

# Hawaii Dental Service ENROLLMENT/CHANGE FORM

HDS Use Only	
Date Processed	Processed By

**A. Group / Contact Information** To be completed by the Group Administrator PLEASE PRINT LEGIBLY

Group/Division #  /  Group Name  Email Address

Contact Person  Contact Phone #  -   ext

**B. Eligible Employee** This section must be completed PLEASE PRINT LEGIBLY (leave a blank box between each word)

Enroll  Terminate  Change / Correct Information

Effective Date of Change  /  / 20  Social Security Number  -  -  Date of Birth  /  /  Sex  M  F

Group Transfer

Fr:  /  Group #  Division #

To:  /

Last Name

First Name  MI

Address  Check here if this is a new address  Apt #

City  State  Zip Code  Phone Number  (  )  -

**C. Eligible Dependents** Please attach a separate sheet for additional dependent(s). Be sure to include the Eligible Employee's Social Security Number and Name when attaching additional sheets.

Enroll  Terminate  Correct Information

Reason For Change:  
 Open Enrollment  Loss of Coverage  
 Probation  Newborn  
 Full-time Student  Disabled  
 Marriage (Date): \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Legal Guardianship / Adoption

Effective Date of Change  /  / 20  Social Security Number  -  -  Date of Birth  /  /  Relationship  Spouse  Domestic Partner  Child

Last Name

First Name  Sex  M  F

Enroll  Terminate  Correct Information

Reason For Change:  
 Open Enrollment  Loss of Coverage  
 Probation  Newborn  
 Full-time Student  Disabled  
 Marriage (Date): \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Legal Guardianship / Adoption

Effective Date of Change  /  / 20  Social Security Number  -  -  Date of Birth  /  /  Relationship  Spouse  Domestic Partner  Child

Last Name

First Name  Sex  M  F

**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 \_\_\_\_\_