

# EMPLOYEE ENROLLMENT FORM

OAHU: TOLL FREE:  
PHONE: 808-529-9230 1-844-829-3256  
FAX: 808-529-9207 1-866-590-7989  
EMAIL: GSC@HawaiiDentalService.com

**A. Group Information** To be completed by the Group Administrator **PLEASE PRINT LEGIBLY**

Group/Division #  /  Group Name   
 Contact Name  Contact Phone #  -  -  ext

**B. Employee** This section must be completed.

EFFECTIVE DATE  /  /  EMPLOYEE IDENTIFICATION NUMBER  BIRTHDATE (MM/DD/YYYY)  /  /  SEX  M  F  
 LAST NAME   
 FIRST NAME/MIDDLE INITIAL   
 MAILING ADDRESS  APT/UNIT NUMBER   
 CITY  STATE  ZIP CODE  (  )  -   
 EMAIL ADDRESS

**C. Family Members** Please attach a separate sheet for additional dependent(s).  
Be sure to include the eligible **employee's identification number and name** when attaching additional sheets.

BIRTHDATE (MM/DD/YYYY)  /  /  RELATION  Spouse  Domestic Partner  Child  Civil Union SEX  M  F  Full-time student  Disabled Child  
 LAST NAME   
 FIRST NAME/MIDDLE INITIAL

BIRTHDATE (MM/DD/YYYY)  /  /  RELATION  Spouse  Domestic Partner  Child  Civil Union SEX  M  F  Full-time student  Disabled Child  
 LAST NAME   
 FIRST NAME/MIDDLE INITIAL

BIRTHDATE (MM/DD/YYYY)  /  /  RELATION  Spouse  Domestic Partner  Child  Civil Union SEX  M  F  Full-time student  Disabled Child  
 LAST NAME   
 FIRST NAME/MIDDLE INITIAL

**D. Authorization** I certify that the information provided is true, correct and meets the terms and conditions of the HDS Agreement.

Group Administrator Signature

Date