Solstice Enrollment/Change Form



Effective	Date (MM/DD/Y	YYY)	
	/		/	

P.O. Box 19199 Plantation, FL 33318 Office 1.877.760.2247

				Fax 954.	370.1701
				Group, Association, or Emp	nlover Name
PLEASE MARK API	dioup, Association, or Emp	pioyer Name			
☐ New enrollmen☐ Change of address	J 1	☐ Change of name☐ Reinstate Terminated €		Group Number	
- Change of additi	<u> </u>	: PLEASE COMPLETE ALL	. ,		
COCIAL CECUDITY			INFORMATION		DATE OF DIDTH
SOCIAL SECURITY	# NAME (Last, First, Middle	! Initial)			DATE OF BIRTH (MM/DD/YYYY)
					/ /
ADDRESS / CITY / S	STATE / ZIP				
DATE EMPLOYED	TELEPHONE NUMBER	GENDER	EMAIL ADDRESS		
(MM/DD/YYYY)	TEEEI HORE ROMDER	☐ Male	EMAIL ADDRESS		
/ /	() -	☐ Female			
	AN (Refer to your Schedule of Bene ision Other (If multiple plan	•		·	
	ision 🗀 Other (il mulupie pian	options have been offered, plea	se write in pian select	ion below)	
		FAMILY INFORMAT	ION		
RELATIONSHIP	NAME (Include last name if different)	FAMILY INFORMAT SOCIAL SECURITY #	ION SEX	DATE OF BIRTH (MM/DD/YYYY)	(CHECK ONE)
RELATIONSHIP SPOUSE					Add
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SPOUSE CHILD CHILD CHILD CHILD CHILD Please submit proo		SOCIAL SECURITY #	SEX M F M F M F M F M F M F M F M F M F Oly for benefits for	(MM/DD/YYYY) / / / / / / / / / which I am eligible as	Add Cancel
SPOUSE CHILD CHILD CHILD CHILD Please submit proo or association mem Any person who insurance or state information concepts	(Include last name if different) f of handicapped status for over ag	social SECURITY #	SEX M	(MM/DD/YYYY) / / / / / which I am eligible as h fees from my salary. person files an appl s for the purpose of which is a crime, an	Add Cancel Add Add Add Add Add Add Add Add Add Ad