



Hawaii Dental Service

PLEASE SEND COMPLETED FORM TO:

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

PLEASE TYPE OR PRINT IN BLACK INK

Customer Service: 808-529-9248
 Toll Free: 1-844-379-4325
 HawaiiDentalService.com

Section 1 | RESPONSIBLE PARTY INFORMATION Date of Change: __ __ / 01 / 20 __ __

HDS Subscriber Number: _____

Subscriber Name: _____ Subscriber Phone # () - _____

Section 2 | UPDATE TYPE

- Address / Email / Phone Change (Complete Section 3)
- Add / Remove Family Members (Complete Section 4)
- Other Changes to Information (Please specify) _____

Section 3 | RESPONSIBLE PARTY 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.*

Section 4 | PERSONS TO BE ADDED, REMOVED OR CHANGED

*Add	Remove	First Name	Last Name	Date of Birth (MM/DD/YYYY)	Relationship to Responsible Party (Self, Spouse or Dependent)	Sex (M/F)	Disabled Child (Y/N)
<input type="checkbox"/>	<input type="checkbox"/>			__ / __ / ____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__ / __ / ____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__ / __ / ____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__ / __ / ____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>			__ / __ / ____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

**Payment is required to process person(s) added to your plan.*

LAST NAME OF RESPONSIBLE PARTY: _____

SECTION 5 - MUST BE SIGNED TO AUTHORIZE REQUESTED CHANGES

Section 5 ACCEPTANCE OF TERMS AND CONDITIONS (REQUIRED)	
<p><i>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.</i></p>	
_____	_____
Responsible Party Signature (Required)	Date

Please mail the entire form 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