Solstice

APPLICATION FOR GROUP BENEFITS

Post Office Box 19199, Plantation, Florida 33318 | Ph. 877.760.2247 | Fax 954.370.1701

SECTION I - GROUP INFORMATION

Legal Business Name: Name of Business:
SIC Code: State of Situs: Tax ID#: Contact Name:
Title: Email Address:
Phone Number: Fax Number:
Street Address: City: State: ZIP:
Mailing Address: (if different) City: State: ZIP:

Please select one of the following:
Corporation (Including S-Corp) Partnership Proprietorship Other (specify)

Are subsidiaries included:
No Yes (*If Yes, please attach name and addresses)*

Separate billing statements required:
No Yes (*If Yes, please provide special billing instructions)*

SECTION II – EMPLOYEE INFORMATION

EMPLOYEE ELIGIBILITY *(please print)*
An Eligible Employee is one who works on a basis with a normal work week of or more hours for compensation.

A non-eligible employee is one who works less than hours per week or works on a basis.

Waiting periods for new employees:
First of the month following days of continuous employment First of the month following months of continuous employment
None Other: (specify)

ELIGIBILITY FOR COVERAGES *(please print)*
Annual open enrollment period? No Yes Duration: (31 days max)

Are dental benefits offered under Section 125 Plan? No Yes

Annual election period from / / Ineligible classes or division: *(if none, please state)*

Prior group coverage? No Yes Carrier: Date of Termination: / /

Plan currently in force? No Yes Effective Date: / / Attach Invoice

SECTION III – COVERAGE

COVERAGE REQUESTED *(please print)*
Select Your Plan: (Refer to your Schedule of Benefits for plan details)

Dental -*If multiple plan options have been offered, please write in plan selection(s)*
Plan 1: Plan 2: Plan 3:

Discount Prescription –*This is an optional free value-added benefit offered at no cost* No Yes

<u>Indicate the number of persons who are eligible for coverage</u>:

Number of COBRA participants: Number of retirees: Domestic Partners covered? No Yes

DENTAL RATES AND CONTRIBUTIONS										
Tier Structure	Rate Tiers	Rates			Number of Enrolled Employees			Employer Contribution %		
		Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3
1 ☐	Composite									
2 ☐	EE									
	EE + Family									
3 ☐	EE									
	EE + 1									
	EE + 2 +									
4 ☐	EE									
	EE + Spouse									
	EE + Child(ren)									
	EE + Family									
Amount of Binder Check:				***This check must accompany the group application.						

APPLICATION FOR GROUP BENEFITS

SECTION IV – AGENT/PRODUCER INFORMATION

Agent/Broker Name: License ID Number / Tax ID: /
Agency Name: % of Credit: E-Mail Address:
Phone Number: ( ) - Fax Number: ( ) -
Address: City: State: ZIP:
Signature: Date:

Agent/Broker Name: License ID Number / Tax ID: /
Agency Name: % of Credit: E-Mail Address:
Phone Number: ( ) - Fax Number: ( ) -
Address: City: State: ZIP:
Signature: Date:

SECTION V - SIGNATURE

It is understood that no agent has power on behalf of Solstice to make or modify any request or application for coverage or to bind Solstice by making any promise or representation or by giving or receiving any information.

It is further understood that no coverage will be effective unless and until the application is accepted in writing by Solstice. Final rates will be based on enrollment data as of the Policy effective date. No coverage is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood and agreed that the Policy, if issued, shall include the Policy and/or membership fees and general provisions of the Policy and be binding upon the applicant and Solstice. Policy and/or membership fees are subject to the approval of Solstice and nothing contained herein shall be binding until this application is approved and accepted by Solstice.

I understand that this application will form a part of the group Policy issued by Solstice, and by my signature below I agree to be bound by the terms and conditions of that group Policy. I understand that Solstice may choose not to accept this application at its sole discretion subject to any state requirements.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Location signed: Date signed:
Print Name of Officer, Partner or Proprietor:
Signature of Officer, Partner or Proprietor:
Witness to Signature: