

Guaranty Assurance Company
DINA Dental Plan
12946 Dairy Ashford, Suite 360
Sugar Land, TX 77478



DINA Dental Plan™
Customer Service (866) 436-3093
Billing (866) 436-3093
Agent/Brokers (800) 376-3462

Application for Membership and Dental Insurance ~ PPO Plan
Louisiana State Employees and Retirees ONLY

Last Name:

First Name:

Middle Initial:

Mailing Address:

City:

State:

Zip:

Phone:

SSN:

Date of Birth:

Male ☐
Female ☐

Employer:

Work Phone:

Date of Hire:

Date of Termination (if cancelling):

Effective Date :

Notes:

Policy Type

Enrollment Status

PPO Plan

Group ☐
Individual ☐

Individual/Employee Only
Individual/Employee + One
Individual/Employee + Family

☐ \$18.40
☐ \$34.95
☐ \$55.20

Include coverage for the listed dependents. Unmarried children up to age 25 may be covered as a dependent.

Dependents	First, Middle Initial, Last Name	Social Security Number	Date of Birth	Male	Female
Spouse				<input type="checkbox"/>	<input type="checkbox"/>
▪ Child				<input type="checkbox"/>	<input type="checkbox"/>
▪ Child				<input type="checkbox"/>	<input type="checkbox"/>
▪ Child				<input type="checkbox"/>	<input type="checkbox"/>
▪ Child				<input type="checkbox"/>	<input type="checkbox"/>
▪ Child				<input type="checkbox"/>	<input type="checkbox"/>
▪ Child				<input type="checkbox"/>	<input type="checkbox"/>

Do you or any dependents listed above have other dental insurance coverage? Yes ☐ No ☐

Membership in the DINA Dental Plan and dental insurance is requested for all persons named in this application. Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Applicant's Signature: _____

Date Signed: _____

Agent's Signature: _____

DINA Agent # _____

Takeover: Yes ☐ No ☐ Prior Carrier & Expiration Date: _____

Premium Payment Mode (Select Only One)

(Individuals must pay 6 months, 12 months, or monthly bank draft. Payroll deduction available for groups only.)

Monthly Options: (Bank Draft & Credit Card Only)					Other Options:		
Payroll Deduction:	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Quarterly	Semi-Annually	Annually
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Company Use Only

Group #

Dentist #

Dentist's Name:

Certificate #

Mode Premium \$

Monthly Premium \$

Amount Paid with App \$