INFORMATIONAL FORM

MEMBER INFORMATION	
Benefit Plan:	Coverage Type:
Last Name:	First Name:
Member SS#:	Date of Birth:
Home Phone:	Email:
Mobile Phone:	Effective Date:
Gender: ◯ Male ◯ Female	Height: Weight:
Street Address:	Apt#:
City:	State:
Zip Code:	Marital Status: Single ◯ Married ◯ Divorced ◯
EMPLOYMENT INFORMATION	
Business Name:	Business Phone:
Occupation/Industry:	Business Email:
Business Address:	Employment Start Date: Compensation Type: Hourly ◯ Salary ◯
Actively Employed: Yes ◯ No ◯	Hours Worked Per Week:
SPOUSE INFORMATION *(If Applicable)*	
Last Name:	First Name:
SS# Height: Weight:	Date of Birth
DEPENDENT INFORMATION *(If Applicable up to age 26)*	
Last Name:	First Name:
SS# Height: Weight:	Date of Birth: GENDER M ◯ F ◯
Last Name:	First Name:
SS# Height: Weight:	Date of Birth: GENDER M ◯ F ◯
Last Name:	First Name:
SS# Height: Weight:	Date of Birth: GENDER M ◯ F ◯
Last Name:	First Name:
SS# Height: Weight:	Date of Birth: GENDER M ◯ F ◯
FULL NAME OF BENEFICIARY	
Primary:	Relationship:
Date of Birth:	SSN:
Contingent 1:	Contingent 1 Relationship:
Contingent 1 Date of Birth:	Contingent 1 SSN:
Contingent 2:	Contingent 2 Relationship:
Contingent 2 Date of Birth:	Contingent 2 SSN:

In the past 10 years has any applicant seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests, or has been advised to have treatment or surgery for anything of the following

a. *Heart attack, brain tumor, stroke, heart disease or heart problems?* YES NO	e. *Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder?* YES NO
b. *Cancer, tumor, lymphoma, or any type of transplant?* YES NO	f. *Seizures, epilepsy, hemophilia, Sleep Apnea or blood disorder?* YES NO
c. *Any surgery or hospitalization in the last 5 years, OR any currently pending, planned or recommended?* YES NO	g. *Diabetes, endocrine, Auto Immune, Crohn's Disease or Arthritis or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+?* YES NO
d. *Emphysema or COPD?* YES NO	h. *Currently pregnant, premature delivery, or multiple births? Pending due date* YES NO

I. **Are you taking or have you taken any medications in the last 12 months? (If yes you must list all below.)** YES NO

Medication Name	Medication Dosage	Medication Frequency

If you answered YES to ANY of the above Health Questions, please provide explanations in boxes below

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? YES NO	Taking Medication? YES NO

Treatment Given or needed?	Medication names:	Surgery or Hospitalization?

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? YES NO	Taking Medication? YES NO

Treatment Given or needed?	Medication names:	Surgery or Hospitalization?

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? YES NO	Taking Medication? YES NO

Treatment Given or needed?	Medication names:	Surgery or Hospitalization?

Please Note these are Optional Third-Party Benefits not affiliated with the Medical Plan

All Dental Plans include $5,000 Basic Life and AD&D at no cost (Vision only does not include Basic Life AD&D)

Solstice EPO (MDG) Dental Plan (NY, NJ, CT, FL only)

Network - S500 A

No Deductible **No Benefit Waiting Periods** **No Claim Forms to Submit**

Member Receives:

Most diagnostic and preventative care at no charge
Restorative, Endodontic Periodontics & Oral Surgery all covered at co-pays
Cosmetic & Orthodontia treatment covered

Solstice Dental PPO 1500 (All 50 States)

Deductible: $50 Single / $150 Family – Waived for preventive care
Plan Covers (In and Out-of-Network): 100% Preventative Care /80% Basic Services /50% Major Services
Out-of-network coverage: Reimbursement for both are based on participating Provider Contracted Fees.
Maximum Yearly Benefit: $1,500

Solstice Dental PPO 2000 (All 50 States)

Deductible: $50 Single / $150 Family – Waived for preventive care
Plan Covers (In and Out-of-Network): 100% Preventative Care /80% Basic Services /50% Major Services
Out-of-network coverage: Reimbursement for both are based on participating Provider Contracted Fees.
Maximum Yearly Benefit: $2,000

Solstice Vision (Davis Vision Network) (All 50 States)

Eye Exam: 12 months
Spectacle Lenses: 12 months
Contact Lenses (in lieu of eyeglasses): 12 months
Frame Allowance (Retail): Up to $100, plus 20% discount (Except Walmart and Sam's Club)
Eyeglass Benefit: Spectacle Lenses – Various Copays
Contact Lenses Benefit (in lieu of eyeglasses): Up to $100, plus 15% discount (Except Walmart and Sam's Club)
Out-of-network Reimbursement Schedule (up to): Eye Exam $40, Single Vision Lenses $40, Trifocal Lenses $80, Elective Contact Lenses $80, Frame $50

www.solsticebenefits.com

Optional: Please Check-off plan selection below to be enrolled. ***(This is in addition to medical premium)***

Solstice Dental EPO
☐ Single: $37.00 ☐ Emp. + Spouse: $61.00 ☐ Emp. + Child(ren): $73.00 ☐ Family: $91.00

Solstice Dental PPO 1500
☐ Single: $62.00 ☐ Emp. + Spouse: $118.00 ☐ Emp. + Child(ren): $133.00 ☐ Family: $182.00

Solstice Dental PPO 2000
☐ Single: $67.00 ☐ Emp. + Spouse: $128.00 ☐ Emp. + Child(ren): $143.00 ☐ Family: $197.00

Solstice Vision
☐ Single: $12.00 ☐ Emp. + Spouse: $20.00 ☐ Emp. + Child(ren): $24.00 ☐ Family: $30.00

Billing Application

Requested effective date (mm/dd/year) ____/____/____

Billing Information – Invoices should be sent to:

_____

Contact Person **Title**

_____

Company Name

_____

Address

_____

City **State** **Zip Code**

_____

Telephone **Fax**

Representative: _____

Payment Options;

☐ EFT-Direct Withdrawal (No Charge, please complete authorization form below)

☐ Monthly Invoice ($20 Billing Fee)

EFT AUTHORIZATION

Please Note there is a $30 Insufficient Funds Fee

Bank Route Code#_____ Bank Account#_____

Please deduct payment of $_____ between the 20th & 30th of the month Prior to the next months coverage.