



Mail-In Application for Individual Dental Plans

For Hawaii residents only. This form is for mail-in applications only.

Apply online at HawaiiDentalService.com for the fastest and easiest way to enroll.

For assistance, call HDS Customer Service at (808) 529-9248 or toll-free at 1-844-379-4325.

PLEASE READ BEFORE YOU BEGIN THIS APPLICATION:

Print clearly and complete sections 1-4.

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

Applications must be received by the end of the month to begin coverage on the first day of the following month.

Section 1: Who will be the subscriber for this dental plan?

Desired Effective Date: __ / 01 / 20 __

Last Name: _____ First Name: _____ Middle Initial: _____ Gender: ☐ M ☐ F

Mailing Address: _____ City: _____ State: __ Zip Code: _____ Phone Number: (__) __ - __

Email Address*: _____ Date of Birth (mm/dd/yyyy): __ / __ / ____ Social Security Number: ____ - __ - ____

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

Is this dental plan for you? ☐ Yes ☐ No (If your answer is no, you acknowledge you are the non-covered subscriber for the members listed in Section 2.)

Select your dental plan.

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

☐ HDS Classic Dental Plan #2525 ☐ HDS Preferred Dental Plan #2851 ☐ HDS Deluxe Dental Plan #1061
☐ Children Only #2999 ☐ HDS Basic for Adults Only #1059

Section 2: Who will be covered under this plan?

First Name	Last Name (If different from Subscriber Name)	Date of Birth (MM / DD / YYYY)	Social Security Number	Relationship to Subscriber (Self, Spouse, or Dependent)	Gender	Check here if this is a disabled child
			__ - __ - ____		☐ M ☐ F	☐
			__ - __ - ____		☐ M ☐ F	☐
			__ - __ - ____		☐ M ☐ F	☐
			__ - __ - ____		☐ M ☐ F	☐
			__ - __ - ____		☐ M ☐ F	☐

LAST NAME OF SUBSCRIBER: _____

MAIL-IN APPLICATION FOR INDIVIDUAL DENTAL PLAN

How did you hear about this dental plan?

☐ Television ☐ Print Ad ☐ Digital Ad ☐ Social Media ☐ Friends/Family ☐ HDS Employee ☐ Dentist ☐ Broker

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.

X _____

Subscriber Signature (Required)

_____ Date

Section 4: Select your payment method. (Required)

I elect to make payment by:

- ☐ Automatic Monthly Deduction from Bank Account *(Complete Monthly Bank Deduction, Section 4A)*
NOTE: 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)*
NOTE: To determine your first year's annual premium, multiply your monthly premium by the number of months remaining in the calendar year.

Note: Credit card information received by email or fax will not be processed by Hawaii Dental Service; please mail all three pages of this form along with payment if applicable to:

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

COMPLETE ONE PAYMENT FORM BELOW.

Your application will not be processed unless payment information is provided. Please complete either 4A or 4B below.

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). <u>You must pay the first month's premium by check or money order, payable to Hawaii Dental Service.</u>	
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.Routing Number _____
5.Bank Account Number	
6.Signature of Bank Account Owner	7.Date

HDS USE ONLY			
Group #	Subscriber ID	Date Processed	Processed By

SECTION 4B: Credit Card Payment	
Select automatic monthly payment or annual payment and complete the credit card information below. The first month's premium will be processed upon receipt of this form.	
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 initial credit card payment will be processed upon receipt of the application. The monthly payment will be automatically charged between the 17th and 20th 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 Name	2.Payment Type (Choose One) ☐ Monthly ☐ Annual Payment: \$ _____
3.Cardholder's Name	
4.Card Type ☐ Visa ☐ MasterCard ☐ Discover	5.Cardholder Billing Address
6.Card Number _____ - _____ - _____ - _____	
7.Expiration Date (MM / YY)	8.Cardholder Phone Number
9.Signature of Cardholder	10.Date