Solstice Enrollment/Change Form

Solstice
P.O. Box 19199
Plantation, FL 33318
Office 1.877.760.2247
Fax 954.370.1701

Effective Date (MM/DD/YYYY)

	/		/	
	/		/	

PLEASE MARK APPROPRIATE BOX

☐ New enrollment ☐ Change of plan ☐ Change of name ☐ Waive
☐ Change of address ☐ Change of dependents ☐ Reinstate Terminated employment

Group, Association, or Employer Name

Group Number

NOTE : PLEASE COMPLETE ALL INFORMATION

SOCIAL SECURITY #	**NAME** (Last, First, Middle Initial)	**DATE OF BIRTH** *(MM/DD/YYYY)*
- -		/ /

ADDRESS / CITY / STATE /ZIP

DATE EMPLOYED *(MM/D/YYYY)*	**TELEPHONE NUMBER**	**GENDER**	**EMAIL ADDRESS**
/ /	( ) -	☐ Male ☐ Female	

SELECT YOUR PLAN (Refer to your Schedule of Benefits for plan details)
☐ Dental ☐ Other ☐ (If multiple plan options have been offered, please write in plan selection below)

FAMILY INFORMATION

RELATIONSHIP	**NAME** (Include last name if different)	**SOCIAL SECURITY #**	**SEX**	**DATE OF BIRTH** *(MM/D/YYYY)*	**(CHECK ONE)**
SPOUSE		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel
CHILD		- -	☐ M ☐ F	/ /	☐ Add ☐ Cancel

Please submit proof of handicapped status for over age dependents. I hereby apply for benefits for which I am eligible as either an employee or association member. If contributions or fees are required, I authorize my employer to deduct such fees from my salary.

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.

*** DOCUMENT CONTINUED AND SIGNATURE REQUIRED ON NEXT PAGE***

HOW MAY WE CONTACT YOU?

If you want to get information from us electronically, we must have your email address. By listing an email address, you agree we may send your Plan information electronically. This electronic delivery will continue through any Plan renewals or changes.

You can go back to paper delivery at any time with no penalty. To make or change your choices, you may call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device.

Do we have permission to communicate electronically with you regarding this enrollment form and this Dental Plan? Y☐ N☐

I have read and accept the provisions printed above	SIGNATURE	DATE / /