



# Enrollment/Change Request

Solstice Healthplans, Inc.

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

**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/Member must be enrolled for spouse/Dependent(s) to have coverage.

<b>Group Name</b>	<b>Group Number</b>
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<b>1. ENROLLMENT</b> <input type="checkbox"/> New Employee/Member  <b>Effective Date</b> ____ / ____ / ____ <b>Date of Hire/Membership</b> ____ / ____ / ____ <b>Hours Worked Per Week (if applicable)</b> ____	<b>2. ADD, CHANGE, REMOVE</b> – Complete all that apply. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Effective Date</th> <th style="text-align: center;">Reason</th> <th style="text-align: center;">Add/Change/Remove Status</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Spouse</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> <tr> <td><input type="checkbox"/> Domestic Partner</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> <tr> <td><input type="checkbox"/> Dependent Child</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> <tr> <td><input type="checkbox"/> Name Change</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> <tr> <td><input type="checkbox"/> Change Plan</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> <tr> <td><input type="checkbox"/> Employee/Member</td> <td style="text-align: center;">__/__/__</td> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove</td> </tr> </tbody> </table>		Effective Date	Reason	Add/Change/Remove Status	<input type="checkbox"/> Spouse	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Domestic Partner	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Dependent Child	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Name Change	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Change Plan	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Other	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	<input type="checkbox"/> Employee/Member	__/__/__	_____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove
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**B. EMPLOYEE/MEMBER INFORMATION** – To be completed by Employee/Member.

Complete sections B-G. Refer to instructions on the next page before completing this form. Please print clearly.

**C. PLAN OPTION**

Your selection must be offered by your Employer/Group.

<b>Last Name, First Name and Middle Initial</b>		<b>Social Security Number</b> ____ - ____ - ____	<b>Home Telephone Number</b> ( ____ ) ____ - ____	<input type="checkbox"/> Dental Plan _____
<b>E-Mail Address</b>		<b>Date of Birth</b> ____/____/____	<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>	
<b>Home Address</b>	<b>Apt. No.</b>	<b>City, State</b>	<b>ZIP Code</b>	

**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 <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth MM DD YYYY	Social Security Number	Other Dental Coverage	Previous Dental Coverage
Spouse[/Partner]			<input type="checkbox"/> <input type="checkbox"/>	/ /	- -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	- -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	- -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>	/ /	- -	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

**F. DEPENDENT INFORMATION**

Is your Spouse [/Partner] Employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please give name & address of Employer: _____	<b>If "Yes" to Previous Dental Coverage (Section D), please provide the following:</b>  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 Creditable Coverage that was issued by the Previous Coverage carrier, if available.	Does any Dependent listed in Section D live at a different address from the Employee/Member? Yes <input type="checkbox"/> No <input type="checkbox"/>  If "Yes", with whom and at what address?  Please explain the circumstances.
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**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 1.888.200.0322 before or after signing this form.

I have read and accept the provisions printed below and hereby apply for benefits for which I am eligible. If contributions or fees are required, I authorize my employer to deduct such contributions from my salary. <b>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.</b>	<b>Employee/Member Signature – Required</b> <b>X</b> Print Name _____ Date ____/____/____
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Please make a copy for your records. Visit us at [www.SolsticeBenefits.com](http://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/group.

#### 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 only if you are enrolling the individual for new dental coverage or if there is a coverage change for dental insurance. 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 for dental insurance only.
- 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 plans are administered and underwritten/Underwritten}by Solstice Healthplans, 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 a maximum of twenty-four (24) months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date, which I can do at any time.
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. This authorization is valid for a maximum of twenty-four (24) months, but I may revoke it at any time.
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.**