DELTA DENTAL

HDS
Hawaii Dental Service

HDS Individual Dental Plan
Automatic Payment by Credit Card Form

STEP 1: Complete the form below to authorize Hawaii Dental Service (HDS) to charge monthly premiums to your credit card or allow changes to your current credit card information. Automatic credit card charges are processed between the 17th and 20th 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:

Completed form received on January 10th	Automatic charge between Jan. 17th and 20th; to be applied for Feb.'s premium
Completed form received on January 11th	Automatic charge between Jan. 17th and 20th; to be applied to 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 to HDS by mail to Hawaii Dental Service, Attn: IDP – Billing Department, 900 Fort Street Mall, Suite 1900, Honolulu, Hawaii 96813. For your security, do not email or fax this form. ***Forms received by email or fax will not be processed.***

Credit Card Authorization Agreement

By electing the credit card payment option, I am authorizing Hawaii Dental Service (HDS) to charge my dental benefit premiums to the credit card indicated. I understand that I will be eligible for coverage only if premium payments have been received by HDS. If my 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 owed. Premiums will be charged between the 17th and 20th of each month for the following month's premium. This authorization will remain in full force and effect until I notify HDS of its termination. In addition, I will be responsible for informing HDS of updated expiration date as needed. I understand that HDS and/or the credit card issuer indicated reserve the right to end this payment plan and my participation therein.

1. Subscriber's Last Name, First Name *(Please Print)*	2. HDS Member ID #
3. Email Address	4. Daytime Telephone # (____ ____ ____) ____ ____ ____- ____ ____ ____ ____
5. Subscriber's Signature	
6. Cardholder's Name	7. Cardholder's Billing Address
8. Card Number ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____	
9. Expiration Date *(month/year)*	10. Card Type *(Check One)* ☐ MasterCard ☐ Visa ☐ Discover
11. Cardholder's Signature *(If different from Box 5)*	12. Date

Return this completed form to HDS by 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.