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	Group, Association, or Employer Name
☐ New enrollment ☐ Change of plan ☐ Change of name ☐ Waive ☐ Change of address ☐ Change of dependents ☐ Reinstate Terminated Employment	Group Number
	Division

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/DD/YYYY)*	**TELEPHONE NUMBER**	**GENDER**	**EMAIL ADDRESS**
/ /	( ) -	☐ Male ☐ Female	

SELECT YOUR PLAN (Refer to your Schedule of Benefits for plan details

☐ Dental ☐ ☐

FAMILY INFORMATION

RELATIONSHIP	NAME (Include last name if different)	SOCIAL SECURITY	SEX	DATE OF BIRTH *(MM/DD/YYYY)*	DENTAL	VISION
SPOUSE		- -	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No
CHILD		- -	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No
CHILD		- -	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No
CHILD		- -	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No
CHILD		- -	☐ M ☐ F	/ /	☐ Yes ☐ No	☐ Yes ☐ No

Please submit proof of incapacity 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.

Authorization: Do we have permission to communicate electronically with you regarding this Plan? Y ☐ N ☐
(If you want to get information from us electronically, you must list your full email address in the specified box above.)

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.

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