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)

10	/	01	/	2020

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
Okaloosa County Board of County Commissioners

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 ☐ Vision (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/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 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 have read and accept the provisions printed above	**SIGNATURE**	**DATE** / /