



**Arkansas  
BlueCross BlueShield**

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 one of these additions outside these time limits, you will need to complete an **Underwriting Change Form**. To request an Underwriting Change Form, call 1-800-634-6314.

**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.
- Any attached sheets must be signed and dated.
- **We strongly encourage you to make a photocopy of this completed form for your records.**

good for  
**you.**

# IMPORTANT:

**We cannot process your application without this completed form.**

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied 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 health care item or service in relation to the health care provider having been paid in full out-of-pocket. I authorize any prior insurance carrier or third party to furnish information, medical or non-medical, concerning my family members listed in my application. I authorize the Office of Driver Services to release applicable family members traffic violation records to Arkansas Blue Cross and Blue Shield. 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 Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. 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 Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. 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).

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

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\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



# Newborn/Adopted Child Change Form

**Return To:**

Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, P.O. Box 2181, Little Rock, AR 72203-2181

## 1 POLICYHOLDER INFORMATION

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

## 2 CONTACT INFORMATION

Primary Phone Number ( ) ( )	Alternate Phone Number ( ) ( )	Best Time to Call AM PM	E-Mail Address
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## 3 NEWBORN OR ADOPTED CHILD(REN) INFORMATION

Indicate below the name of the dependents you want added to this policy.

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

If the child(ren) is adopted, please indicate the adoption petition filing date \_\_\_/\_\_\_/\_\_\_

Do 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 to the child(ren): \_\_\_\_\_  
 Primary Phone Number: (\_\_\_\_) \_\_\_\_\_ Alternate Phone Number: (\_\_\_\_) \_\_\_\_\_  
 Best Time to Call: AM PM

## 4 PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected. (2) If accepted, 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. (3) 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 false information. (4) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (5) Arkansas Blue Cross and Blue Shield 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	<b>X</b>	Date Signed
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## 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 Underwriting Division. In such instances, your newborn or adopted child will be added to your policy only upon approval by our Underwriting Division; and the effective date of coverage will be subsequent to the approval date.



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P.O. Box 2181, Little Rock, AR 72203-2181  
[www.ArkansasBlueCross.com](http://www.ArkansasBlueCross.com)