



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

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**Health Advantage**



**Health Advantage**  
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## NEWBORN ENROLLMENT REQUEST

A newborn child may be covered from the date of birth if the newborn is enrolled within 90 days of the date of birth. This form may be used to request enrollment of a newborn child. The member will receive an Identification Card once enrolled. Newborns not enrolled within 90 days of the date of birth will be subject to plan rules governing Late Enrollees.

This completed form may be mailed, faxed, or e-mailed. Please refer to the applicable information above. If you have any questions, please refer to your membership materials or contact Customer Service.

Sincerely,  
Customer Accounts

## NEWBORN ENROLLMENT INFORMATION

Policyholder \_\_\_\_\_

Member ID # \_\_\_\_\_ Member SSN \_\_\_\_\_

**Group Name** \_\_\_\_\_ **Group Number** \_\_\_\_\_

Newborn Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex \_\_\_\_\_ Newborn Social Security Number: \_\_\_\_\_

Primary Care Physician (PCP) 5-digit code\* \_\_\_\_\_

Will Newborn be covered by any other insurance? *(Please check Yes or NO)* \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, Plan name and address \_\_\_\_\_

**Member Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Group Administrator  
Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**A signed copy of this form may be given to the employee before the expected date of birth to complete and mail , fax, or e-mail when the baby is born.**

**For multiple births, such as twins, please write Name, Sex, SSN and the PCP\*, information on the bottom of this form.**

*\*PCP information needed for Health Advantage Members ONLY*