

Healthy Families Infant Registration Form

Immediately after your baby's birth, complete and mail this form to Healthy Families. Your baby's coverage will not begin with the Healthy Families Program unless we receive this form. For more information about Healthy Families, including your dental and vision plan choices, visit www.healthyfamilies.ca.gov or call 1-800-880-5305. If your family income has gone down, your baby may qualify for free Medi-Cal.

Subscriber Name: _____ Subscriber Date of Birth: ___/___/___

AIM Family Member Number: _____

Residence Address: _____

1. Infant Information:

Is infant currently enrolled in employer-sponsored insurance? ___ No ___ Yes

If yes, provide the infant's effective date of coverage: ___/___/___ (mo/day/year)

Note: If you answered yes, your infant is not eligible to be enrolled in the Healthy Families Program.

Was infant previously enrolled in employer-sponsored insurance in the last 3 months? ___ No ___ Yes

Infant's First Name _____ Middle Initial _____ Last Name _____

Gender: Male ___ Female ___ Birth Date: ___/___/___ Birth Weight: ___ pounds ___ ounces

Primary Care Provider *optional*: _____

Dental Plan Selection (refer to Healthy Families Handbook) *optional*: _____

Vision Plan Selection (refer to Healthy Families Handbook) *optional*: _____

Change of Address/Phone Number: _____

2. Do you now have or have you ever had children enrolled in the Healthy Families Program? If so, please provide names and Family Member Numbers below:

Name: _____ Family Member Number: _____

Name: _____ Family Member Number: _____

Name: _____ Family Member Number: _____

Note: If you have other children currently enrolled in Healthy Families, your infant will be enrolled into the same dental and vision plans as your other children. On the third month after birth, your infant will be transferred to the same health plan as your other children.

I declare that each person I am enrolling:

- is a resident of California.
- is not eligible for Medicare Part A and Part B.

I further declare that:

- All individuals listed on this form will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the Healthy Families Handbook. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am enrolling, and all other facts on this application.
- I agree to notify the Program within 30 days of any change of address of any person enrolled into the Program and any change in the applicant's billing address.
- I understand that if my pregnancy ends after my effective date, I will be disenrolled 60 days after the end of my pregnancy. AIM will not cover any medical services I receive after the 60th day from when my pregnancy ended. I understand I will still have to pay any outstanding payments to AIM, even if I choose to pay the subscriber contribution over 12 months.

I certify that I have read and understand the information above. **I also certify** that the information I have given on this form is true and correct.

Signature _____ Date _____

Send this completed form to: Healthy Families Program, P.O. Box 138005, Sacramento, CA 95813-8005