Benefits

For State Employees

David Dearie Insurance

Hi,

Thanks! Here is the application, payroll form and brochure for the insurance you requested. Complete the application and payroll form the best you can and send it to me. I'll check it and email you when I receive it.

You can send it to me either:

By mail: David Dearie, 3001 Jodie Place, Metairie, LA 70002

By fax: 504-717-4808 (faxes come directly to my email, so it is safe)

By email: Scan and send it to dearie@cox.net

Or call me, and I will come pick it up.

Thanks again,

David B. Dearie

David Dearie

504-616-3537 cell

504-717-4808 fax

DINA DENTAL PLAN

We have a plan to fit every smile.

Louisiana State Employees and Retirees

Prepaid Plan ~ Highlights

***NO Claim Forms** ***NO Deductibles**
***NO Maximums** ***NO Waiting Period**

Over 180 procedures covered by co-payments.

Must Select Dentist from Dina Network of Dentists

Network Includes Dentists Across the State of Louisiana

Operating in Louisiana Since 1978

Qualifies for Section 125 (Cafeteria Plan) Deductions

Special Premiums for State Employees and Retirees Only

Prepaid Plan Monthly Premiums

Employee Only	$12.00
Employee + One	$19.50
Employee + Family	$26.00

DINA DENTAL PLAN

We have a plan to fit every smile.

Louisiana State Employees and Retirees

Prepaid Plan ~ Benefits

*No Waiting Periods * No Deductibles * No Annual Maximums*

Diagnostic Procedures	Co-payment
Comprehensive oral exam	$ 47.00
Limited oral evaluation – problem focused	$ 33.00
Periodic exam – once every 6 months	$ 27.00
X-ray – intraoral – periapical - first film – once every 6 months	$ 15.00
X-ray – intraoral – occlusal – once every 6 months	$ 21.00
X-ray – extraoral – first film – once every 6 months	$ 15.00
X-ray – bitewing – 2 films – once every 6 months	$ 22.00
X-ray – intraoral – complete series – once every 36 months	$ 59.00
Diagnostic casts	$ 47.00

Preventive Procedures	Co-payment
Routine teeth cleaning – adult – once every 6 months	$ 48.00
Routine teeth cleaning – child – once every 6 months	$ 35.00
Fluoride treatment – child – once every 12 months	$ 20.00
Sealant – each tooth – once every 36 months	$ 26.00

Restorative Procedures	Co-payment
Amalgam filling – 1 surface – primary (baby) tooth	$ 64.00
Amalgam filling – 2 surface – primary (baby) tooth	$ 81.00
Amalgam filling – 3 surface – permanent tooth	$ 98.00
Resin filling – 1 surface – anterior (front tooth)	$ 75.00
Resin filling – 2 surface – anterior (front tooth)	$ 93.00
Resin filling – 3 surface – anterior (front tooth)	$115.00
Crown – porcelain-fused to predominately based metal	$525.00
Crown – porcelain-fused to high noble metal	$567.00
Crown – full cast – predominately based metal	$440.00
Core buildup – including any pins	$127.00
Temporary crown (fractured tooth)	$ 75.00
Root canal – Anterior (front tooth)	$350.00
Periodontal scaling and root planning-per quadrant	$ 96.00
Full mouth debridement for comprehensive periodontal evaluation	$ 86.00
Denture – complete upper or lower	$600.00
Immediate denture – upper or lower	$525.00
Upper partial – resin base – complete	$471.00
Add tooth to existing partial denture	$ 83.00
Extraction – single tooth	$ 64.00
Removal of impacted tooth – soft tissue	$150.00
Incision and drainage of abscess – intraoral soft tissue	$109.00

This is only a summary of over 180 dental services included in the plan (participating dentist must be used).

2018

Guaranty Assurance Company
A Life, Accident & Health Insurer
PO Box 40017
Baton Rouge, LA 70835-0017

DINA Dental Plan™

DINA Dental Plan ™
and
DINA Dental Network
1-800-376-DINA (3462)

Application for Membership
Louisiana State Employees and Retirees ONLY

Last Name:	First Name:	Middle Initial:
Mailing Address:	E Mail Address:	
City:	State:	Zip:
Phone:	Social Security Number:	Date of Birth: Male ☐ Female ☐
Employer:	Work Phone:	

Policy Type	Enrollment Status	Prepaid Plan	Name of Selected Dentist
	Individual or Employee	☐ $12.00	
Group ☒	Individual or Employee + One	☐ $19.50	
Individual ☐	Individual or Employee + Family	☐ $26.00	

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				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐
• Child				☐	☐

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.

Applicant's Signature: X _____ **Date Signed:** _____

Agent's Signature: _____ DINA Agent # 468

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

Premium Payment Mode (Select Only One)

Monthly Options: (Bank Draft & Credit Card Only)	Bank Draft	Credit Card	Other Options:		
Payroll Deduction: Weekly ☐	Bi-Weekly ☐	Semi-Monthly ☐	Monthly ☒	Quarterly ☐	Semi-Annually ☐	Annually ☐

Company Use Only

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

SED-4 (R 01/10)

Guaranty Assurance Company

P.O. Box 40017, Baton Rouge, LA 70835-0017
LOCAL (225) 291-3172 OR 1-800-376-DINA (3462)

State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. Sec. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $_____, monthly rate, from my salary until further notice and remit same to **Guaranty Assurance**. A TOTAL Semi-Monthly Deduction in the amount of $ _____ represents one half of the total monthly premium required for the coverage(s) detailed below.

The Office of State Uniform Payroll and the employing agency are **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the **employee and the vendor** to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to **both** the vendor **and** his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the ISIS HR payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee **and** the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART CD	PLAN PART YES	PLAN PART NO	125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
Dental (DINA)	23		N	Y	$	**NA**	$	
Dental (DINA)	23	P		Y	$	**PA**		$

	Total Mo. Prem.	$	
PP Begin Date	Total Semi-Mo. **Ineligible**		
	Total Semi-Mo. **Non-Part.**	$	
Date Authorized	Total Semi-Mo. **Part.**		$

By: _____
Employee Signature

TOTAL SEMI-MONTHLY $

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by: _____ (800)376-3462 _____
Guaranty Assurance Representative — Phone — Date

PO Box 40017, Baton Rouge, LA 70835-0017
Address