HOW TO ENROLL

DCSMEC MEMBER ONLY BENEFITS

2015

• Complete enrollment form for:

Solstice Dental/Vision
Family Life Insurance Company GAP Plan

- Complete a DOE-70 form for each plan (authorization for the School Board to deduct the premium from your pay)
- Give the completed enrollment applications and DOE-70s to your Union Officer or deliver to the DCSMEC office at 2315 N.W. 107 Avenue, Room 1 M 36. You may also fax to the number listed below.
- Applications can be downloaded from our web site (www.DCSMEC.org)

Attention DSCMEC Members who are currently enrolled in the Family Life Hospital Supplement/Gap Plan. If you wish to change plans or add a dependent please contact John Moody at 1-888-358-8808 ext. 4144.

If you have any questions please call:

Solstice Dental

954-370-1736
Fax-954-370-1737

Family Life Hospital Supplement Plan

1-888-358-8808 ext. 4144
Fax-904-339-9793

FAMILYLIFE INSURANCE COMPANY **Application for Insurance**

10777 Northwest Freeway, Houston, Texas 77092

FRAUD: Any person who knowingly and with inte nt 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.

☐ Check if replacing or changing existing coverage in this company. **Policy Number** _____

PERSONS PROPOSED FOR INSURANCE								
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
			Primary Insured	/ /				
			Spouse	/ /				
			Child	/ /				
			Child	/ /				
			Child	/ /				

Address	City	State	Zip	Home Telephone ( )
Secondary Address	City	State	Zip	Home Telephone ( )

Payor or Owner if other than Primary Insured	☐ Payor ☐ Owner	Social Security No. - -	Relationship to Primary Insured
Employer	Date Employed	Occupation	
Hours Worked/Week	Monthly Income $	Group Number	Employee/Payroll Number
Beneficiary (Estate of Primary Insured unless beneficiary named)		Age	Relationship

FOR THE PAS T 30 DAYS: Have all proposed Insureds bee n performing no rmal activities a nd been activel y at work full time at their re gular occupation? _____ Yes _____ No. If "No", explain: _____

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? _____ Yes _____ No.
If "Yes", name of Company _____ Policy Number _____ Complete replacement form where required.

INSURANCE PLANS									Monthly Premium
HOSPITAL Elim./Max Ben		Base Policy	AD & D Rider	Emergency Acc. Rider	Hospital Injury Rider	ICU Rider	Lump Sum Rider	Outpatient Sick.Rider	
Inj. ☐ 0/180 ☐ 0/365	Primary Insured	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
Sick ☐ 0/180 ☐ 0/365	Spouse	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
☐ 3/365	Children	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
		Private Nurse Rider	Surgical Rider	Surgical + Rider	Spec. Injury Rider	1st Hospital Conf. Rider	Diagnosis Benefit Rider	_____	
Primary Insured		$ _____	$ _____	$ _____	☐	☐	$ _____	$ _____	
Spouse		$ _____	$ _____	$ _____	☐	☐	$ _____	$ _____	
Children		$ _____	$ _____	$ _____	☐	☐	$ _____	$ _____	$ _____

If Guaranteed Issues requirements are met, medical underwriting will be waived.

1. **HAS ANY PROPOSED INSURED:** Ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV or other sickness or condition derived from some infection? _____ Yes _____No
2. **HAS ANY PR OPOSED INSURED:** Consulted a Physician or licensed medical professional , received medical treatment of any kind from a licensed medical professional, or been hospitalized or confined during the past 4 years? _____ Yes _____ No
3. **IS ANY PROPOSED INSURE D** currently covered or eligible for Medicare? _ _____ Yes _____ _ No. If Yes, a "Guide to Healt h Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.

Details of "Yes" answers in 1 or 2 above. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury/Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Authorization to Obtain and Release Information: I hereby AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Family Life Insurance Company, its reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the MIB Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Family Life's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

I certify that I have received the Outline of Coverage.

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ☐ is ☐ is not involved at this time.

Signed at _____ this _____ day of _____ 20 _____
City, State

X _____ X _____ X _____
Signature of Primary Insured (Parent if person to be insured is less than 15 years old) | Payor/Owner (if other than Proposed Insured) | Spouse

X _____ _____ _____ _____ % _____
Signature of Agent | Agent's Name (printed) | Florida License No. | % Credit | State ID No.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO FAMILY LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct $ _____ from my pay according to the deduction mode indicated below, until further notice from me, and remit to Family Life Insurance Company 10777 Northwest Freeway, Houston, Texas 77092.

Premiums will be deducted ☐ Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other Specify _____

Name _____ Date _____

Employee's Signature _____ Agent's Signature _____

BANK DRAFT AUTHORIZATION TO HONOR CHECKS DRAWN BY FAMILY LIFE INSURANCE COMPANY

To _____

Your Bank's Address _____

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of Family Life Insurance Company of Houston, Texas provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date _____ X _____
Your signature Exactly as it appears on Bank Records Account No.

Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

To obtain further information, contact
Family Life Insurance Company
10777 Northwest Freeway, Houston, TX 77092

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicant to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the address on the front of this Notice..

MIB, Inc. Notice

While the information regarding your insurability is treated as confidential, Family Life Insurance Company or its reinsurers may make a brief report thereon to MIB, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, MIB, upon request from that member company, will supply the information in its file. Upon written request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (781) 751-6000. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

Dental Enrollment/Change Request

Solstice Benefits, Inc.

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

Group Name	Group Number
DCSMEC	

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 must be enrolled for spouse/dependent(s) to have coverage.

1. ENROLLMENT

☐ New Employee/Member

Effective Date
_____ / _____ / _____

Date of Hire/Membership
_____ / _____ / _____

Hours Worked Per Week *(if applicable)*
_____ / _____

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

	Effective Date	Reason	Add/Change/Remove Status
▪ Spouse	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Domestic Partner	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Dependent Child	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Name Change	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Change Plan	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Other	___/___/___	_____	☐ Add ☐ Change ☐ Remove
▪ Employee	___/___/___	_____	☐ Employee Withdrawal ☐ Termination

B. EMPLOYEE/MEMBER INFORMATION – To be completed by Employee/Member
Complete sections B-G. *Refer to instructions on back before completing this form. Please print clearly.*

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

C. PLAN OPTION
Your selection must be offered by your Employer/Group.

☐ Dental Prepaid Plan No. S200A or S700A

☐ Dental PPO/Indemnity Plan No. DPPO1 or 11004

☐ Vision Plan No. Clear 10

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 Credible 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 Employee/Member? Yes ☐ No ☐

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

Please explain the circumstances.

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 **1.877.760.2247** before or after signing this form.

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 hereby apply for benefits for which I am eligible as either an employee or member. If contributions or fees are required, I authorize my employer to deduct such contributions from my salary.

Employee Signature – Required
X

Print Name

Date
/ /

Please make a copy for your records. Visit us at 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.

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 – 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 EPO, PPO, and Indemnity dental plans are administered and underwritten by Solstice Benefits, 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 thirty (30) months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
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.
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.**

DCSMEC UNION PLANS

PPO HIGH Plan Rate Comparison:

26 pay periods

	District Plans		Union Member Plan
	Delta	UHC	Solstice
Single	$18.75	$17.50	$14.87
Single + 1 dependent	$56.06	$52.32	$26.55
Single + 2 or more dependents	$56.06	$52.32	$43.80

	Delta Dental (District Plan)		UHC Dental (District Plan)		Solstice Benefits (Union Member Plan)	
	In-Network / Out-of-Network		In-Network / Out-of-Network		In-Network / Out-of-Network	
Annual Deductible	$50.00	$50.00	$50.00	$50.00	$50.00	$50.00
Annual Benefit Maximum	$1,500.00	$1,500.00	$1,500.00	$1,500.00	$2,000.00	$2,000.00
Waiting Periods	None	None	None	None	None	None
Office Visit	100%	90%	100%	100%	100%	100%
Comprehensive Oral Evaluation	100%	90%	100%	100%	100%	100%
X-ray Intraoral-Complete Series	100%	90%	100%	100%	100%	100%
Routine Prophylaxis - Adult	100%	90%	100%	100%	100%	100%
Amalgam - 1 Surface - Permanent	80%	80%	80%	80%	90%	80%
Composite Resin - 2 Surface - Anterior	50%	50%	80%	80%	90%	80%
Crown - Porcelain to High Noble Metal	50%	50%	80%	80%	60%	50%
Endodontic Therapy - Molar (ex final restoration)	50%	50%	80%	80%	60%	50%
Periodontal Scaling and Root Planing per Quad	50%	50%	80%	80%	60%	50%
Complete Upper Denture	50%	50%	50%	50%	60%	50%
Removal of Impacted Tooth - Bony	50%	50%	50%	50%	60%	50%
Child Orthodontics Coverage	50%	50%	50%	50%	50%	50%

DCSMEC UNION PLANS

DHMO HIGH Dental Plan & Rate Comparison:

26 pay periods

	District Plans		Union Member Plan
	Delta	UHC	Solstice
Single	$6.14	$5.01	$4.86
Single + 1 Dependent	$15.68	$12.78	$8.82
Single + 2 or more Dependents	$15.68	$12.78	$12.55

DHMO PLAN COMPARISON

		Delta High	UHC High	Solstice S200A
Code	Description	Co-Pay	Co-Pay	Co-Pay
D0120	Periodic oral evaluation - established patient	$ -	$ -	$ -
D0150	Comprehensive oral evaluation - new or established patient	$ -	$ -	$ -
D0210	Intraoral - complete series (including bitewings)	$ -	$ -	$ -
D0274	Bitewings - four radiographic images	$ -	$ -	$ -
D1110	Prophylaxis - adult	$ -	$ -	$ -
D1351	Sealant - per tooth	$ -	$ 5.00	$ -
D2140	Amalgam - one surface, primary or permanent	$ -	$ -	$ -
D2330	resin-based composite - one surface, anterior	$ 35.00	$ 35.00	$ 20.00
D2391	Resin-based composite - one surface, posterior	$ 60.00	$ 60.00	$ 45.00
D2392	Resin-based composite - two surfaces, posterior	$ 80.00	$ 80.00	$ 65.00
D2750	Crown - porcelain fused to high noble metal	$ 280.00	$ 280.00	$ 195.00
D2950	Core buildup, including any pins	$ 45.00	$ 45.00	$ 35.00
D3330	Endodontic therapy, molar (excluding final restoration)	$ 200.00	$ 200.00	$ 210.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$ 40.00	$ 40.00	$ 36.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$ 40.00	$ 40.00	$ 35.00
D4910	Periodontal maintenance	$ 55.00	$ 55.00	$ 40.00
D5110	Complete denture - maxillary	$ 210.00	$ 210.00	$ 210.00
D5214	Partial Denture - Mandibular cast metal	$ 260.00	$ 260.00	$ 220.00
D7210	Surgical removal of an erupted tooth	$ 30.00	$ 30.00	$ 25.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$ 1,800.00	$ 1,800.00	$ 1,850.00