ArcLight Insurance

Newborn Health Insurance Submission Form

Newborn Information

Full Name of Baby A

First | Middle | Last

Baby A's Date of Birth

Baby A's Sex

Full Name of Baby B

First | Middle | Last

Baby B's Date of Birth

Baby B's Sex

www.arclightinsurance.com | ***submissions@arclightinsurance.com***
Lic. #0129653 | *Phone: (310)550-6862* | *Fax: (310)550-6863*

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Delivery Hospital Information

Delivery Hospital Name

Delivery Hospital Address

Street Address

Address Line 2

City

State

ZIP Code

Please provide a copy of proof of birth from the hospital and/or Birth Certificate.

Attach the document(s) to this form, or email us at submissions@arclightinsurance.com following your submission of this form.

Accepted file types: jpg, png, pdf, heic
Max. file size: 50MB
Max. files: 2

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Intended Parent Information

Intended Parent 1 Name

First

Last

Intended Parent 2 Name

First

Last

Intended Parent Address

Please list your United States address.

Street Address

Address Line 2

City

State

ZIP Code

Intended Parent Phone Number

Please list your United States phone number.

Intended Parent Email

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Send billing information to:

Agency Name (if applicable)

Name

First

Last

Email

Phone Number

Please review the following terms of agreement:

By submitting this request, you are authorizing ArcLight Insurance to obtain a health insurance policy for the newborn(s) listed in this submission. It is agreed that the requesting party will be charged a fee of $365 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

First

Last

Signature

Date

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Additional Comments