DELTA DENTAL

HDS
Hawaii Dental Service

Authorization for Automatic Payment Form

Please complete the Authorization for Automatic Payment Form below to authorize HDS to debit monthly premiums from your bank account. Automatic payment deductions will be made by HDS on the 3rd business day at the beginning of each month for the current month's premiums.

ALL items MUST be completed on the Authorization for Automatic Payment Form in order for HDS to process monthly payments automatically from your bank account.

Please return completed form to HDS by fax to 529-9343 or toll-free 1-866-721-1951 or mail form to: Hawaii Dental Service, Attn: Billing Department, 700 Bishop Street, Suite 700, Honolulu, HI 96813.

If you have any questions regarding your automatic bill payment, please contact the HDS Billing department at 529-9285 or toll-free at 1-844-379-4326. *Mahalo!*

PLEASE ATTACH VOIDED CHECK HERE

Authorization for Automatic Payment Form for EMPLOYER GROUPS

As an authorized representative of the group, I hereby authorize Hawaii Dental Service (HDS) to deduct our group dental premiums from the bank account with the financial institution indicated below. The amount to be deducted will equal to Total Amount due as indicated on each monthly HDS invoice. 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. I further understand that our group will be responsible for making payment and will be subject to the collection and eligibility/enrollment processes as described in the Contract for Dental Services. This authorization will remain in full force and effect until you receive written notification from me 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.

1. GROUP NAME (Please Print)	2. HDS GROUP NUMBER ___ ___ ___ ___ - ___ ___ ___ ___
3. AUTHORIZED REPRESENTATIVE (Print Name & Title)	4. AUTHORIZED SIGNATURE & DATE
5. TELEPHONE NUMBER (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___	6. EMAIL ADDRESS

BANK ACCOUNT INFORMATION

7. FINANCIAL INSTITUTION NAME			
8. FINANCIAL INSTITUTION ADDRESS	CITY	STATE	ZIP CODE

9. NAME AS SHOWN ON BANK ACCOUNT	10. ACCOUNT TYPE (Check one): ☐ Savings ☐ Checking
11. FINANCIAL INSTITUTION ROUTING NUMBER TRANSIT ABA ⑆ ___ ___ ___ ___ ___ ___ ___ ___ ___ ⑆	12. BANK ACCOUNT NUMBER INFORMATION ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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.

(Revised 1/19)