DINA Dental Plan™
Guaranty Assurance Company
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

DINA Dental Plan™
Marketing: 225-291-3172
~ or ~ 800-376-3462
Fax: 225-292-3075

Group ☐Passive PPO or ☐Indemnity Plan

Application for Membership & Dental Insurance

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 Requested: (Must be 1st of Month)

2 Tier Rating		Premium
E Only	☐	$
E + Family	☐	$

3 Tier Rating		Premium
E Only	☐	$
E + One	☐	$
E + Family	☐	$

4 Tier Rating		Premium
E Only	☐	$
E + Spouse	☐	$
E + Child/ren	☐	$
E + Family	☐	$

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 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) ~ 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 $	