

EMPLOYEE ENROLLMENT FORM

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

A.	Group Information	To be completed by the Group Administrator	PLEASE PRINT LEGIBLY
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Group/Division # <input type="text"/> / <input type="text"/>	Group Name <input style="width: 90%;" type="text"/>
Contact Name <input style="width: 80%;" type="text"/>	Contact Phone # <input type="text"/> - <input type="text"/> - <input type="text"/> ext <input type="text"/>

B.	Employee	This section must be completed.
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EFFECTIVE DATE <input type="text"/> / <input type="text"/> / <input type="text"/>	EMPLOYEE IDENTIFICATION NUMBER <input type="text"/>	BIRTHDATE (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	SEX M <input type="checkbox"/> F <input type="checkbox"/>
LAST NAME <input style="width: 100%;" type="text"/>			
FIRST NAME/MIDDLE INITIAL <input style="width: 100%;" type="text"/>			
MAILING ADDRESS <input style="width: 100%;" type="text"/>		APT/UNIT NUMBER <input style="width: 100%;" type="text"/>	
CITY <input style="width: 40%;" type="text"/>	STATE <input style="width: 10%;" type="text"/>	ZIP CODE <input style="width: 15%;" type="text"/>	PHONE NUMBER (<input style="width: 10%;" type="text"/>) <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/>
EMAIL ADDRESS <input style="width: 100%;" type="text"/>			

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.
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BIRTHDATE (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Civil Union	SEX <input type="checkbox"/> M <input type="checkbox"/> Full-time student <input type="checkbox"/> F <input type="checkbox"/> Disabled Child	
LAST NAME <input style="width: 100%;" type="text"/>			
FIRST NAME/MIDDLE INITIAL <input style="width: 100%;" type="text"/>			
<hr/>			
BIRTHDATE (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Civil Union	SEX <input type="checkbox"/> M <input type="checkbox"/> Full-time student <input type="checkbox"/> F <input type="checkbox"/> Disabled Child	
LAST NAME <input style="width: 100%;" type="text"/>			
FIRST NAME/MIDDLE INITIAL <input style="width: 100%;" type="text"/>			
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BIRTHDATE (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	RELATION <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Civil Union	SEX <input type="checkbox"/> M <input type="checkbox"/> Full-time student <input type="checkbox"/> F <input type="checkbox"/> Disabled Child	
LAST NAME <input style="width: 100%;" type="text"/>			
FIRST NAME/MIDDLE INITIAL <input style="width: 100%;" type="text"/>			

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

Date