

DINA Dental Plan™
 Guaranty Assurance Company
 101 Parklane Blvd, Ste 301
 Sugar Land, TX 77478



DINA Dental Plan™
 Customer Service: 866-436-3093
 Marketing: 800-376-3462
 Fax application to: 832-415-0131

Application for Membership
PREPAID PLAN

Last Name:		First Name:		Middle Initial:	
Mailing Address:					
City:			State:	Zip:	
Phone:	Social Security Number:		Date of Birth:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Employer:			Work Phone:		

Policy Type	Enrollment Status	Prepaid Plan	Name of Selected Dentist
Group <input type="checkbox"/>	Individual or Employee	<input type="checkbox"/> \$13.00	_____
Individual <input type="checkbox"/>	Individual or Employee + One	<input type="checkbox"/> \$21.00	
	Individual or Employee + Family	<input type="checkbox"/> \$28.00	

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				<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 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.

Applicant's Signature: _____ Date Signed: _____
 Agent's Signature: _____ DINA Agent # _____
 Takeover: Yes No Prior Carrier & Expiration Date: _____

Premium Payment Mode (Select Only One)

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

Company Use Only

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