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 (Discount) Plan 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:** _____

Individual Prepaid Plan / Rates		Group Prepaid Plan / Rates	
Individual Only	☐ $13.00	Employee Only	☐ $13.00
Individual + 1	☐ $21.00	Employee + 1	☐ $21.00
Individual + 2 or 3	☐ $28.00	Employee + Family	☐ $28.00
Individual + 4 or More	☐ $32.00		

Name of Selected Dentist Using the DINA Dental Network of Providers
_____

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) ~ Include 1st month's premium & bank draft or credit card form.
(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
	☐	☐

Payroll Deduction:	Weekly	Bi-Weekly	Semi-Monthly	Monthly
	☐	☐	☐	☐

Other Options:		
Quarterly	Semi-Annually	Annually
☐	☐	☐

Company Use Only

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