



## HDS Individual Dental Plan Automatic Payment by Bank Deduction Form

HDS USE ONLY	
ENTERED BY	DATE

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 23<sup>rd</sup> of each month for the following month's premium. The completed form must be received by the **10<sup>th</sup> of the month** to be effective for the same month.

Example:

Completed form received on January 10 <sup>th</sup>	Automatic deduction on January 23 <sup>rd</sup> ; to be applied to February's premium
Completed form received on January 11 <sup>th</sup>	Automatic deduction on February 23 <sup>rd</sup> ; 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 below 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 (808) 529-9343 or toll-free to 1-866-721-1951 or email to IDP@HawaiiDentalService.com or mail to: Hawaii Dental Service, Attn: IDP, 900 Fort Street Mall, Suite 1900, Honolulu, HI 96813.

If you have any questions, please contact HDS Individual Dental Plan - Billing at (808) 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 23<sup>rd</sup> 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.**