

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



DINA Dental Plan™
 Customer Service: 866-436-3093
dina@fcdental.com
 Fax: 832-415-0131

An SED-4 Payroll Deduction form must accompany all applications.
Send both forms to: dina@fcdental.com or Fax: 832-415-0131

Application/Change Form for Membership and Dental Insurance

Louisiana State Employees and Retirees ~ Prepaid Plan

Last Name:		First Name:		Middle Initial:	
Mailing Address:					
City:			State:		Zip:
Phone:	SSN:	Date of Birth:		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Employer:		Agency No.:		Work Phone:	
Date of Hire:		Email:		Date of Termination (if cancelling)	

Effective Date: _____ **Notes:** _____

Enrollment Status	Prepaid Plan	Name of Selected Dentist Using the DINA Dental Network of Providers
Individual or Employee Only	<input type="checkbox"/> \$12.00	
Individual or Employee + One	<input type="checkbox"/> \$19.50	
Individual or Employee + Family	<input type="checkbox"/> \$26.00	

Include coverage for the listed dependents. Unmarried children up to age 26 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"/>

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.

Deductions from the applicant's payroll will begin on the next payroll run following the date of this application. If there is a gap between the applicant's effective date and payroll deduction date, DINA requires a payment to be submitted for coverage between the applicant's effective date and first payroll deduction date so that coverage can begin on the first of the month following the date of 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: _____

Semi-Monthly Payroll Deductions for Louisiana State Employees and Retirees

Payroll Deduction Start Date: _____ **Check the box below that corresponds to your pay structure:**
Amount of Deduction Per Pay Period: _____ 9 Month 10 Month 12 Month

Company Use Only

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