DELTA DENTAL

HDS
Hawaii Dental Service

# HDS Individual Dental Plan
# Automatic Payment by Bank Deduction Form

**STEP 1: Complete the form below to authorize Hawaii Dental Service (HDS) to debit monthly premiums from your bank account or allow changes to your current bank account information.** Automatic payment by bank deduction will be made by HDS on the 23rd 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:

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| Completed form received on January 10th | Automatic deduction on January 23rd; to be applied for February's premium |
| Completed form received on January 11th | Automatic deduction on February 23rd; to be applied for March's premium |

In order for HDS to set up the monthly processing of automatic payments from your bank account, all items below must be completed. Incomplete/incorrect form may cause a delay in processing your payment and affect your eligibility in the plan.

**STEP 2: Return this completed form with a voided check or account statement to HDS** by fax to (808) 529-9343 or toll-free to 1-866-721-1951, by email to IDP@HawaiiDentalService.com, or mail to Hawaii Dental Service, Attn: IDP – Billing Department, 900 Fort Street Mall, Suite 1900, Honolulu, Hawaii 96813.

## Authorization for Automatic Payment by Bank Deduction

I hereby authorize Hawaii Dental Service (HDS) to deduct payment of my dental benefit premiums from the account with the financial institution indicated below. 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 I will be eligible for coverage 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) in addition to the monthly premium due. This authorization will remain in full force and effect until HDS receives written notification from me or the bank owner 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.

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|---|---|
| 1. Subscriber's Last Name, First Name *(Please Print)* | 2. HDS Member ID # |
| 3. Email Address | 4. Daytime Telephone #<br>(____ ____ ____) ____ ____ ____- ____ ____ ____ ____ |
| 5. Subscriber's Signature | |
| 6. Name and Address of Financial Institution *(Name of your bank, savings & loan or credit union)* | |
| 7. Name as Shown on Bank Account | 8. Type of Account *(Choose One)*<br>☐ Checking ☐ Savings |
| 9. Financial Institution Routing Number<br>____ ____ ____ ____ ____ ____ ____ ____ ____ | 10. Bank Account Number |
| 11. Signature of Bank Account Owner *(If different from Box 1)* | 12. Date |

*REMINDER: Bank validation is required. Please attach documentation to validate the account number provided (such as a voided check or account statement).*

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by fax to (808) 529-9343 or toll-free to 1-866-721-1951, by email to IDP@HawaiiDentalService.com, or mail to:

Hawaii Dental Service
Attn: IDP – Billing Department
900 Fort Street Mall, Suite 1900
Honolulu, HI 96813

Questions? We're here to help. Please call (808) 529-9313 or toll free at 1-800-232-2533, extension 313.