

Guaranty Assurance Company  
 DINA Dental Plan  
 12946 Dairy Ashford, Ste 360  
 Sugar Land, TX 77478



DINA Dental Plan™  
 Customer Service (866) 436-3093  
 Billing (866) 436-3093  
 Agent/Brokers (800) 376-3462

## Group Indemnity Plan Only

### Application for Membership & Dental Insurance

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:			Work Phone:		
Date of Hire:			Date of Termination (if cancelling):		

**Effective Date Requested:**

(Must be 1<sup>st</sup> of Month)

2 Tier Rating	Premium
E Only <input type="checkbox"/>	\$
E + Family <input type="checkbox"/>	\$

3 Tier Rating	Premium
E Only <input type="checkbox"/>	\$
E + One <input type="checkbox"/>	\$
E + Family <input type="checkbox"/>	\$

4 Tier Rating	Premium
E Only <input type="checkbox"/>	\$
E + Spouse <input type="checkbox"/>	\$
E + Child/ren <input type="checkbox"/>	\$
E + Family <input type="checkbox"/>	\$

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				<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"/>
▪ 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. 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 1<sup>st</sup> 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 <input type="checkbox"/>	Credit Card <input type="checkbox"/>	Other Options:			
Payroll Deduction:	Weekly <input type="checkbox"/>	Bi-Weekly <input type="checkbox"/>	Semi-Monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Semi-Annually <input type="checkbox"/>	Annually <input type="checkbox"/>

**Company Use Only**

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