DELTA DENTAL

HDS
Hawaii Dental Service

ENROLLMENT FORM

HDS GROUP SERVICE CENTER
OAHU: (808) 529-9230
TOLL-FREE: 1-844-829-3256
FAX: (808) 529-9207
gsc@hawaiidentalservice.com

To ensure security and confidentiality, you must encrypt electronic files before transmitting them by email or other electronic means.

A. Group Information: To be completed by the Group Administrator (Please print clearly.)

Group/Division # ____ / ____ Group Name ____

Contact Name ____ Contact Phone # ___ - ___ - ____ ext ____

B. Employee: This section must be completed.

Effective Date __ / __ / 2 0 __ Employee Social Security Number ___ - __ - ____ Birthdate (MM/DD/YYYY) __ / __ / ____ Sex ☐ M ☐ F

Last Name ____

First Name / Middle Initial ____

Mailing Address ____ APT / Unit Number ____

City ____ State __ Zip Code _____ Phone Number (___) ___ - ____

Email Address ____

C. Family Members

Please attach a separate sheet for additional dependent(s).
Be sure to include the eligible **Employee's Social Security Number** and **Name** when attaching additional sheets.

Birthdate (MM/DD/YYYY) __ / __ / ____ Social Security Number ___ - __ - ____ Relation ☐ Spouse ☐ Child Sex ☐ M ☐ F Status ☐ Full-time student ☐ Disabled Child

Last Name ____

First Name / Middle Initial ____

Birthdate (MM/DD/YYYY) __ / __ / ____ Social Security Number ___ - __ - ____ Relation ☐ Spouse ☐ Child Sex ☐ M ☐ F Status ☐ Full-time student ☐ Disabled Child

Last Name ____

First Name / Middle Initial ____

Birthdate (MM/DD/YYYY) __ / __ / ____ Social Security Number ___ - __ - ____ Relation ☐ Spouse ☐ Child Sex ☐ M ☐ F Status ☐ Full-time student ☐ Disabled Child

Last Name ____

First Name / Middle Initial ____

D. Authorization: I certify that the information provided is true, correct and meets the terms and conditions of the HDS Agreement.

Group Administrator Signature ____ Date ____