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

Newborn/Adopted Child Change Form

This form should be completed if you are requesting to add to your policy a newborn within 90 days of birth or adopted child within 60 days of filing the adoption petition. Documentation is required to add an adoptive child(ren) and the appropriate documentation such as a copy of adoption papers or other court papers must accompany this form, in order to support this change. If you are requesting to add a newborn or adopted child outside the above referenced time limits, you will need to complete an **Underwriting Change Form. To request an Underwriting Change Form, call 1-800-843-1329.**

Medical underwriting may apply to the addition of a newborn/adopted child. Please refer to your policy for more information.

Please Note: Do not submit this change form prior to a newborn's date of birth or prior to the filing of the adoption petition.

BEFORE COMPLETING THIS CHANGE FORM, PLEASE READ THE FOLLOWING INSTRUCTIONS:

- This form is a legal document. It is very important that you provide **all** requested information and that it is accurate and legible.
- Please ensure that all required parties sign and date the form.
- This form must be completed in dark blue or black ink.
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- **Do not use liquid paper, correction tape or "white out" to correct any mistakes you make on this application**.
- Any attached sheets must be signed and dated.
- **We strongly encourage you to make a photocopy of this completed form for your records.**

****IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS****

Your Health Advantage coverage **may** be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health Advantage Customer Service at **1-800-843-1329**. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

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IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of healthcare services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Health Advantage and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any healthcare item or service in relation to the healthcare provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Health Advantage in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Health Advantage may disclose this information to others as required or permitted by law and as set out in the Health Advantage Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Health Advantage, P.O. Box 8069, Little Rock, AR 72203-8069. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

Name of Newborn/Adopted Child(ren) (Please Print)

_____

_____

_____

_____

_____

_____ _____ _____/_____/_____

Parent/Legal Guardian's Signature Date

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Return To: **Health Advantage**
Attn: CRM Operations and Service
P.O. Box 8069
Little Rock, AR 72203-8069

OR

Fax: **501-378-3752**
Email: **CRMCustomerService@arkbluecross.com**

1 POLICYHOLDER INFORMATION

Member ID:_____ Group Number:_____ Date of Birth: ____/_____/_____

First Name:_____ M.I.: ___ Last Name: _____ Social Security No.: _____

Residential Address: _____ City: _____ State: _____ Zip: _____

2 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-Mail Address
( )	( )	AM PM	

*Health Advantage may contact you, either directly or through a business associate, using your postal or email addresses,telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks,disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Health Advantage.

3 NEWBORN OR ADOPTED CHILD(REN) INFORMATION

Indicate below the name of the dependent(s) you want added to this policy.

First Name	M.I.	Last Name	Suffix	Sex	Date of Birth	Adoption Petition Date	Social Security No.	Newborn or Adopted

Does the proposed child(ren) reside with the policyholder? _____Yes _____No
If "no," please provide the following:

Name of Parent/Guardian child(ren) resides with: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____)_____ Alternate Phone Number: (_____)_____

Best Time to Call: AM PM

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) The insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (2) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (3) My signature authorizes Health Advantage to coordinate benefits under this policy with other insurance I have which is subject to coordination. (4) Health Advantage may phone me for additional information that may help with the timely processing of my application. In signing below, I: represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify that I signed this change form in the state of Arkansas.

Signature of Policyholder	X	Date Signed

FOR HOME OFFICE ENDORSEMENTS

Important Note: If the addition of your newborn or adopted child requires medical underwriting, you will receive a telephone call from our enrollment department. In such instances, your newborn or adopted child will be added to your policy only upon approval by underwriting; and the effective date of coverage will be subsequent to the approval date.

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