Dental Application/Change Request

Solstice Health Insurance Company

A. TYPE OF ACTIVITY – *Refer to instructions on the next page before completing this form. Please print clearly.*

1. ENROLLMENT

☐ New Member

Effective Date

_____ / _____ / _______

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

	Effective Date	Reason	Add/Change/Remove Status		
▪ Spouse	___/___/___	______________________	☐ Add	☐ Change	☐ Remove
▪ Domestic Partner	___/___/___	______________________	☐ Add	☐ Change	☐ Remove
▪ Child	___/___/___	______________________	☐ Add	☐ Change	☐ Remove
▪ Name Change	___/___/___	______________________	☐ Add	☐ Change	☐ Remove
▪ Change Plan	___/___/___	______________________	☐ Add	☐ Change	☐ Remove
▪ Other	___/___/___	______________________	☐ Add	☐ Change	☐ Remove
▪ Subscriber	___/___/___	______________________	☐ Add	☐ Change	☐ Remove

B. SUBSCRIBER/RESPONSIBLE ADULT INFORMATION

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

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

C. PLAN OPTION

☐ Essential*Smile* 111

☐ Essential*Smile* Ped 111

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 Creditable 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 Subscriber?

Yes ☐ No ☐

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

Please explain the circumstances.

G. SUBSCRIBER/RESPONSIBLE ADULT 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.

I have read and accept the provisions printed below and hereby apply for benefits for which I am eligible:

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.

Subscriber/Responsible Adult Signature – Required

X

Print Name

Date / /

INSTRUCTIONS

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.

Section B – Subscriber/Responsible Adult 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 the desired plan option.

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 – Subscriber/Responsible Adult Signature

- Complete this section for all new enrollments, coverage changes, removals/terminations.
- The Subscriber or Responsible Adult 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 dental plans are underwritten by Solstice Health Insurance Company. ("Solstice").
2. By signing this form, I authorize Solstice to debit/charge the account indicated on the payment authorization form. The account will be debited/charged on the 1st business day of the month of the billing cycle.
3. 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.
4. I understand that I may receive a copy of this authorization if I request one.
5. I agree that a photocopy of this authorization is as valid as the original.
6. I agree that Solstice will provide coverage in accordance with the terms, conditions, limitations, and exclusions of the policy.
7. I agree that enrollment of myself and my listed Dependent(s) into the plan is effective upon acceptance by Solstice.
8. 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 policy if premiums are not timely paid.
9. **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.**