



Hawaii Dental Service

**PLEASE SEND COMPLETED FORM TO:**

Hawaii Dental Service  
 Attn: Group Service Center  
 900 Fort Street Mall, Suite 1900  
 Honolulu, HI 96813-3705

**PLEASE TYPE OR PRINT IN BLACK INK**

Customer Service: 808-529-9248  
 Toll Free: 1-844-379-4325  
 HawaiiDentalService.com

**Section 1 | RESPONSIBLE PARTY INFORMATION** Date of Change: \_\_ \_\_ / 01 / 20\_\_ \_\_

HDS Subscriber Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Phone # ( ) - \_\_\_\_\_

**Section 2 | UPDATE TYPE**

- Address / Email / Phone Change (Complete Section 3)
- Add / Remove Family Members (Complete Section 4)
- Other Changes to Information (Please specify) \_\_\_\_\_

**Section 3 | RESPONSIBLE PARTY INFORMATION UPDATE**

New Mailing Address: \_\_\_\_\_ City, State, & Zip Code: \_\_\_\_\_

Phone Number:  Home ( ) - \_\_\_\_\_  Cell: ( ) - \_\_\_\_\_  Work: ( ) - \_\_\_\_\_

Email Address: \_\_\_\_\_

*\*By providing my email address, I agree to receive communications regarding my policy and benefits electronically.*

**Section 4 | PERSONS TO BE ADDED, REMOVED OR CHANGED**

Add	Remove	First Name	Last Name	Date of Birth (MM/DD/YYYY)	Relationship to Responsible Party (Self, Spouse or Dependent)	Sex (M/F)	Disabled Child (Y/N)
<input type="checkbox"/>	<input type="checkbox"/>			__/__/____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__/__/____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__/__/____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__/__/____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__/__/____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

(CONTINUED ON NEXT PAGE)

LAST NAME OF RESPONSIBLE PARTY: \_\_\_\_\_

**SECTION 5 - MUST BE SIGNED TO AUTHORIZE REQUESTED CHANGES**

Section 5   ACCEPTANCE OF TERMS AND CONDITIONS (REQUIRED)	
<p><i>I have read the Terms and Conditions for the HDS Individual Dental Plan. I understand and agree to the benefits, restrictions and other plan terms covered under the HDS Dental Plan. The Terms and Conditions will apply regardless if any dental services have been used. I hereby certify under the penalty of perjury that the information contained in this application is true and complete and choose to update the people identified in this application. HDS has the right to deny this update form if the information is inaccurate or incomplete.</i></p>	
_____	_____
<b>Responsible Party Signature (Required)</b>	<b>Date</b>

**Hawaii Dental Service**  
**Attention: Membership Services Department**  
**900 Fort Street Mall, Suite 1900**  
**Honolulu, HI 96813-3705**

HDS USE ONLY							
HDS Group #		HDS Member ID:		Entered By:		Date Entered:	