MUNICIPAL HEALTH BENEFIT PROGRAM

NEWBORN ENROLLMENT APPLICATION

A newborn child may be covered from the date of birth if enrolled within the MHBP within 60 days of the date of birth. Newborns not enrolled within this timeframe may not be enrolled until the next open enrollment period.

Newborn Enrollment Information

Employee/Policyholder Name: ____

Employee Mailing Address: ____

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Employee SSN: ____________________ Employee Date of Birth: _________________________

Newborn Name: ____

Newborn Date of Birth: ___________________________________

Newborn SSN (if available. Please attach copy of SSN card): _____________________________

Newborn Gender: _____Male _____Female

For multiple births, such as twins, please complete a separate form

Will this newborn be covered by any other insurance? _____Yes _____No

If Yes, please complete the following information:

Other insurance company name: ____

Other insurance company phone number: ____

Other insurance Policyholder Name: ____

Other insurance Policyholder Relationship to Newborn: _______________________________________

Other insurance Identification/Policy number: ____

Member Signature: ____ Date: _____________________

Group Representative Signature: _______________________________ Date: _____________________

A signed copy of this form may be given to the employee before the expected date of birth to complete and submit when the baby is born. Form can be faxed to 501-537-7265 or emailed to mhbpgrpsvcs@arml.org