

Guaranty Assurance Company  
DINA Dental Plan  
11969 Bricksome Avenue  
Baton Rouge, LA 70816



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

### 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

- 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.
- 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 \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
(Location of Office) (Day) (Month) (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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_