DELTA DENTAL

HDS
Hawaii Dental Service

EMPLOYEE ENROLLMENT 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. Employee

This section must be completed.

EFFECTIVE DATE __ / __ / 2 0 __ 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 ____ PHONE NUMBER (____) ____ - ____

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 ____

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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 ____