DELTA DENTAL®

HDS
Hawaii Dental Service

Application Form for Individual Dental Plans

PLEASE TYPE OR PRINT IN BLACK INK
COMPLETE SECTIONS 1-4
Customer Service: (808) 529-9248 or
Toll-Free: 1-844-379-4325
HawaiiDentalService.com

The Application Form must be received by the end of the month to take effect the first of the following month

Please send completed application to:
Hawaii Dental Service
Attn: IDP Department
900 Fort Street Mall, Suite 1900
Honolulu, HI 96813-3705

Section 1 | RESPONSIBLE PARTY INFORMATION

Desired Effective Date: __ __/ 01 /20__ __ (M M Y Y)

Last Name	First Name	Middle Initial	☐ Male ☐ Female

Home Address (Mailing)	City	State	Zip	Phone No. (with area code)
				(__ __ __) __ __ __-__ __ __ __

Email Address*	Date of Birth (mm/dd/yyyy)	Age
	__ __/__ __/__ __ __ __	

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

I AM ALSO ELECTING COVERAGE FOR MYSELF ☐ YES ☐ NO;
If "NO," I acknowledge that I am the Responsible Party for the members listed in Section 2.

PLAN SELECTION:

☐ **HDS Deluxe** Dental Plan #1061
☐ **HDS Classic** Dental Plan #2525
☐ HDS Individual Dental Plan for **Children** #2999 *(Children only, through age 25)*
☐ **HDS Preferred** Dental Plan #2851
☐ **HDS Basic** Dental Plan #1059 *(Adults only, Minimum age 19)*

To learn more about plan designs and rates visit HawaiiDentalService.com or call 1-844-379-4325.

Section 2 | PERSONS TO BE COVERED

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
				☐M ☐F	☐Y ☐N
				☐M ☐F	☐Y ☐N
				☐M ☐F	☐Y ☐N
				☐M ☐F	☐Y ☐N
				☐M ☐F	☐Y ☐N
				☐M ☐F	☐Y ☐N

HOW DID YOU HEAR ABOUT THIS PLAN? (Required)

☐ Television ☐ Print Ad ☐ HDS Website ☐ Social Media ☐ Friends/Family ☐ HDS Employee/Dentist*

**Please provide FULL details below if you were referred to a dental plan by an HDS Employee or Dentist:*

☐ **HDS Employee:** First Name: _____ Last Name: _____

☐ **Dentist or Broker:** First Name: _____ Last Name: _____

Office Street Address: _____ City _____, HI, Zip _____

(CONTINUED ON PAGES 2 & 3)

LAST NAME OF RESPONSIBLE PARTY: _____

Section 3 | ACCEPTANCE OF TERMS AND CONDITIONS (REQUIRED)

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 enroll the people identified in this application. HDS has the right to deny this application or terminate enrollment if the information is inaccurate or incomplete.

_____ _____

Responsible Party Signature (Required) **Date**

Section 4 | PAYMENT METHOD SELECTION (REQUIRED)

I elect to make payment by:

☐ Automatic Monthly Deduction from Bank Account (Complete Monthly Bank Deduction, **Section 4A**. You must pay the first month's premium by check or money order, payable to Hawaii Dental Service and submit with this application.)

☐ Automatic Monthly Charge by Credit Card (Complete Credit Card Payment, **Section 4B**)

☐ *Annual Payment by Credit Card (Complete Credit Card Payment, **Section 4B**)

☐ *Annual Payment by Check (Make payable to Hawaii Dental Service and submit with this application)

*The first year's annual premium equals: Monthly Premium $_____ X _____ # of months remaining in the calendar year

Section 4A MONTHLY BANK DEDUCTION	Complete bank account information below for Monthly Bank Deduction. **Attach documentation to validate the account number provided (such as a voided check or account statement). You must pay the first month's premium by check or money order, payable to Hawaii Dental Service.**

By electing the monthly bank deduction option, I certify that I am the owner of the designated financial account and have authority to direct payments from the account. I authorize HDS to deduct payment of dental benefit premiums from the account with the financial institution indicated. 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 coverage will be granted 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 $25.00) in addition to the monthly premium due. I understand that HDS is not required to inform me of any change in the amount of premiums and this authorization will remain in full force and effect until HDS receives written notification 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 certify the bank account information provided by me is true, correct and complete.

1. Name of Financial Institution (Name of your bank, savings & loan or credit union)	
2. Name as Shown on Bank Account	3. Type of Account (Choose One) ☐ Checking ☐ Savings
4. Financial Institution Routing Number ___ ___ ___ ___ ___ ___ ___ ___ ___	5. Bank Account Number
6. Signature of Bank Account Owner	7. Date

(SECTION 4B CREDIT CARD PAYMENT ON PAGE 3)

Section 4B CREDIT CARD PAYMENT	Select automatic monthly payment or annual payment and complete the credit card information below.

By electing the credit card payment option, I certify that I am the cardholder of the designated credit card account and have authority to direct payments on the account. I authorize HDS to charge dental benefit premiums to the credit card account indicated. The monthly payment will be automatically charged on or about the 17th of each month for the following month's premium. I understand that coverage will be granted only if premium payments have been received by HDS. If the payment transaction is dishonored by my credit card issuer, HDS may charge a special handling fee (currently $25.00) in addition to the monthly premium due. I understand that HDS is not required to inform me of any change in the amount of premiums and this authorization will remain in full force and effect until HDS receives written notification of its termination. I will be responsible for informing HDS of any updated card expiration date. I understand that HDS and/or the credit card issuer indicated reserve the right to end this payment plan and my participation therein. I hereby certify the account information provided by me is true, correct and complete.

1. Subscriber or Responsible Party Name

2. Payment Option (Check One)

☐ Automatic Monthly Payment ☐ Annual Payment – Amount $ _____

3. Card Holder's Name	4. Card Holder's Billing Address & Phone Number

5. Card Number

____ ____ ____ ____-____ ____ ____ ____-____ ____ ____ ____-____ ____ ____ ____

6. Expiration Date (mo./yr.)	7. Card Type (Check One) ☐ Visa ☐ MasterCard ☐ Discover
8. Signature of Card Holder	9. Date

Note: Credit card information received by email or fax will not be processed by Hawaii Dental Service; please mail the entire form to:

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

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