



HDS Individual Dental Plan Automatic Payment by Bank Deduction Form

Complete below to authorize Hawaii Dental Service (HDS) to 1) debit monthly premiums from your bank account, or 2) allow changes to your current bank account information. Automatic payment by bank deduction will be made by HDS on the 23rd of each month for the following month's premium. The completed form must be received by the **15th of the month** to be effective for the same month.

Example:

Completed form received on January 15 th	Automatic deduction on January 23 rd ; to be applied to February's premium
Completed form received on January 16 th	Automatic deduction on February 23 rd ; to be applied to March's premium

In order for HDS to set up the monthly processing of automatic payments from your bank account, **ALL items MUST be completed.** Incomplete/incorrect forms may cause a delay in processing your payment and affect your eligibility in the plan.

Return completed form with a voided check to HDS by fax to 529-9343 or toll-free to 1-866-721-1951 or email to HDSIndividualDentalPlan@HawaiiDentalService.com or mail to: Hawaii Dental Service, Attn: IDP, 700 Bishop Street, Suite 700, Honolulu, HI 96813.

If you have any questions regarding automatic payment, please contact HDS Individual Dental Plan - Billing at 529-9313 or toll free at 1-800-232-2533, extension 313.

Authorization for Automatic Payment by Bank Deduction	
<i>I hereby authorize Hawaii Dental Service (HDS) to deduct payment of my dental benefit premiums from the account with the financial institution indicated below. The monthly payment will be automatically deducted on the 23rd or next business day of each month for the next month's premium. I understand that I will be eligible for coverage only if premium payments have been received by HDS. If sufficient funds are not available at the time of deduction, HDS may charge a special handling fee (currently \$25) in addition to the monthly premium due. This authorization will remain in full force and effect until HDS receives written notification from me or the bank owner of its termination. I understand that HDS and/or the financial institution indicated reserve the right to end this payment plan and my participation therein.</i>	
1. Subscriber's Last Name, First Name (Please Print)	2. HDS Member ID #
3. Email Address	4. Daytime Telephone # (_____) - _____ - _____
5. Subscriber's Signature	
6. Financial Institution Name and Address	
7. Name as shown on Bank Account	8. Account Type (Check one): <input type="checkbox"/> Savings <input type="checkbox"/> Checking
9. Financial Institution Routing Number _____	10. Bank Account Number Information _____
11. Signature of Bank Owner (If different from subscriber)	12. Date

REMINDER: If you are using a checking account to pay for your premiums, please attach a voided check showing your complete account number and name.

HDS USE ONLY	
ENTERED BY	DATE