DELTA DENTAL®

HDS
Hawaii Dental Service

Update Form for Individual Dental Plans

PLEASE SEND COMPLETED FORM TO:
Hawaii Dental Service
Attn: Group Service Center
900 Fort Street Mall, Suite 1900
Honolulu, HI 96813-3705

PLEASE TYPE OR PRINT IN BLACK INK
Customer Service: 808-529-9248
Toll Free: 1-844-379-4325
HawaiiDentalService.com

Section 1 | RESPONSIBLE PARTY INFORMATION

Date of Change: __ __/ 01 /20__ __

HDS Subscriber Number: _____

Subscriber Name: _____ **Subscriber Phone #** (___) ___-____

Section 2 | UPDATE TYPE

- ☐ Address / Email / Phone Change (Complete Section 3)
- ☐ Add / Remove Family Members (Complete Section 4)
- ☐ Other Changes to Information (Please specify) _____

Section 3 | RESPONSIBLE PARTY INFORMATION UPDATE

New Mailing Address: _____ **City, State, & Zip Code:** _____

Phone Number: ☐ Home (___) ___-____ ☐ Cell: (___) ___-____ ☐ Work: (___) ___-____

Email Address: _____

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

Section 4 | PERSONS TO BE ADDED, REMOVED OR CHANGED

*Add	Remove	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

Payment is required to process person(s) added to your plan.

(Continued on next page)

LAST NAME OF RESPONSIBLE PARTY: _____

UPDATE FORM FOR
INDIVIDUAL DENTAL PLANS

SECTION 5 – *MUST BE SIGNED TO AUTHORIZE REQUESTED CHANGES*

Section 5 | 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 update the people identified in this application. HDS has the right to deny this update form if the information is inaccurate or incomplete.

_____ _____

Responsible Party Signature (Required) **Date**

Please mail the entire form to:

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

HDS USE ONLY

Group #	Subscriber ID	Date Processed	Processed By