DELTA DENTAL

HDS
Hawaii Dental Service

# HDS Individual Dental Plan
# Automatic Payment by Credit Card

| HDS USE ONLY | |
|---|---|
| ENTERED BY | DATE |
| | |

Complete below to authorize Hawaii Dental Service (HDS) to 1) charge monthly premiums to your credit card, or 2) allow changes to your current credit card information. Automatic credit card charges are processed on or about the 17th of each month for the following month's premium. The completed form must be received by the **10th of the month** to be effective for the same month.

Example:

| | |
|---|---|
| Completed form received on January 10th | Automatic charge on January 17th; to be applied to February's premium |
| Completed form received on January 11th | Automatic charge on February 17th; to be applied to March's premium |

In order for HDS to set up the monthly processing of automatic credit card payments, 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 to HDS by mail to: Hawaii Dental Service, Attn: IDP, 900 Fort Street Mall, Suite 1900, Honolulu, HI 96813. **For your security, do not email or fax. Forms received by email or fax will NOT be processed.**

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.

## Credit Card Authorization Agreement

*By electing the credit card payment option, I am authorizing Hawaii Dental Service (HDS) to charge my dental benefit premiums to the credit card indicated. I understand that I will be eligible for coverage only if premium payments have been received by HDS. If my 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 owed. Premiums will be charged on or about the 17th of each month for the following month's premium. This authorization will remain in full force and effect until I notify HDS of its termination. In addition, I will be responsible for informing HDS of updated expiration date as needed. I understand that HDS and/or the credit card issuer indicated reserve the right to end this payment plan and my participation therein.*

| | |
|---|---|
| 1. Subscriber's Last, First Name (Please Print) | 2. HDS Member ID # |
| 3. Email Address | 1. Daytime Telephone #<br>(___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___ |
| 4. Subscriber's Signature | |
| 5. Card Holder's Name | 6. Card Holder's Billing Address |
| 7. Card Number<br>___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ | |
| 8. Expiration Date (mo/yr.) | 9. Card Type (Check One)<br>☐ Visa ☐ MasterCard<br>☐ Discover |
| 10. Card Holder's Signature (If different from subscriber) | 11. Date |