HDS
Hawaii Dental Service
DELTA DENTAL®

ENROLLMENT FORM

SUBSCRIBER INFORMATION

1. SOCIAL SECURITY NO.	2. LAST NAME FIRST MIDDLE INITIAL	3. ELIGIBILITY DATE *(completion by Group Administrator)* / 01 / MO DAY YEAR
4. EMPLOYED DATE / / MO DAY YEAR	5. MAILING ADDRESS CITY STATE ZIP CODE	
6. NAME OF GROUP/DIVISION	7. GROUP/DIVISION NUMBER	
8. MARITAL STATUS (circle one) SINGLE MARRIED	9. SEX (circle one) MALE FEMALE	10. BIRTHDATE / / MO DAY YEAR
11. HOME PHONE NO. ( ) -		

SPOUSE INFORMATION

(Complete boxes #12 - 15 only if spouse will be enrolled)

12. LAST NAME FIRST MIDDLE INITIAL	13. BIRTH DATE / / MO DAY YEAR	14. SOCIAL SECURITY NUMBER - -	15. SEX (circle one) M F

DEPENDENT INFORMATION

(Complete boxes #16 - 40 only if dependent will be enrolled)

16. LAST NAME FIRST MIDDLE INITIAL	17. SOCIAL SECURITY NO. - -	18. BIRTH DATE / / MO DAY YEAR	19. SEX (circle one) M F	20. STATUS (if applicable, circle one) FULL TIME STUDENT DISABLED
21. LAST NAME FIRST MIDDLE INITIAL	22. SOCIAL SECURITY NO. - -	23. BIRTH DATE / / MO DAY YEAR	24. SEX (circle one) M F	25. STATUS (if applicable, circle one) FULL TIME STUDENT DISABLED
26. LAST NAME FIRST MIDDLE INITIAL	27. SOCIAL SECURITY NO. - -	28. BIRTH DATE / / MO DAY YEAR	29. SEX (circle one) M F	30. STATUS (if applicable, circle one) FULL TIME STUDENT DISABLED
31. LAST NAME FIRST MIDDLE INITIAL	32. SOCIAL SECURITY NO. - -	33. BIRTH DATE / / MO DAY YEAR	34. SEX (circle one) M F	35. STATUS (if applicable, circle one) FULL TIME STUDENT DISABLED
36. LAST NAME FIRST MIDDLE INITIAL	37. SOCIAL SECURITY NO. - -	38. BIRTH DATE / / MO DAY YEAR	39. SEX (circle one) M F	40. STATUS (if applicable, circle one) FULL TIME STUDENT DISABLED

(If you or any of your family members have any other dental coverage, please complete #41 - 60)

41. LAST NAME FIRST MIDDLE INITIAL	42. CARRIER NAME	43. PLAN I.D. NUMBER	44. COVERAGE EFFECTIVE DATE / / MO DAY YEAR
45. LAST NAME FIRST MIDDLE INITIAL	46. CARRIER NAME	47. PLAN I.D. NUMBER	48. COVERAGE EFFECTIVE DATE / / MO DAY YEAR
49. LAST NAME FIRST MIDDLE INITIAL	50. CARRIER NAME	51. PLAN I.D. NUMBER	52. COVERAGE EFFECTIVE DATE / / MO DAY YEAR
53. LAST NAME FIRST MIDDLE INITIAL	54. CARRIER NAME	55. PLAN I.D. NUMBER	56. COVERAGE EFFECTIVE DATE / / MO DAY YEAR
57. LAST NAME FIRST MIDDLE INITIAL	58. CARRIER NAME	59. PLAN I.D. NUMBER	60. COVERAGE EFFECTIVE DATE / / MO DAY YEAR

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE: (sign below)

61. SUBSCRIBER SIGNATURE	62. SIGNATURE DATE / / MO DAY YEAR
63. AUTHORIZED SIGNATURE	64. SIGNATURE DATE / / MO DAY YEAR

(See reverse side for instructions on how to complete the Enrollment Form)

WHITE COPY - HDS; YELLOW COPY - EMPLOYER; PINK COPY - SUBSCRIBER

HOW TO COMPLETE THE HDS ENROLLMENT FORM

BLOCK NUMBER	BLOCK NAME	DESCRIPTION
SUBSCRIBER INFORMATION (complete blocks #1 - 11)		
1	SOCIAL SECURITY NO.	Enter the subscriber's (employee) social security number. This is the identification number for all claims information.
2	NAME	Enter the subscriber's last name, first name and middle initial.
3	ELIGIBILITY DATE	**TO BE COMPLETED BY AN AUTHORIZED GROUP REPRESENTATIVE.** Enter the enrollee's eligibility start date.
4	DATE EMPLOYED	Enter the subscriber's hire date.
5	MAILING ADDRESS	Enter the subscriber's mailing address.
6	NAME OF GROUP/DIVISION	Enter the subscriber's group and division name.
7	GROUP/DIVISION NUMBER	Enter the subscriber's group and division number.
8	MARITAL STATUS	Circle 'married' or 'single'.
9	SEX	Circle appropriate sex of subscriber - male or female.
10	BIRTH DATE	Enter the subscriber's birth date.
11	HOME PHONE NO.	Enter the subscriber's home phone number.
SPOUSE INFORMATION (complete blocks #12 - 15 if spouse will be covered)		
12	NAME	Enter the subscriber's spouse last name, first name and middle initial if employee's spouse is to receive benefits under this plan. Leave blank if spouse **will not** be covered.
13	BIRTH DATE	Enter the spouse's birth date.
14	SOCIAL SECURITY NUMBER	Enter spouse's social security number.
15	SEX	Circle 'M' for male or 'F' for female.
DEPENDENT INFORMATION (complete blocks #16 - 40 if dependent(s) will be covered)		
16, 21, 26, 31, 36	NAME	Enter the subscriber's dependent last name, first name and middle initial if they will be covered. If dependent will not be covered, leave blank..
17, 22, 27, 32, 37	SOCIAL SECURITY NUMBER	Enter the dependent's social security number.
18, 23, 28, 33, 38	BIRTH DATE	Enter the dependent's birth date.
19, 24, 29, 34, 39	SEX	Circle 'M' for male and 'F' for female for the dependent.
20, 25, 30, 35, 40	STATUS	Circle 'full-time student' or 'disabled' if applicable for the dependent.
OTHER COVERAGE INFORMATION (complete blocks #41 - 60 if subscriber, spouse and/or dependent has other coverage)		
41, 45, 49, 53, 57	NAME	Enter the name of the subscriber, spouse and/or dependent who has another dental coverage.
42, 46, 50, 54, 58	CARRIER NAME	Enter the other coverage carrier name.
43, 47, 51, 55, 59	PLAN ID NUMBER	Enter the other plan's identification number.
44, 48, 52, 56, 60	COVERAGE EFFECTIVE DATE	Enter the other coverage's effective date.
61	SUBSCRIBER SIGNATURE	Signature of the subscriber.
62	DATE	Date of form completion by the subscriber.
63	AUTHORIZED SIGNATURE	Group Administrator's signature.
64	DATE	Date Group Administrator reviewed and approved the form.