DELTA DENTAL

HDS
Hawaii Dental Service

EMPLOYEE CHANGE FORM

OAHU: TOLL FREE:
PHONE: (808) 529-9230 1-844-829-3256
FAX: (808) 529-9207 1-866-590-7989
EMAIL: MS@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. Update Type

Indicate the transaction type requesting.

☐ Add Family Member(s) ☐ Terminate Family Members ☐ Reinstatement

☐ Change/Correction to Information ☐ Address/Email Change ☐ Transfer from _____ to _____

C. Reason for Change

Indicate the reason/qualifying event of the change.

☐ Open Enrollment ☐ Loss of Coverage ☐ Probation ☐ Marriage/Civil Union (Date) _____ / _____ / _____

☐ Newborn ☐ Adoption (Date) _____ / _____ / _____ ☐ Legal Guardianship (Date) _____ / _____ / _____

D. Employee

Complete the employee's information.

EFFECTIVE DATE OF CHANGE/UPDATE ____ / ____ / 20__ EMPLOYEE IDENTIFICATION NUMBER _____ BIRTHDATE (MM/DD/YYYY) ____ / ____ / ____ SEX ☐ M ☐ F

LAST NAME

FIRST NAME/MIDDLE INITIAL

MAILING ADDRESS

CITY

STATE ZIP CODE PHONE NUMBER (___) ___ - ____ EMAIL ADDRESS

E. Family Members

Complete this section to add or terminate family member(s). 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 ☐ Child ☐ Civil Union Partner

SEX ☐ M ☐ F

☐ Full-time student ☐ Disabled Child

LAST NAME

FIRST NAME/MIDDLE INITIAL

BIRTHDATE (MM/DD/YYYY) ____ / ____ / ____

RELATION ☐ Spouse ☐ Child ☐ Civil Union Partner

SEX ☐ M ☐ F

☐ Full-time student ☐ Disabled Child

LAST NAME

FIRST NAME/MIDDLE INITIAL

F. Authorization

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

Group Administrator Signature _____ Date _____