



PLEASE SEND COMPLETED FORM TO:

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

Update Form for HDS IDP Members

If you receive dental benefits through your employer,
please do not submit this form. Instead, contact your
employer to request any changes.

PLEASE TYPE OR PRINT IN BLACK INK

Customer Service: 808-529-9248

Toll Free: 1-844-379-4325

HawaiiDentalService.com

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

Section 1 | SUBSCRIBER INFORMATION

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

HDS Subscriber Number: _____

Subscriber Name: _____

Subscriber Phone # () - _____

Section 2 | UPDATE TYPE

☐ Address / Email / Phone Change (Complete Section 3)

☐ Other Changes to Information

☐ Add / Remove Family Members (Complete Section 4)

(Please specify): _____

Section 3 | SUBSCRIBER 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.*

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LAST NAME OF SUBSCRIBER: _____

UPDATE FORM FOR
INDIVIDUAL DENTAL PLANS

Section 4 | PERSONS TO BE ADDED, REMOVED OR CHANGED

**Payment is required to add a person to your plan. The change will not be processed unless payment is provided.*

*Add	Remove	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 (Leave blank if you prefer not to say)	Check here if this is a disabled child
☐	☐				____ - ____ - _____		☐ M ☐ F	☐
☐	☐				____ - ____ - _____		☐ M ☐ F	☐
☐	☐				____ - ____ - _____		☐ M ☐ F	☐
☐	☐				____ - ____ - _____		☐ M ☐ F	☐
☐	☐				____ - ____ - _____		☐ M ☐ F	☐

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.

X

Subscriber Signature (Required)

Date

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Please mail the entire form along with payment if applicable 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