

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 ~ Passive PPO

Last Name:		First Name:		Middle Initial:	
Mailing Address:					
City:			State:	Zip:	
Phone:	SSN:	Date of Birth:		Male	Female
Employer: DELGADO		Agency No.:	Work Phone:		
Date of Hire:	Email:	Date of Termination (if cancelling):			

Effective Date: _____

Add _____

Delete _____

Change _____

Cancel _____

Other _____

Louisiana State Employees and Retirees Enrollment Status		Passive PPO Plan	
Employee Only	<input type="checkbox"/>	\$25.71	
Employee + Spouse	<input type="checkbox"/>	\$50.14	
Employee + Child/ren	<input type="checkbox"/>	\$60.93	
Employee + Family	<input type="checkbox"/>	\$84.12	

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 Plan and dental insurance 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: Kathy C. Penegy **DINA Agent #** 76001

Takeover: Yes No **Prior Carrier & Expiration Date:** _____

Semi-Monthly Payroll Deductions for Louisiana State Employees and Retirees

Check the box below that corresponds to your pay structure:

Payroll Deduction Start Date: _____

Amount of Deduction Per Pay Period: _____ 9 Month 10 Month 12 Month

Company Use Only

Group #	Certificate #
Mode Premium \$	Monthly Premium \$
	Amount Paid with App \$