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

DINA Dental Plan™

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

Application for Membership ~ Prepaid 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	Prepaid Plan	Name of Selected Dentist Using the DINA Dental Network of Providers
	Individual or Employee Only	☐ $12.00	
Group ☐	Individual or Employee + One	☐ $19.50	
Individual ☐	Individual or Employee + Family	☐ $26.00	_____

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				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐

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

Membership in the DINA Dental Prepaid Plan 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)	Bank Draft ☐	Credit Card ☐	Other Options:		
Payroll Deduction: Weekly ☐	Bi-Weekly ☐	Semi-Monthly ☐	Monthly ☐	Quarterly ☐	Semi-Annually ☐	Annually ☐

Company Use Only

Group #	Dentist #	Dentist's Name:	Certificate #
Mode Premium $	Monthly Premium $	Amount Paid with App $	