Dental Enrollment/Change Request

Solstice Benefits, Inc.

EMPLOYER/GROUP INFORMATION – To be completed by Employer/Group

Group Name	Group Number
Palm Beach Co Palm Tran	

A. TYPE OF ACTIVITY – To be completed by Employer/Group. *Refer to instructions on the next page before completing this form. Please print clearly.*
Note: Employee must be enrolled for spouse/dependent(s) to have coverage.

1. ENROLLMENT

☐ New Employee/Member

Effective Date
_____ / _____ / _____

Date of Hire/Membership
_____ / _____ / _____

Hours Worked Per Week *(if applicable)*
_____ / _____

2. ADD, CHANGE, REMOVE – *Complete all that apply.*

	Effective Date	Reason	Add/Change/Remove Status
▪ Spouse	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Domestic Partner	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Dependent Child	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Name Change	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Change Plan	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Other	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Employee	___/___/___	_____	☐ Employee Withdrawal ☐ Termination

B. EMPLOYEE/MEMBER INFORMATION – To be completed by Employee/Member
Complete sections B-G. *Refer to instructions on back before completing this form. Please print clearly.*

Last Name		**Social Security Number** - -	**Home Telephone Number** ( )
First Name, M.I.		**Date of Birth**	**Sex** M ☐ F ☐
Home Address	**Apt. No.**	**City, State**	**ZIP Code**

C. PLAN OPTION
Your selection must be offered by your Employer/Group.

☐ Dental Prepaid Plan No. Option 1 - DHMO

☐ Dental PPO/Indemnity Plan No. Option 2 - PPO LOw

☐ Vision Plan No. Option 3 - PPO High

D. INDIVIDUALS COVERED List individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages, if necessary, with your signature and the date signed.

	(A) Add (C) Change (R) Remove	Last Name, First Name, M. I.	Sex M ☐ F ☐	Date of Birth MM DD YYYY	Social Security Number	Other Dental Coverage	Previous Dental Coverage
Spouse/ Partner			☐ ☐	/ /	- -	Yes ☐ No ☐	Yes ☐ No ☐
Child			☐ ☐	/ /	- -	Yes ☐ No ☐	Yes ☐ No ☐
Child			☐ ☐	/ /	- -	Yes ☐ No ☐	Yes ☐ No ☐
Child			☐ ☐	/ /	- -	Yes ☐ No ☐	Yes ☐ No ☐

E. OTHER/PREVIOUS INSURANCE Attach additional pages, if necessary, with your signature and the date signed.

Is your Spouse/Partner Employed? Yes ☐ No ☐
If "Yes", please give name & address of Employer:

If "Yes" to Other Dental Coverage (Section D), give the name and policy number(s) of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, please identify the coverage and provide the Medicare ID number.

If "Yes" to Previous Dental Coverage (Section D), please provide the following:

*Name of person with previous coverage:*_____
Previous coverage effective date: _____
*Previous coverage termination date:*_____
*Name of previous coverage carrier*_____
Name of previous coverage plan _____

Please submit a copy of the Certificate of Credible Coverage that was issued by the Previous Coverage carrier, if available.

F. DEPENDENT INFORMATION

Does any Dependent listed in Section D live at a different address from the Employee/Member? Yes ☐ No ☐

If "Yes", with whom and at what address?

Please explain the circumstances.

G. EMPLOYEE/MEMBER SIGNATURE If you have any questions about the benefits provided by or excluded under this Policy, contact a Member Services Representative at **1.877.760.2247** before or after signing this form.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
I hereby apply for benefits for which I am eligible as either an employee or member. If contributions or fees are required, I authorize my employer to deduct such contributions from my salary.

Employee Signature – Required
X

Print Name

Date / /

Please make a copy for your records. Visit us at www.SolsticeBenefits.com.

INSTRUCTIONS

Employer/Group - Complete Employer/Group Information and Section A

Employer/Group Information
Complete this section located in the upper right corner of the form.

Section A: Type of Activity

- Check boxes indicating reason(s) for submitting Enrollment/Change Request.
- For "Enroll," "Add," or "Change," Effective Dates should occur on the first of the month.
- For "Terminate," or "Remove," Effective Dates should occur on the last day of the month.

Employee/Member - Complete Sections B –G

Section B – Employee/Member Information
Complete **all** information, if applicable, in order for your Enrollment/Change Request to be processed.

Section C – Plan Option

- Check your Plan Option.
- Select only a Plan Option offered by your employer.

Section D – Individuals Covered

- For the "Add/Change/Remove" column, use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for each individual listed.
- Print the full name of each individual listed.
- Indicate Sex, Date of Birth, and Social Security Number for each individual listed.
- Indicate whether any individual listed currently has other dental coverage. Coverage includes group coverage, governmental coverage, a church plan or Medicare.
- Indicate whether any individual had previous coverage.
- If a Dependent is disabled and being continued beyond the limiting age, please attach proof of disability.

Section E – Other/Previous Insurance

- Complete this section for all new enrollments or coverage changes.
- Coverage includes group coverage, governmental coverage, a church plan or Medicare.
- Attach additional pages, if necessary, with your signature and the date signed.
- If not applicable, please mark as "N/A".

Section F – Dependent Information

- Complete this section for all new enrollments or coverage changes.
- Attach additional pages, if necessary, with your signature and the date signed.
- If not applicable, please mark as "N/A".

Section G – Employee/Member Signature

- Complete this section for all new enrollments, coverage changes, removals/terminations.
- Employee/Member must sign and date the Enrollment/Change Request in order for it to be processed.

CONDITIONS OF ENROLLMENT

Applicant Acknowledgements and Agreements

On behalf of myself and the Dependent(s) listed in this Enrollment/Change Request form, I acknowledge that:

1. Solstice EPO, PPO, and Indemnity dental plans are administered and underwritten by Solstice Benefits, Inc. ("Solstice").
2. I authorize the authorized sources stated below to give to Solstice or any consumer-reporting agency acting on Solstice's behalf, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or to a minor dependent applying for coverage. Authorized sources are any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer-reporting agency, and employer.
3. I agree that this authorization shall be valid for thirty (30) months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
4. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Solstice has taken in reliance on the authorization.
5. I understand that I may receive a copy of this authorization if I request one.
6. I agree that a photocopy of this authorization is as valid as the original.
7. I agree that Solstice will provide coverage in accordance with the terms, conditions, limitations, and exclusions of the group policy.
8. I agree that enrollment of myself and my listed Dependent(s) into the plan is effective upon acceptance by Solstice.
9. I agree that the provision of coverage and benefits is contingent upon timely payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not timely paid.
10. I authorize my Employer/Group to withhold payments from my wages as contribution to the premium, as appropriate.
11. **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**