DELTA DENTAL
HDS
Hawaii Dental Service

EMPLOYEE ENROLLMENT FORM

OAHU: PHONE: 529-9230 FAX: 529-9207
TOLL FREE: 1-844-829-3256 1-866-590-7989
MembershipServices@HawaiiDentalService.com

A. Group Information

To be completed by the Group Administrator **PLEASE PRINT LEGIBLY**

Group/Division # / Group Name

Contact Name Contact Phone # - - ext

B. Employee

This section must be completed.

EFFECTIVE DATE / / 20 EMPLOYEE IDENTIFICATION NUMBER BIRTHDATE (MM/DD/YYYY) / / SEX ☐ M ☐ F

LAST NAME

FIRST NAME/MIDDLE INITIAL

MAILING ADDRESS APT/UNIT NUMBER

CITY STATE ZIP CODE PHONE NUMBER ( ) -

EMAIL ADDRESS

C. Family Members

Please attach a separate sheet for additional dependent(s).
Be sure to include the eligible **employee's identification number** and **name** when attaching additional sheets.

BIRTHDATE (MM/DD/YYYY) / /

RELATION ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Civil Union

SEX ☐ M ☐ F

☐ Full-time student ☐ Disabled Child

LAST NAME

FIRST NAME/MIDDLE INITIAL

BIRTHDATE (MM/DD/YYYY) / /

RELATION ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Civil Union

SEX ☐ M ☐ F

☐ Full-time student ☐ Disabled Child

LAST NAME

FIRST NAME/MIDDLE INITIAL

BIRTHDATE (MM/DD/YYYY) / /

RELATION ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Civil Union

SEX ☐ M ☐ F

☐ Full-time student ☐ Disabled Child

LAST NAME

FIRST NAME/MIDDLE INITIAL

D. Authorization

I certify that the information provided is true, correct and meets the terms and conditions of the HDS Agreement.

Group Administrator Signature

Date