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 Application to: 225-292-3075

Application for Group Dental Policy

(Plan Sponsor ~ Employer) _____ (Effective Date) _____

(Mailing Address) _____ (City) _____ (State) _____ (Zip Code) _____

(Telephone Number ~ Include Area Code) _____ (Contact Person) _____

(Fax # ~ Include Area Code) _____ (E-mail Address) _____ (Number of Eligible Members in Group) _____

Does the Group have a Cafeteria Plan? Yes ☐ No ☐ (Anniversary Month of Group's Plan Year) _____

Group Plan Type (Select Only One)

Prepaid Plan ☐ PPO Plan ☐ Indemnity Plan ☐

1. All eligible persons who are members of the group prior to the requested date of issue shall be eligible for coverage under the group policy as of the date of issue.
2. All eligible persons who become members of the group after the first day of the group's plan year shall be eligible for coverage on the first day of the month which will follow the completion of the number of continuous days of employment required by the plan's sponsor.

Coverage under this Group Policy will be offered to (Choose only 1): Employee Only ☐ Employee & Dependents ☐

Sponsor will contribute _____ % of the premium for (Choose only 1): Employee Only ☐ Employee & Dependents ☐

Sponsor will contribute _____ % of the premium for (Choose only 1): Employee Only ☐ Employee & Dependents ☐

Premiums will be paid by the plan sponsor in advance of each covered period. Choose only one option:

Monthly ☐ Quarterly ☐ Semi-Annually ☐

No agent has the authority to modify, enlarge, vary or waive any provision of the group policy which Guaranty Assurance Company will issue in connection with this application. It is agreed that Guaranty Assurance Company shall promptly refund any premium paid with this application if the group's policy is not issued for any reason or if it is returned within ten (10) days of receipt by the plan sponsor. Checks payable to DINA Dental Plan.

Application executed at _____ (Location of Office) this _____ (Day) day of _____ (Month) 20 _____ (Year)

_____ (Group Sponsor's Signature) _____ (Title)

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.

_____ (Agent's Signature) _____ (Agent Number)

Application accepted by: _____ (Guaranty Officer's Signature) _____ (Date Signed)

Group Number: _____ Premiums: ____/____/____/____

Group Number: _____ Premiums: ____/____/____/____