Newborn Health Insurance Request Form

- Full Name of Baby A:
- Full Name of Baby B:
- DOB of Baby A:
- DOB of Baby B:
- Gender of Baby A:
- Gender of Baby B:
- Name and Address of Delivery Hospital:
- Name of Parent 1:
- Name of Parent 2:
- Parents' Full US Residence Address:
- Parents' US Phone Number:
- Parents' Email Address:
- Please provide a copy of proof of birth from the hospital and/or Birth Certificate.

Send billing information to:

Name:

Email:

Phone Number:

By submitting this request, you are authorizing ArcLight Insurance to obtain a health insurance policy for the newborn(s) listed above. It is agreed that the requesting party will be charged a fee of **$350** PER INSURED (BABY) for the application submission. Once this request form is received by ArcLight Insurance the above fees are fully earned. If this request is subsequently canceled on the same day as it is sent to us there will not be any fees that are due. If a cancellation request is received, all fees for services provided by ArcLight Insurance will still be due. By signing this form, you agree to the above fees.

_____	_____	_____
Name: (please print)	Signature	Date