

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

Application for Membership ~ Prepaid (Discount) Plan Only

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: _____ **Notes:** _____

Individual Prepaid Plan / Rates	Group Prepaid Plan / Rates	Name of Selected Dentist Using the DINA Dental Network of Providers
Individual Only <input type="checkbox"/> \$13.00	Employee Only <input type="checkbox"/> \$13.00	_____
Individual + 1 <input type="checkbox"/> \$21.00	Employee + 1 <input type="checkbox"/> \$21.00	
Individual + 2 or 3 <input type="checkbox"/> \$28.00	Employee + Family <input type="checkbox"/> \$28.00	
Individual + 4 or More <input type="checkbox"/> \$32.00		

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 Prepaid Plan 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 1st 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 <input type="checkbox"/>	Credit Card <input type="checkbox"/>	Other Options:		
(Bank Draft & Credit Card Only)				Quarterly <input type="checkbox"/>	Semi-Annually <input type="checkbox"/>	Annually <input type="checkbox"/>
Payroll Deduction:	Weekly <input type="checkbox"/>	Bi-Weekly <input type="checkbox"/>	Semi-Monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>		

Company Use Only

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