Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

PLEASE RETURN COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR

P.O. Box 8069
Little Rock, Arkansas 72203-8069

REQUEST FOR MEMBER SSN

Subscriber Name_____

Subscriber ID#_____Home phone_____

Subscriber SSN_____Work phone_____

Address_____

Group Name_____Group Number_____

Health Advantage requires the Social Security Number (SSN) on all members in order to insure proper payment of claims and coordination of benefits. The SSN was not provided at the time of enrollment for above member.

If this is a newborn child, please complete this form when you receive the SSN for the child.

Sincerely,

Customer Accounts

SOCIAL SECURITY NUMBER (SSN) INFORMATION

Subscriber ID #_____Subscriber SSN_____

Subscriber Name_____

Group name_____Group number_____

Member name_____

Member SSN_____

Subscriber Signature_____Date_____

5/2004

FAX 501-301-6869