



Hawaii Dental Service ENROLLMENT/CHANGE FORM

HDS Use Only

FORM NO. FAFMS0004 (11/07)

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	Effective Date of Change	Social Security Number	Date of Birth	Sex
Change / Correct Information		<input type="text"/> / <input type="text"/> / 2 0 <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	M F
Group Transfer		Last Name <input type="text"/>			
Fr: <input type="text"/> / <input type="text"/>		First Name <input type="text"/> MI <input type="text"/>			
To: <input type="text"/> / <input type="text"/>					

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	Effective Date of Change	Social Security Number	Date of Birth	Relationship
Reason For Change:			<input type="text"/> / <input type="text"/> / 2 0 <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	Spouse Domestic Partner Child
Open Enrollment		Loss of Coverage	Last Name <input type="text"/>			
Probation		Newborn	First Name <input type="text"/>			
Full-time Student		Disabled				
Marriage			Sex M F			
(Date): __/__/__						
Legal Guardianship / Adoption						

<input type="checkbox"/> Enroll	<input type="checkbox"/> Terminate	<input type="checkbox"/> Correct Information	Effective Date of Change	Social Security Number	Date of Birth	Relationship
Reason For Change:			<input type="text"/> / <input type="text"/> / 2 0 <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	Spouse Domestic Partner Child
Open Enrollment		Loss of Coverage	Last Name <input type="text"/>			
Probation		Newborn	First Name <input type="text"/>			
Full-time Student		Disabled				
Marriage			Sex M F			
(Date): __/__/__						
Legal Guardianship / Adoption						

D. Authorization I certify that the information in this form is true, correct and meets the terms and conditions of the HDS Agreement.

Group Administrator Signature _____ Date _____