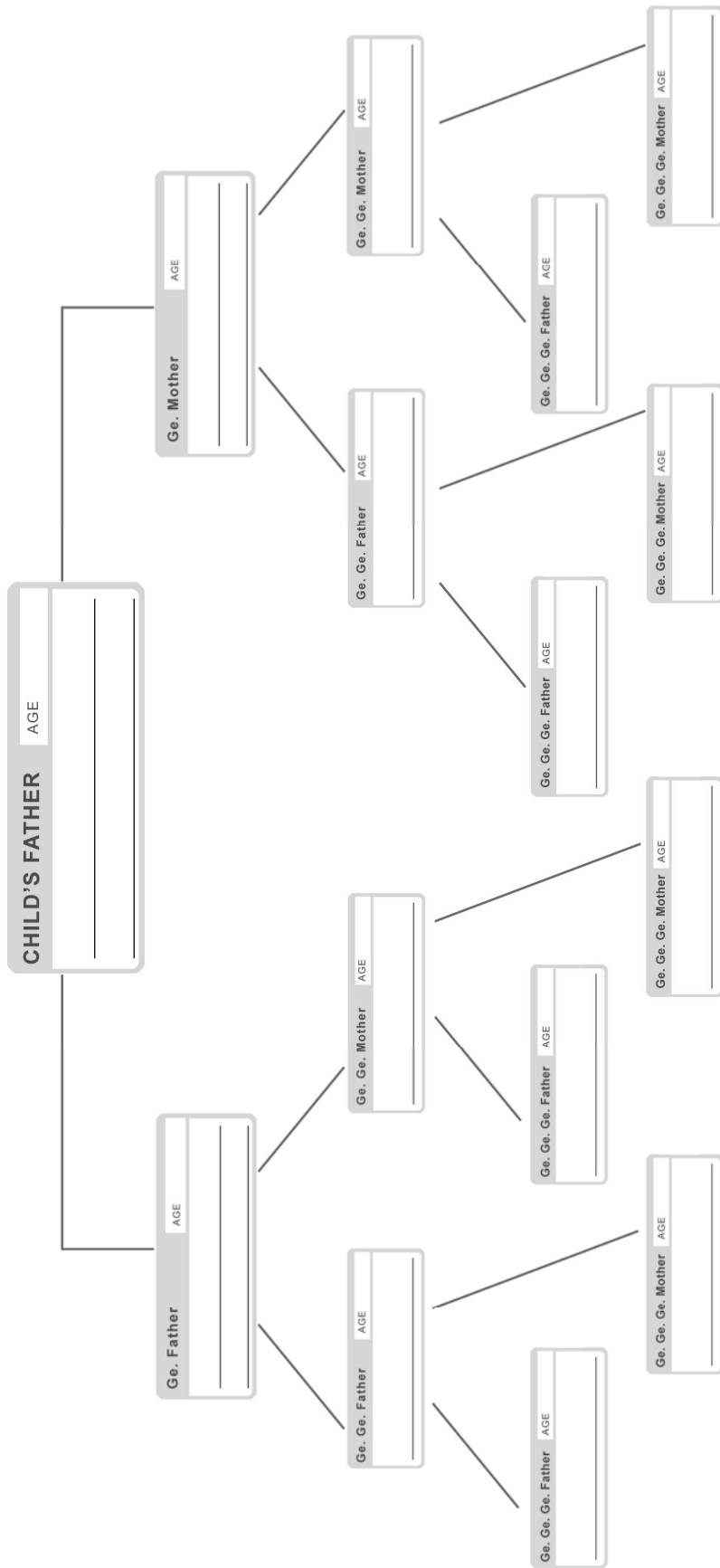
## Genealogical History of Mother

Using the following chart, please fill in the age of your relatives. If they have already passed away, please circle their age. Please give a brief description of what they died from in the space below.



## Genealogical History of Father

Using the following chart, please fill in the age of your relatives. If they have already passed away, please circle their age. Please give a brief description of what they died from in the space below.



# PAYMENT AGREEMENT

## First Year Costs for the StemCure Tissue Banking Program Include:

- Enrollment Fee
- Processing Fee
- Annual Storage for First Year

A Fee in the amount of \$470.00 per person is payable upon your enrollment. This amount is nonrefundable and includes registration, tissue sample kit, and a prepaid FedEx mailer.

The remaining balance is due after the transportation of your tissue samples as well as the processing and storage of them has been completed. This amount includes your processing fee and first year storage fee and will vary depending on the number of family members that join our program and the payment plan you choose from the list of prices below. However, we offer valued savings for every additional family member that joins the program.

The following table shows the pricing discounts for each family member as more members are added to the program.

## Six Month Payment Plan for Each Family Member

	Enrollment fee	Processing Fee		Total Charges
		Monthly Payment	Total Six Month	
Single Member	<b>\$470.00</b>	\$185.00	<b>\$1,110.00</b>	<b>\$1,580.00</b>
Second Family Member	<b>\$470.00</b>	\$155.00	<b>\$930.00</b>	<b>\$1,400.00</b>
Third Family Member	<b>\$470.00</b>	\$125.00	<b>\$750.00</b>	<b>\$1,220.00</b>
Fourth or More Family Members	<b>\$470.00</b>	\$95.00	<b>\$570.00</b>	<b>\$1,040.00</b>

The following table shows the total costs for your family based on the amount of family members that are joining the program.

## Six Month Payment Plan for Entire Family

	Enrollment Fee	Processing Fee		Total Charges
		Monthly Payment	Six Month Total	
Single Member	<b>\$470.00</b>	\$185.00	<b>\$1,110.00</b>	<b>\$1,580.00</b>
Two Family Members	<b>\$940.00</b>	\$340.00	<b>\$2,040.00</b>	<b>\$2,980.00</b>
Three Family Members	<b>\$1,410.00</b>	\$465.00	<b>\$2,790.00</b>	<b>\$4,200.00</b>
Four Family Members	<b>\$1,880.00</b>	\$560.00	<b>\$3,360.00</b>	<b>\$5,240.00</b>

You have the option to save 10% of the processing fee by making your payment in full right after we have completely processed your application and tissue samples.

Please see below for a complete list of savings.

**10% Discount of Processing Fee for Payments in Full for Each Family Member**

	Enrollment Fee	Processing Fee After Discount	Total Charges
Single Member	<b>\$470.00</b>	<b>\$1,000.00</b>	<b>\$1,470.00</b>
Second Family Member	<b>\$470.00</b>	<b>\$840.00</b>	<b>\$1,310.00</b>
Third Family Member	<b>\$470.00</b>	<b>\$680.00</b>	<b>\$1,150.00</b>
Fourth or More Family Members	<b>\$470.00</b>	<b>\$520.00</b>	<b>\$990.00</b>

**10% Discount of Processing Fee for Payments in Full for Entire Family**

	Enrollment Fee	Processing Fee After Discount	Total Charges
Single Member	<b>\$470.00</b>	<b>\$1,000.00</b>	<b>\$1,470.00</b>
Two Family Members	<b>\$940.00</b>	<b>\$1,840.00</b>	<b>\$2,780.00</b>
Three Family Members	<b>\$1,410.00</b>	<b>\$2,520.00</b>	<b>\$3,930.00</b>
Four Family Members	<b>\$1,880.00</b>	<b>\$3,040.00</b>	<b>\$4,920.00</b>

If for any reason your tissue samples do not reach our company and/or we are unable to process and store your tissues properly, your processing fee will be waived

Storage Payment Fee for the second and subsequent years will be charged to your credit card in the amount of **\$95.00** per person. It will be due one month prior to the anniversary of your contract agreement and for as long as the tissue samples remain in storage. Annual Storage Fees are guaranteed not to increase from the amount stated in the original contract.

I understand the fees as outlined in this document .My signature below certifies that I agree to be responsible for payment of these fees.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

## Credit Card Authorization

---

I hereby authorize StemCure to charge the following credit card account, or bank account, in accordance with the contract plan selected above. I understand that I will remain responsible for any recurring charges and additional late fees should my credit card be cancelled or otherwise made unavailable for payment. I also understand that I will remain responsible for recurring charges and additional late fees and other applicable charges if the withdrawal to the bank account I have listed above is denied for insufficient funds or the account otherwise becomes unavailable. I also agree to payment of the non-refundable deposit outlined above should I cancel this contract prior to the collection of the tissue samples.

MasterCard \$ \_\_\_\_\_  Visa \$ \_\_\_\_\_  American Express \$ \_\_\_\_\_  Discover \$ \_\_\_\_\_

\_\_\_\_\_

Card Number	Security Code*	Expiration Date
-------------	----------------	-----------------

\_\_\_\_\_  
Name as it appears on the Credit Card

\_\_\_\_\_  
Billing Address

State	Zip Code
-------	----------

\_\_\_\_\_  
Authorized Signature of Cardholder

Today's Date
--------------

\*The Security Code is the last three digits located on the back of your Credit Card usually inside the signature area. On American Express cards, it is 4 digits and located on the front of the card above the credit card number.