DINA DENTAL PLAN™

Retiree Payment Change Form

Employee Name: _____
SSN: _____
Address: _____
City: _____
State & Zip Code: _____
Monthly Premium: _____ **Phone:** _____
Group Name: _____ **Email Address:** _____
Group Number: _____
Effective Date: _____

(This form and all necessary documentation must be received by the last day of the month in order to be effective on the 1st of the following month)

To DINA Dental:

Due to the fact that I have retired, please change my premium payment mode to the option I have elected below:

Monthly Bank Draft:
(Drafted on the 5th of every month) ☐ *(Complete this form and Bank Draft Authorization Form)

Monthly Credit Card Draft:
(Drafted on the 28th of every month) ☐ *(Complete this form and Credit Card Payment Form)

Monthly Draft from LASERS ☐ (Complete this form only)

Monthly Draft from TRSL ☐ (Complete this form only)

*To print Bank Draft and Credit Card Payment Forms: Go to MENU > FORMS > AUTHORIZATIONS. Select and print the payment form needed.

Policyholder Signature: _____

Date: _____

Please make sure you notify your HR Department!

Mail, Fax or E-mail Documents to:

Guaranty Assurance Company
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478

David and Robert Dearie
504-616-3537 504-236-8997
504-717-4808 FAX