DINA DENTAL PLAN™

Group Retiree Payment Change Form

Employee Name: _____
SSN: _____
Address: _____
City: _____
State & Zip Code: _____
Monthly Premium: _____
Group Name: _____
Group Number: _____
Effective Date: _____

(This form and all necessary documentation must be received by the last day of the month in order to be effective on the 1st of the following month)

To DINA Dental:

Due to the fact that I have retired, please change my premium payment mode to the mode I have elected below:

Monthly Bank Draft from Checking Account:
(Drafted on the 5th of every month) ☐ (Complete Correct Form & Attach)

Monthly Bank Draft from Credit Card:
(Drafted on the 28th or 29th of every month) ☐ (Complete Correct Form & Attach)

Policyholder Signature: _____

Date: _____

Please make sure you notify your HR department!

Mail, Fax or E-mail Documents to:

Guaranty Assurance Company
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478

Fax (832) 415-0131

E-mail: ldouglas@nstci.com